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| **Behavioral Contracts** | | | | | |
| *Date Implemented:* |  | *Date Reviewed/*  *Revised:* |  | *Reviewed/*  *Revised By:* |  |

**Policy:**

Residents who exhibit behaviors which could endanger themselves, other residents, or staff may benefit from a behavioral contract to ensure they are receiving appropriate services and interventions to meet their needs.

**Definitions:**

**“Mental disorder”** is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

**“Substance use disorder (SUD)”** is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home

**Policy Explanation and Compliance Guidelines:**

1. Upon admission of a new resident, the Unit Coordinator or designee will determine if the resident’s behaviors may benefit from a behavioral contract.
2. Within twenty-four hours of admission, the Unit Coordinator or designee should develop an interim behavioral contract, until the comprehensive assessment and plan of care are developed. Any behavioral interventions should also be included on the baseline care plan.
3. The interdisciplinary team, including the resident, and as appropriate the resident’s family, should develop a behavioral contract with identified behaviors through the RAI process.
4. Information regarding the resident’s usual routine may be gathered from the pre-screening application tool, from the resident and family members, and/or the comprehensive assessment.
5. Behaviors should be documented clearly and concisely by facility staff. Documentation should include specific behaviors, time and frequency of behaviors, observation of what may be triggering behaviors, what interventions were utilized, and the outcomes of the interventions.
6. Behaviors should be identified and approaches for modification or redirection should be included in the comprehensive plan of care.
7. The plan of care and behavioral contract should be reviewed at least quarterly for continued need of behavior management and appropriate interventions.
8. If a behavioral contract is used, it will only be used with residents who have the capacity to understand it. A contract will only be used as a method of encouraging the resident to follow their plan of care, and not as a system of reward and punishment. The contract will not conflict with resident rights or other requirements of participation.
9. Resident refusal to accept, or non-adherence to the terms of a behavioral contract, will not be the sole basis for a denial of admission, transfer or discharge.
10. A behavioral contract can include a schedule of daily life events, which addresses the individuality of the resident. The contract should reflect the resident’s personal preferences and usual routine, to the extent possible. The contract should include the recreation schedule, non-pharmacological interventions, and environmental adjustments needed to help the resident meet his or her highest practicable well-being.
11. A contract may also address:
    1. The resident’s right to have a leave of absence and the health and safety risks of leaving without facility knowledge or leaving against medical advice (AMA).
    2. Facility efforts to help residents with mental disorder and/or Substance Use Disorder, such as individual counseling services, access to group counseling, or access to a Medication Assisted Treatment program, if applicable.
    3. Steps the facility may take if substance use is suspected, which may include:
       1. Increased monitoring and supervision in the facility to maintain the health and safety of the resident suspected of substance use, as well as all residents.
       2. Restricted or supervised visitation, if the resident’s visitor(s) are deemed to be a danger to the resident, other residents, and/or staff.
       3. Voluntary drug testing if there are concerns that suspected illegal drug use could adversely affect the resident’s condition.
       4. Voluntary inspections, if there is reasonable suspicion of possession of illegal drugs, weapons or other unauthorized items which could endanger the resident or others.
    4. Referral to local law enforcement for suspicion of a crime in accordance with state laws, such as possession of illegal substances, paraphernalia or weapons.

**References:**

Centers for Medicare & Medicaid Services, Department of Health and Human Services. *State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities* (October 2022 Revision). F740 – Behavioral Health Services. 42 C.F.R. §483.40.