Clinical Practice in Long Term Care

Psychosocial Assessment of Nursing Home Residents via MDS 3.0: Recommendations for Social Service Training, Staffing, and Roles in Interdisciplinary Care

Kelsey Simons PhD, MSWa,+, Robert P. Connolly MSW, LCSW-Cb, Robin Bonifas MSW, PhDc, Priscilla D. Allen PhD, MSWd, Kathleen Bailey PhD, MSWe, Deirdre Downes MSW, LCSWf, Colleen Galambos PhD, MSWg

a Baycrest, Kunin Lunenfeld Applied and Evaluative Research Unit, University of Toronto, Factor Inwentash Faculty of Social Work, Toronto, Canada
b Consultant (Retired from the Centers for Medicare & Medicaid Services, Ellicott City, MD)
c Arizona State University, School of Social Work, Phoenix, AZ
d Louisiana State University, School of Social Work, LSU Life Course and Aging Center, Baton Rouge, LA
e Bridgewater State University, School of Social Work, Bridgewater, MA
f Jewish Home Lifecare, New York, NY
g University of Missouri, School of Social Work, Columbia, MO

Keywords:
Psychosocial assessment
social work
MDS 3.0
nursing home quality

Abstract

The Minimum Data Set 3.0 has introduced a higher set of expectations for assessment of residents’ psychosocial needs, including new interviewing requirements, new measures of depression and resident choice, and new discharge screening procedures. Social service staff are primary providers of psychosocial assessment and care in nursing homes; yet, research demonstrates that many do not possess the minimum qualifications, as specified in federal regulations, to effectively provide these services given the clinical complexity of this client population. Likewise, social service caseloads generally exceed manageable levels. This article addresses the need for enhanced training and support of social service and interdisciplinary staff in long term care facilities in light of the new Minimum Data Set 3.0 assessment procedures as well as new survey and certification guidelines emphasizing quality of life. A set of recommendations will be made with regard to training, appropriate role functions within the context of interdisciplinary care, and needs for more realistic staffing ratios.

Introduction of the new Minimum Data Set 3.0 (MDS 3.0), as part of the broader Resident Assessment Instrument, presents a major change in the clinical assessment of residents in US nursing homes and is a major leap forward in its engagement of residents in reporting quality of life needs and concerns. Developed and implemented in response to the Nursing Home Reform Act of 1987,1 the MDS is a federally mandated, standardized assessment tool for all nursing homes certified for Medicare and Medicaid payments. It informs treatment planning, provides a payment mechanism to homes for reimbursement of care, and provides indicator data that is used to monitor system-wide quality. Stated goals for this latest version are “to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase user satisfaction, and increase the resident’s voice by introducing more resident interview items.”2 (pp1–10) Table 1 details changes in MDS 3.0 most relevant to psychosocial care, including direct interview items for cognition, mood, customary routines and preferences, and goal setting, that are designed to better engage the resident in assessment and care planning. For more information regarding development of the MDS 3.0 and these changes, please see the RAND Corporation’s April 2008 report (Development and Validation of Revised Nursing Home Assessment Tool).3

The purpose of this article is to draw attention to the social work and social service role in psychosocial assessment of nursing home residents via MDS 3.0. Social workers are primary providers of psychosocial services in this setting, attending to both residents and their family members’ needs and concerns.7 Preliminary
Table 1
Changes in Resident Psychosocial Assessment – MDS 2.0 to MDS 3.0

<table>
<thead>
<tr>
<th>Domain</th>
<th>MDS 2.0 Items</th>
<th>New MDS 3.0 Items</th>
<th>Key Changes</th>
</tr>
</thead>
</table>
| Customary Routine and Activity Preference Psychosocial well-being | Section AC: Staff observation of resident routines only upon admission. Section F: Staff observation of presence or absence of indicators related to residents’ sense of initiative or involvement, unsettled relationships, and identification with past roles and activities. | Section F: Direct resident interview or staff assessment regarding daily routines and activity preferences, which replaces MDS 2.0 Customary Routine and some Psychosocial Well-being items. | • A new preference assessment tool allows staff to obtain resident importance ratings for daily customary routine and for activities. 
• MDS 3.0 Section F is now required on all assessments except the discharge assessment to elicit resident voice/choice. 
• Psychosocial well-being also addressed in MDS 3.0 Mood and Behavior sections (see below). 
• BIMS performance-based assessment preferred for most residents who can participate. 
• BIMS and CAM are standardized instruments. 
• Staff observation mental status items are used only if BIMS interview cannot be completed. |
| Cognitive Patterns                      | Section B: Observational items of resident cognition and indicators of delirium. | Section C: (1) Direct resident interview using BIMS. (2) Staff observation of delirium symptoms using CAM. | • PHQ-9 staff interviews allow identification of changes in depression severity over time. 
• The PHQ-9 is a well-established, standardized instrument. 
• PHQ-9 OV is the staff assessment for residents who cannot be interviewed. 
• PHQ-9 replaces less reliable MDS 2.0 items used for RUGs payment. 
• MDS 3.0 wording of behavior items clearer and less negative. 
• MDS 3.0 behavior items demonstrated high kappa agreement with other gold standard measures of behavior and psychosis. 
• Revised items directly ask residents if they want information about long term care community options. 
• Promotes linkages and information exchange between nursing homes, local contact agencies, and community-based providers. 
• Promotes collaboration between nursing homes and local contact agencies. 
• Offers residents choices, care options, and available supports to meet care preferences and needs in the least-restrictive setting possible, consistent with the Americans with Disabilities Act (1990) and the Olmstead Supreme Court Decision (1999). |
| Mood and Behavior Patterns              | Section E: Observational items of depression and behavior patterns.           | Section D: Direct resident interview using PHQ-9.3,6 Section E: Revised behavior items aimed at identifying physical, verbal, and other behavioral symptoms of agitation along with their impact on the resident and others in the care environment. Also includes items to assess psychosis. | • Revised items directly ask residents if they want information about long term care community options. 
• Promotes linkages and information exchange between nursing homes, local contact agencies, and community-based providers. 
• Promotes collaboration between nursing homes and local contact agencies. 
• Offers residents choices, care options, and available supports to meet care preferences and needs in the least-restrictive setting possible, consistent with the Americans with Disabilities Act (1990) and the Olmstead Supreme Court Decision (1999). |
| Section Q                               | Section Q: Discharge Potential and Overall Status: Resident’s discharge potential and availability of support persons assessed by staff. | Section Q: Participation in Assessment and Goal Setting: New Return to Community Referral item asks residents if they are interested in speaking with someone about “the possibility of returning to the community.” Staff must (1) evaluate for discharge potential, (2) interview residents with discharge potential, and (3) actively partner with a local contact agency to educate the resident and family regarding community-based long term care options and effectuate the discharge. | • A new preference assessment tool allows staff to obtain resident importance ratings for daily customary routine and for activities. 
• MDS 3.0 Section F is now required on all assessments except the discharge assessment to elicit resident voice/choice. 
• Psychosocial well-being also addressed in MDS 3.0 Mood and Behavior sections (see below). 
• BIMS performance-based assessment preferred for most residents who can participate. 
• BIMS and CAM are standardized instruments. 
• Staff observation mental status items are used only if BIMS interview cannot be completed. |

BIMS, Brief Interview for Metal Status; CAM, Confusion Assessment Methods; MDS, Minimum Data Set; PHQ-9, Patient Health Questionnaire; PHQ-9 OV, Patient Health Questionnaire observational version; RUGs, resource utilization groups.

Research by Connolly et al found that nursing home social workers taking part in focus groups expressed discomfort with completion of the mood interview component of the MDS 3.0, particularly an item related to suicidal ideation, and with ability to access a limited pool of community resources given new items related to a resident’s potential for discharge. Social workers also reported large caseloads as a barrier to adequate psychosocial assessment as well as variations in clinical training opportunities for social service professionals that could limit roles in mental health and behavioral intervention. After examining the implications of current social service staffing realities in relation to the recently implemented MDS 3.0, recommendations will be made relative to the training, staffing, and appropriate roles for social service staff as key members of interdisciplinary care teams towards the ultimate goal of best practice psychosocial assessment and care planning in this setting.

Challenges to the Provision of Medically Related Psychosocial Services

Insufficient Regulation and Staffing

It is the opinion of the authors of this article that long-standing barriers to the provision of adequate social services may impede implementation of psychosocial aspects of the new MDS assessment procedures in long term care facilities. Of primary concern, current federal regulations do not provide adequate guidance regarding staffing of social workers (ie, staff with undergraduate or graduate degrees in social work) and social service staff, a term encompassing social service designees and others who lack formal training in social work. As stated in the Nursing Home Reform Act, homes certified for Medicare and Medicaid payments are required to provide “medically related social services to attain or maintain
the highest practicable resident physical, mental and psychosocial well-being"; yet only homes with more than 120 beds are required to staff a full-time qualified social worker. Homes with fewer than 121 beds may have the discretion to hire part-time or consultant social service staff depending on individual state’s interpretation of this regulation. The US Code of Federal Regulations (42 CFR 483.15) describes a qualified social worker as having (1) a bachelor’s degree in social work or human services field such as sociology, special education rehabilitation counseling, and psychology and (2) 1 year of supervised social work experience in a health setting.

How these requirements are regulated and enforced at the state level is also a concern. Bern-Klug identified large discrepancies in state administrative codes and oversight relative to regulation of social service delivery in long term care facilities in her review. She found 8 states to be out of compliance with federal regulations in this area and most states were providing exceptions to hiring qualified social service professionals as per federal requirements.

The weakness of federal regulations relative to the staffing of social service professionals paired with inconsistent enforcement at the state level has encouraged broad variation in the training and credentialing of such staff. In the most definitive study of this topic, Bern-Klug et al. found that most US nursing homes (> 90%) staff at least 1 part-time social service worker, including homes with fewer than 121 beds; however, training and credentials of such staff varied greatly. The most common degree among social service directors (n = 1071) was a bachelor’s in social work (30.6%), followed by, in descending order, bachelor’s degrees that were not in social work (24%), masters in social work degrees (17.2%), a high school or GED degree (14%), a master’s in a field other than social work (8%), and an associate’s degree (6.1%). Consistent with these results, fewer than half (38.8%) of social service directors Bern-Klug et al. surveyed possessed a license in social work.

Additional concerns exist regarding the ability of social work and social service staff to adequately serve the number of residents typically assigned to them. Simons identified social service directors in homes with 121 beds or more as having an average of 90 residents on their caseload (SD = 47.9, range 0–300), with a mode of 120 residents per director, reflecting the federal requirement for 1 full-time social service staff in these larger facilities. Bern-Klug et al. found the mean number of residents per full-time equivalent (FTE) social service staff was 89.3 in homes with 3 or fewer social service staff. The median number was 79 residents; however, there was a tri-modal distribution of scores with the most frequent ratio being 120 residents per social worker.

A survey of Washington State facilities’ social service directors identified caseloads of 72.88 residents on average (SD = 34.67, range 4–180), with directors in for-profit homes reporting significantly larger caseloads (P < .001). It should be noted, federal regulations pertaining to staffing of social workers in long term care facilities have remained the same since implementation of the Nursing Home Reform Act despite a substantial increase in the number of residents with mental illness, especially depression.

Quality Concerns

The US Department of Health and Human Services Inspector General investigated issues with quality of psychosocial services among residents whose care was reimbursed through Medicare Part A, suggesting a population that was newly admitted and receiving skilled nursing care or physical rehabilitation services. Their subsequent report identified 39% of residents with psychosocial needs having inadequate care plans to meet those needs. Insufficient staffing, burdensome paperwork, and lack of time were reasons cited by social service staff as limiting their ability to provide effective care. Zhang et al. identified fewer deficiencies in psychosocial care in homes staffing greater numbers of qualified social service and mental health staff. Although there is no evidence-based standard for what constitutes a manageable caseload for social workers in long term care, social service providers have reported that a manageable caseload is, on average, 60 or fewer long term care residents or 20 or fewer subacute care residents.

The Ambiguous Role of Nursing Home Social Service Provider

The scope of practice and subsequent roles of a nursing home social service provider are not always well defined, creating a potential for limited organizational influence in matters pertaining to residents’ quality of life and lack of focus on clinical care roles, described by Allen and her colleagues as “inappropriate job emphasis.” This, in turn, may limit social service staff involvement in interdisciplinary psychosocial assessment via MDS 3.0. Although the function of the nursing home social service provider is tied to broad clinical functions related to quality of life outcomes and medically related psychosocial services in federal code, social service staff in many facilities are relegated to roles that fulfill the instrumental needs of residents, such as finding lost personal items, arranging for transportation services, and obtaining specialty provider care. They may also perform as Admissions staff, fulfilling a basic financial function in the home. Although these are certainly important tasks that can contribute to residents’ quality of life, they do not necessarily require specialized education or training in social work, family systems work, or mental health. It is more likely that such roles fall to social service staff who lack adequate training to provide clinical services or do not understand or clearly articulate their role at the facility, allowing the work environment itself, including preexisting precedent, to shape the nature of their work.

Fogler addressed role ambiguity in terms of social workers needing to simultaneously balance the needs of residents, the economic needs of the organization, and their role in policy reform initiatives at the national, state, and local levels. Bern-Klug et al. suggested the possibility of two provider roles: a social work (clinical) role and a social services (non-clinical) role, comparable to those of the registered nurse and certified nurse aide. With new pressures for discharge of long-stay residents to the community and Patient Health Questionnaire (PHQ)-9 items now part of the nursing home’s resource utilization groups (RUGs) payment, nursing home social workers are confronted with ethical dilemmas about how to best meet client needs within a framework of payment, reform, and regulation.

Need for Increased Interdisciplinary Psychosocial Training

As all staff are involved in psychosocial assessment and care, with the potential for multiple disciplines completing psychosocial items on the MDS 3.0, there is a need to improve the psychosocial assessment and intervention skills of the entire interdisciplinary team, beginning with the social service staff who are typically lead providers in this area. First, as social service staff most often have bachelor’s degrees, either in social work or other fields, efforts should be targeted toward preparing professionals at this stage in their career. However, psychosocial portions of the MDS 3.0 may be completed by different disciplines other than social services. For example, nursing may complete the interviews for cognition and pain, whereas recreation activity staff often complete the preference items, suggesting the need for all clinical staff to have competencies in psychosocial assessment. Finally, care planning and interventions, drawing on MDS 3.0 assessment information, require coordination and skills by front-line staff, including the
certified nurse assistants who most regularly interact with resi-
dents and who are observers of resident psychosocial status across
shifts.

Training and education are vital to effective team functioning and the roll out of the MDS 3.0; yet, nursing home team members may have differing perspectives as to their roles, the roles of their colleagues, and the role of the resident and family caregivers. In support of quality psychosocial services, all members of the care team need to be trained to work effectively and collaboratively, and to articulate their role clearly to other team members. Rubin and Beckhard identified key factors influencing how well teams work together: establishing clear goals, agreeing on clear role expectations, creating flexible decision-making processes, maintaining a flexible approach to decision making, maintaining open communication patterns, and leadership and the ability of the team to “treat itself,” or in other words, resolve its own barriers in effective teamwork.

Although this is a critical component of nursing home social work and students are often exposed to interdisciplinary collabora-
tion through fieldwork, there is less knowledge of how it is being taught across the social work curriculum. Learning to work as an effective team member is a skill that needs to be developed through the coordination of classroom and field education with different disciplines learning as a unit. Collaborative case studies, problem solving, and conflict management can be integrated into a learning curriculum to guide the development of teamwork through pro-
grams such as the John A. Hartford–funded Geriatric Interdisci-
plinary Team Training Program.

Clinical Training Needs

Increase Competencies for Dementia, Delirium, and Depression

Guidelines put forth by the American Geriatrics Society and the American Association of Geriatric Psychiatry convey the impor-
tance of psychosocial approaches to address the mental health needs of individuals living in long term care settings. To support
greater clinical training of social workers, social service staff, and interdisciplinary staff engaged in psychosocial assessment and care, we recommend increased training relative to 3 disorders that are highly prevalent in nursing homes: (1) Alzheimer’s disease and other dementias; (2) depression, often a comorbid condition with Alzheimer’s disease; and (3) delirium, a disorder that can be diffi-
cult to diagnose. Readers are also referred to the American Medical
Directors Association’s Clinical Practice Guidelines in these areas.

Alzheimer’s Disease and Other Dementias

Interviewing in the context of the cognitive limitations associ-
ated with a dementing illness requires special skill. Although
dividuals with cognitive impairment may be able to respond to many questions on the MDS 3.0, as was noted by RAND re-
searchers, care must be taken to determine the accuracy of these self-reported responses. As such, it will be critical for social service providers, as well as any staff involved in cognitive assessment, to be prepared to incorporate observational assessments as a secondary source of data. To do so requires training and skills development in effective communication with individuals with dementia. Furthermore, it is vital for all staff to also understand residents’ cognitive strengths in the context of those limitations identified by the Brief Interview for Mental Status (BIMS), which can help ensure residents’ voices are heard as much as possible.

Along with developing interviewing skills appropriate for indi-
viduals with cognitive deficits, knowledge regarding psychosocial intervention in dementia is necessary and requires a keen under-
standing of the neurological processes associated with the condition. Recognizing this, some states, including Louisiana, recently passed legislation in conjunction with the MDS 3.0 mandating dementia training for nursing home staff. Behavioral
symptoms of Alzheimer’s disease, such as resisting care, repetitive
vocalizations, and wandering, vary by the stage of the disease. The
BIMS provides an initial step in identifying basic cognitive limita-
tions, but is not sufficient for Alzheimer’s dementia staging, which
must be considered in both individualized care planning and the
environment of care. The Global Deterioration Scale and the
Functional Assessment Staging Tool are 2 suggested instruments that can further assist in staging.

MDS 3.0 also prompts staff to screen for factors potentially contribut-
ing to the occurrence of such symptoms. For quality of life and person-centered care, it will be vital for staff engaged in completing this section to possess behavioral assessment skills. For example, the need-driven dementia-compromised behavioral
model indicates situational factors play a primary role in behav-
ioral symptoms. Critical assessment areas include physiological need states (ie, pain, fatigue), psychological need states (ie, fear, anxiety), and characteristics of the social environment (ie, chaotic noise). In addition, staff need to be apprised of residents’ baseline behavior, medications, and acute and chronic conditions that may affect well-being.

Depression and Depression Secondary to Dementia

Inclusion of the PHQ-9 significantly enhances the depression screening capacity of the comprehensive assessment process in nursing home settings, yet the measure is also not without limi-
tations. For instance, although an observational version is included for use with residents who have cognitive and communication impairments, this version may not capture depressive symptoms in the context of moderate to severe dementia as well as other depression screening tools developed specifically for the dementia population. Similarly, the PHQ-9 may not be the best choice for assessing depression among ethnically diverse residents. Sympt-
toms of anxiety are often comorbid with depression among the older adult population and may be overlooked if mood assess-
ment relies exclusively on the PHQ-9.

Given these potential drawbacks, it will be essential for staff completing these items to recognize when residents may need further assessment of depressive symptoms beyond the MDS 3.0 so as to develop an effective care plan. Familiarity with supplementary
depression screening and other mood assessment tools is critical.
The following are recommended components for the social worker’s depression assessment inventory: the Cornell Scale for
Depression in Dementia, the Hamilton Anxiety Inventory, the
Geriatric Depression Scale, a depression assessment tool found to be culturally relevant for Latino elders, and the Indian Depression Schedule.

As noted earlier, the PHQ-9 contains 1 item designed to screen for suicidal ideation. Because nursing home social service providers have expressed discomfort asking this particular question, it follows that additional training regarding late-life suicide is warranted. Further knowledge needed includes how to conduct a suicide risk assessment and the range of interventions to put into place depending on assessment results. A comprehensive under-
standing of suicide prevention resources available in the commu-
nity is also crucial. Reiss and Tishler’s 2008 article “Suicidality in
nursing home residents: Part I. Prevalence, risk factors, methods, assessment, and management” is an excellent resource for care providers to advance their learning in this area.

Delirium

Delirium is common among older adults, but is often unrecog-
nized in clinical settings. Indeed, evidence suggests 7 out of 10
The MDS 3.0 includes the Confusion Assessment Method (CAM), a measure with high sensitivity and specificity in detecting delirium, which should enable nursing home staff to more effectively identify this condition. Family members can recognize delirium-related mental status changes in their loved one nearly 100% of the time; therefore, it is imperative that staff are familiar not only with CAM, but with strategies for asking family members about changes in their loved ones’ mental status. The Hartford Institute for Geriatric Nursing’s “try this” feature has helpful guidance for administering the CAM.

Increase Skills for Discharge Planning and Care Transitions

Consistent with Money Follows the Person programs and efforts at the state level to rebalance the long term care system, the MDS 3.0 Section Q requires that social workers and interdisciplinary staff discuss transition needs for long-stay residents. Although the nursing home’s discharge focus has been primarily for the Medicare skilled rehabilitation resident, there is a need for increased skill and planning to address complex community services and supports for long-stay residents who had previously not been considered for discharge. Discharge of long-stay residents requires new linkages and referrals, expanded services, longer discharge time frames, especially if community housing is required, and greater internal and community coordination for staff with typically high caseloads. There has been very little research on discharge of long-stay residents to the community and clinical guidelines in this area are lacking. Readers are, however, encouraged to familiarize themselves with the transitions of care work conducted by Naylor and her colleagues.

Social Work Role Functions to Support MDS 3.0 Assessment and Resident Quality of Life

Survey regulation directly related to quality of life of residents is extensive, encompassing 6 primary categories: Resident Rights; Admission, Transfer, and Discharge Rights; Resident Behavior and Facility Practices; Quality of Life; and Physical Environment. In June 2009, the Centers for Medicare and Medicaid Services revised survey and certification interpretive guidelines for 42 CFR 483.15 Quality of Life and the survey deficiency F-Tags F241 and F242, which encompass the subcategories of dignity and self-determination. These changes put more emphasis and review of quality of life as a key element to a resident’s adjustment to and satisfaction with the facility, offering social workers and the interdisciplinary team new opportunities and responsibilities in improving a facility’s ability to monitor and maintain compliance with quality of care and quality of life regulations. With nursing homes undergoing surveys every 9 to 15 months for compliance with federal and state regulations, there can be no doubt that the renewed focus on resident voice and resident-centered care via MDS 3.0 will be enforced by the surveyors. A well-trained and qualified social worker will be critical to the success of the facility in meeting residents’ preferences and integrating the resident’s voice into care plans. There are a variety of roles and functions that social workers can assume within the context of an interdisciplinary care team, which will help facilities maintain compliance with these new requirements.

Roles In MDS 3.0 and Psychosocial Care

 Initially, well-trained social workers and social service staff can assist with the admissions process by providing support and reassurance to the resident and family members through the transition to a nursing home setting. In addition, they can ensure that the Preadmission Screening and Resident Review (PASRR) is complete and accurate on admission and can review records and medical reports to screen for evidence of developmental disabilities (MR/DD status). Well-qualified social workers are in an excellent position to provide information on advance directives, including how the nursing home will honor any current advance directives, and can also conduct ongoing screenings and updates of both the PASRR and advance directives documents.

Once a resident is admitted, social workers can be an integral part of the MDS 3.0 interview by conducting the Brief Interview for Mental Status (BIMS) and screening for delirium, mood (PHQ-9), and behavioral concerns (Sections C–E), which includes assessing the impact of these symptoms on self and others, and wandering risk. Social workers also have the skills and knowledge to be able to conduct interviews to obtain information on residents’ preferences including the new section for customary routines (Section F). Finally, with training in family systems work, social workers can engage residents, families, and legal guardians to participate in the assessment and goal-setting process, which includes conducting interviews to periodically assess the resident’s expectations about placement and discharge planning (Section Q). Overall, it is critical for social workers to maintain a clinical function within the facility, as they are often the only staff whose primary role is to address residents’ psychosocial needs. Their involvement in MDS 3.0 assessment is indicative of this clinical role. Table 2 contains a list of social work role functions as described in 2 best practice sources.

Recommendations for Staffing and Training of Social Service Providers

MDS 3.0 is bringing renewed interest in psychosocial assessment and care and, along with it, the roles of social workers and social service providers. Likewise, it brings attention to the need for collaboration between the nursing home industry, social work professional associations, including the National Association of Social Workers and its state and local chapters, and Schools of Social Work to develop appropriate training and clinical resources for nursing home social workers and designees, many of who are working in relative isolation. This change will require a paradigm shift for administrators to understand the value of social work training to improve clinical and interdisciplinary care planning, payment, and survey and certification pertaining to quality of life, and to engage person-centered care. Also critical are the needs for revised educational and professional standards that, as they currently exist in regulation, are too broad and do not support quality psychosocial care.

To further the professional development of this workforce, social work academics, nursing home social workers, and administrators must be ardent supporters of a plan to galvanize competencies needed for effective MDS 3.0 implementation for the resident-centered care the revised MDS intends to promote. To advance the leadership and skills, as well as number, of social workers effectively trained to meet the psychosocial needs of a growing number of elders, the Council on Social Work Education (CSWE) in collaboration with the Hartford Partnership Program for Aging Education (HPPAE) developed an Advanced Gero Social Work Practice Guide based on the current version of the CSWE’s Educational Policy and Accreditation Standards (EPAS) and the HPPAE’s Geriatric Social Work Competency Scale. The new guide establishes a competency-based approach to training social workers in aging practice settings. Administrators and practitioners in long term care are encouraged to review the Advanced Gero Social Work Practice Guide as a basis for identifying areas of core training needs for their social work and social service staff. They can also
Table 2
Best Practice Social Work Role Functions in Long-term Care Facilities

1. Psychosocial assessment of residents and family members as a basis for interdisciplinary care planning and intervention.
2. Resident and family education related to illness, including teaching coping and problem-solving skills to maintain or enhance psychosocial functioning.
3. Provision of, or referral for, mental health services.
4. Coordination of discharge planning and follow-up with the resident, family, interdisciplinary team, and community service providers.
5. Documentation of resident’s psychosocial status, initial and ongoing, progress notes, review of treatment goals, and so forth.
6. Case management services to facilitate coordination and continuity of care and to assist residents and families with obtaining necessary services in the home or in the community.
7. Psychosocial interventions with individuals, families, and groups related to a range of health, social, and emotional needs.
8. Crisis intervention.
9. Liaison to family members, including coordination-of-care planning meetings.
10. Advocating with and for residents within the long term care facility and system to ensure greater choice, quality of life, and quality of care. This may include consultation with the facility ombudsman.
11. Assisting with end-of-life planning, including legal and health-related matters.
12. Serving as a staff resource for training staff in nonpharmacological approaches to managing problem behaviors.
13. Participation in resident and family council as requested.
14. Supervision of fieldwork students.
15. Participation in independent or collaborative research projects.

Conclusion

The MDS 3.0, with its increased emphasis on resident voice and quality of life outcomes, also calls to attention the critical need for well-qualified, appropriately used social workers and for improved interdisciplinary psychosocial competencies and teamwork. This article addressed several concerns as they relate to the roles, staffing, and training needs of social workers in nursing homes that we believe should be addressed to effectively implement MDS 3.0 and to enhance quality psychosocial care system-wide. This included (1) the weakness of federal regulations that do not specifically require training in social work or adequate staffing of such providers; (2) currently underqualified providers of nursing home social services and inconsistent enforcement by states of existing federal regulation pertaining to this aspect of care; (3) unrealistic caseloads that limit the ability to effectively meet residents’ psychosocial needs; and (4) poorly articulated social service roles in many homes that limit involvement in psychosocial assessment and service provision as supports to quality of life.

Simultaneously, introduction of the MDS 3.0 demands greater competencies in psychosocial assessment and interdisciplinary care to effectively address identified needs, with special emphasis on greater training in the assessment of common mental health and behavioral symptoms including dementia, delirium, and depression. We argue that such training be targeted toward the needs of the interdisciplinary staff who contribute to psychosocial assessment processes. Likewise, the revised Section Q demands greater time and skill spent on discharge planning and care transitions for long-stay residents who may be capable of returning to home or less-restrictive settings with adequate supports and services. The additional demands of Section Q and the potential for more accurate identification of mental health and behavioral needs via MDS 3.0, presents an increase in workload for social service staff and further reinforces the need for more realistic staff-to-resident ratios.

Although we believe all social service staff should have a minimum of a bachelor’s degree in social work, we acknowledged the current realities of social work staffing in long term care and offered practical suggestions for training and supervision of designees, who lack formal social work training. Last, we encourage the NASW, schools of social work, and nursing home organizations to collaboratively develop continuing education training and clinical resources for nursing home social workers and designees, many of whom are working in isolation with limited access to training and professional supports. This may require direct advertising and outreach, as these staff are typically not well connected with professional associations or other networks that could encourage development of knowledge and skills specific to this unique practice area.
References