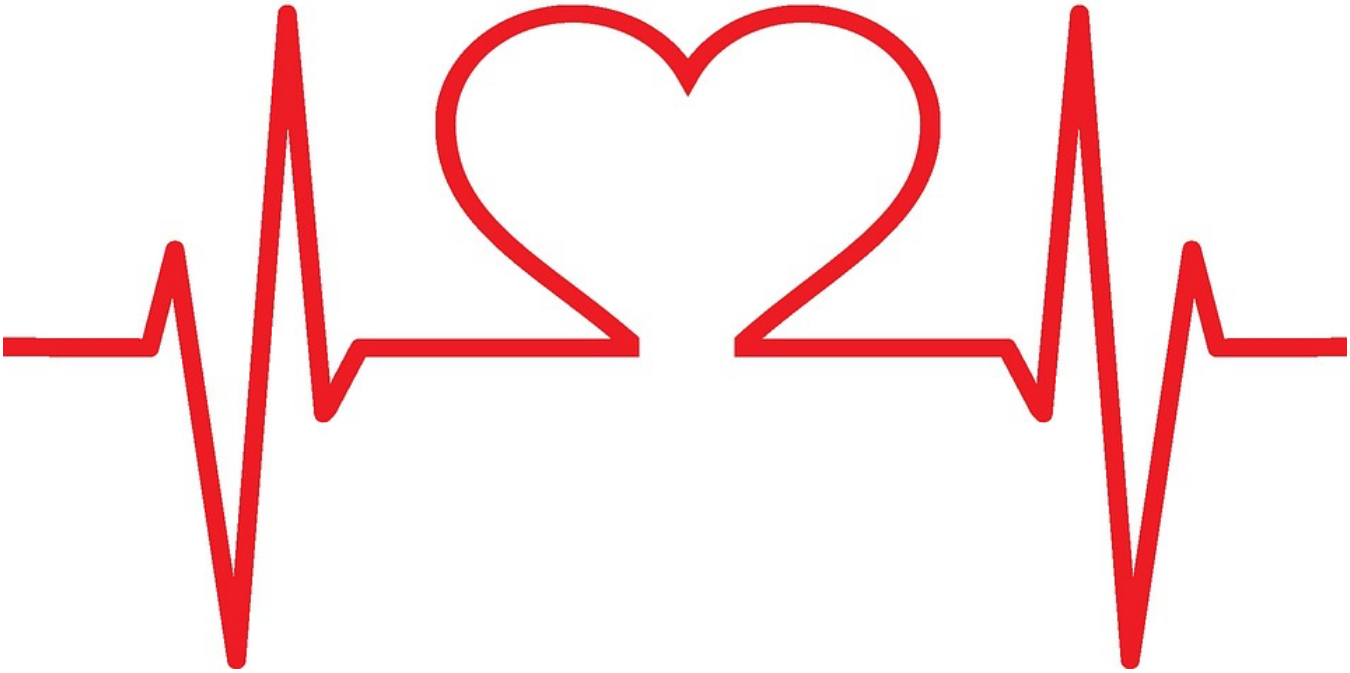
PADONA UPDATES February 5, 2024



February is American Heart Health month!

Nurses spend so much of their time ensuring that others have a health heart/cardiovascular status that they often don't even think about their own. This is a reminder from PADONA to show some love to yourself too and take care of YOUR heart as well!

- Take a walk – while listening to the PADONA infection prevention and control course on February 28 (and many other webinars)
- Exercise while dancing at the celebration party at conference
- Eat a healthy lunch while at work – while attending a PADONA webinar during the lunch break
- Keep your blood pressure under control while getting the support you need from PADONA and the daily email updates
- Stretch yourself by joining a PADONA committee or becoming a Board member or getting involved in one of the partnerships we share
- Make your heart feel good and reach out to a fellow nurse leader

YOU ARE THE HEART OF PADONA!

THANK YOU FOR THE OPPORTUNITY TO SERVE AND SUPPORT YOU!

PADONA HOSTED EDUCATION WEBINARS

- **Bullying in the Long-Term Care Setting – It's Not Just A Playground Problem**
  Date: February 8, 2024,
  Time: 11:30 am until 12:30 pm
  Educator: Dr. Kathleen Weissberg of Select Rehabilitation;
  Topic: addressing the issue of adult bullying especially in the congregate setting of the nursing home and how to spot the signs plus measures to address it
  Registration Fee: $35 members and $50 non-members.

- **Who's decision Is It?**
  Date: February 15, 2024,
  Time: 11:30 am until 12:30 pm
  Educator: Paula Sanders of Post & Schell;
  Topic: Addressing the struggle between resident healthcare choices and the choices of the representative/family/POA addressed by a healthcare attorney;
  Registration Fee: $35 members and $50 non-members.

- **Suicidal Ideations in Long Term Care**;
  Date: **February 22, 2024,**
  Time: 11:30 am until 12:30 pm
  Educator: Dr. Erica Featherson, geriatric psychologist of The Supportive Care;
  Topic: addressing the suicidal ideations of the geriatric population in long term care and providing some guidance in managing these situations;
  Registration Fee: $35 members and $50 non-members.

- **Scabies, Bed Bugs and Head Lice And Other Things That Go Bump and Itch in The Night**;
  Date: **March 5, 2024**,
  Time: 11:30 am until 12:30 pm,
  Educator: Dr. Jennifer Wallace of the Pennsylvania Department of Health Bureau of Epidemiology;
  Topic: – Identification and Treatment in the Long-Term Care Population; **Registration Fee**: no registration fee based on the PADONA and Bureau of Epidemiology partnership (Registration is required).
  There will be both nursing and administrator continuing education hours provided through PA TRAIN.

- **Legionella – Prevention, Recognition and Management in Long Term Care**;
  Date: April 18, 2024,
  Time: 11:30 am until 12:30 pm
  Educator: Dr Kristina Zwolenik of the Pennsylvania Department of Health Bureau of Epidemiology;
  Topic: Addressing the preventative steps from water management and treatment through the recognition of signs and symptoms and management of residents who have been diagnosed;
  Registration Fee: no registration fee for this webinar education based on the partnership between PADONA and the PA DOH Bureau of Epidemiology. (Registration is required).
  There will be both nursing and nursing home administrator continuing education hours for this education provided by the PA DOH through PA TRAIN

EDUCATION COURSE: Infection Prevention in Long-term Care – Challenges and Opportunities:

A Primer for the New Infection Preventionist and a Refresher for the Experienced Infection Preventionist

DATE: February 28, 2024

TIME: 8:30 am until 1:00 pm

REGISTRATION FEE: $90 Members and Infection Preventionists from Facilities with a PADONA member.

$105 for non-members and Infection Preventionists from Facilities who do not have a PADONA member.

Course Description and Professional Practice Gap: A strong infection prevention and control program is necessary for the safety of everyone in your facility – including residents, staff, visitors, and contractors. The awareness of the role of the infection preventionist was heightened during the pandemic and with the current outbreak and tripledemic situation in long term care, the infection preventionist role has become both a catalyst for prevention and lightening rod for criticism. The facility infection preventionist is the center of the infection prevention and control program.

This course will review the necessary parts of an infection prevention program, discuss high-risk pathogens, and review ways to minimize exposure and transmission of pathogens within your facility. Tools and education available to assist with infection prevention will be discussed and resources provided to assist in the development or review of your infection prevention and control program.

This program is intended for the newer infection preventionist in long term care or the experienced infection preventionist seeking a refresher. It is also well suited for the nurse leader/DON/ADON who assists, supervises or works with the infection preventionist.

Course Educator: JoAnn Adkins, BSN, RN, CIC, LTC-CIP, FAPIC is a registered nurse and infection prevention advisor for the Patient Safety Authority.

PADONA Education Recordings

If you have been unable to attend PADONA hosted webinars but want the education, information, AND Nursing Continuing Professional Development continuing education hours –

PADONA EDUCATION RECORDINGS PROVIDE NURSING CONTINUING PROFESSIONAL DEVELOPMENT CONTINUING EDUCATION HOURS!

And some of the education sessions provide nursing home administrator credit hours approved by NAB.

Nursing Continuing Professional Development continuing education hours are available for all recorded education provided by PADONA (which is provider-directed, and learner paced education) following:

1) Education evaluation completion including license number and correct beginning/ending codes.
2) Education post-test completion and returned with an 80% correct score.
3) Both items must be completed and submitted within 30 days of the purchase

Certificate of Nursing Continuing Professional Development continuing education hours will be issued within 15 days of completion and receipt of these items.

*This does not include the webinars provided in partnership with the PA Department of Health Bureau of Epidemiology who follow their guidelines on TRAIN PA.

PADONA also provides the following education:

- DON Education and Mentoring: This education is a series of educational sessions to assist the new DON with the areas critical to being effective in the role of DON. It is also a great refresher for the experienced DON as well as for the ADONs.
    - Education sessions are scheduled weekly for 90 minutes sessions
    - Education is virtual eliminating travel time for the DON and costs to the provider
    - Sessions can be menu selected from the list of topics for the experienced DON
    - Mentoring through discussion and addressing facility specific situations is included

- Directed In-Service Education: PADONA is an approved provider of directed in-service education by the Pennsylvania Department of Health
    - Fees are reasonable
    - Recordings are completed for those staff unable to attend

- Nursing specific or Interdisciplinary team education
    - Root cause analysis
    - Medical record documentation
    - Medicaid Case Mix Index
    - Care Planning
    - Regulatory compliance

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PADONA IS A PROUD PARTNER WITH AMI RISE IN THE SOUTWEST, NORTH CENTRAL AND NORTHEAST REGIONS OF PENNSYLVANIA TO PARTNER IN THE DON RESILIENCY PROJECT.

PADONA IS A PROUD PARTNER OF THE TEACHING NURSING HOME COLLABORATIVE

TEACHING NURSING HOME COLLABORATIVE

The Collaborative is a dynamic and evolving network of nursing homes, schools of nursing, and advocates dedicated to advancing excellence in nursing home care through education and workforce support.

Website: **www.patnhc.org**

Email: **info@patnhc.org**

What's New from the Collaborative

Thank you for your interest in the Pennsylvania Teaching Nursing Home Collaborative!

While our Learning Series webinars are over for this fall, below you can access all the meeting materials and our Tips to Get Started for both nursing homes and schools.

Our next Learning Series webinar will be held on Thursday, February 1st, 2024.

We hope to see you there, and please email us at info@patnhc.org if you have any questions or suggestions in the meantime!

Register for Webinars

This winter, join our Learning Series webinars to hear promising practices from nursing homes and nursing schools.

Our first Learning Series webinar will take place on Thursday, February 1st at 11 am ET.

Nursing home administrators and staff, nursing educators, healthcare policymakers, and advocates are all welcome to join. Register on the website.

Jewish Healthcare Foundation 625 Liberty Ave Ste 2500, Pittsburgh, PA 15222

Leadership Snippets

4 Questions to Ask Yourself to Know if You're Committed to Your Job, or Just Interested

Too much time in the wrong job can devastate your professional life and career—but so can the wrong mindset. You feel you've been putting a lot of effort into your current job or career. But are your feelings jibing with the facts? What are your actions telling others about your level of commitment to your work?

The two terms illustrate much different levels of involvement due to a difference in mindset. When you're interested in something, your thoughts and beliefs (mindset) about it lead you to enjoy exploring the opportunities and ideas associated with it.

When you're committed, however, your level of interest is much higher. You are all in. You are, "wholeheartedly dedicated." Your thoughts and beliefs cause you to want to do whatever it takes (within reason, of course) to not only achieve the result but also to own the journey.

Mindset is a choice—you choose what you think or believe, and those choices lead you to higher or lower levels of feeling (in this case, interest versus commitment). When you're just interested but not committed, it shows in subtle ways. Your coworkers, supervisors, and/or subordinates may feel you're not really giving it your all or that you have conflicting priorities.

Self-awareness is therefore vital in choosing productive thoughts/beliefs. To gauge your commitment level, ask yourself four questions:

1) Am I focused on obstacles or results?
2) How would I feel if I no longer had the chance to do this job?
3) Do I find other activities to keep me from achieving my work goals?
4) Do I consider it others responsibility to motivate me to do this job?

If your answers indicate a lack of commitment, chances are that others already see what you haven't. But you don't necessarily have to start putting together your résumé or consider a career change. Remember: Mindset is a choice.

GETTING TO THE RIGHT MINDSET

Too much time in the wrong job can devastate your professional life and career—but so can the wrong mindset. You owe it to yourself and those around you to be where you truly can commit and put your entire self into your work. That may require you to change jobs or careers, but it may be as simple as shifting your thoughts and beliefs. If you need to dig further into what's going on, talk to a coach who can help you get on track. Owning and honoring your authentic self is the first step toward doing what you really love.

(Excerpted from The Four Minute Read by Andrea Liebross)

Nurse Sentenced for Taking Resident's Pain Medication at Pennsylvania Nursing Home

In early January, a registered nurse (RN) was sentenced to serve 24 months' probation for taking a resident's pain medication at a Pennsylvania nursing home. She also had her nursing license placed on probation for three years by the State Board of Nursing. The RN was sentenced to serve two consecutive 12-month terms of probation after pleading guilty to misdemeanor charges of possession of a controlled substance and theft by unlawful taking.

While working at the nursing home on Sept. 15, 2022, the RN was seen getting narcotics from a medicine cart by other staff during early morning hours when residents were normally sleeping. She did not respond when staff questioned her about discrepancies in the medication count.

The police were notified, and staff told officers that the RN appeared to be impaired and was nodding off at the nurses' station. Police said the RN had made withdrawals of seven doses of Lorazepam, nine doses of morphine sulfate, and 11 doses of oxycodone for the resident, but the medications were not given to him.

During an interview with police in March 2023, the RN admitted to removing substances from the medication cart on Sept. 14 and 15, 2022, and then ingesting them.

According to her attorney, the RN self-reported the incident to the State Board of Nursing in February 2023. She was diagnosed with substance use disorder, is receiving outpatient treatment, and now submits to random drug testing.

This was the second time the State Board of Nursing imposed disciplinary action against this RN for a drug-related offense. In January 2019, she was arrested for taking narcotic pain relievers from a hospital pharmacy over a four-month period. Hospital officials had become suspicious that she was diverting prescription medication after a review of her dispensing activity between December 2017 and March 2018. They said amounts of three medications were unaccounted for: hydromorphone, fentanyl, and lorazepam. She told the hospital officials that she sometimes diverted medications requested for patients or kept other narcotics that a patient ended up not taking without documenting it as waste, police reported. She said she had not withheld medication from patients.

Compliance Considerations:

1) Review policies and procedures related to drug diversion and ensure all staff are educated and aware of the process for reporting.
2) Review policies and procedures for narcotic counts and medication discrepancies and that all licensed staff are aware of the process for reporting.
3) Review signs and symptoms of narcotic use and overdose with all staff so they can assist in recognizing these and reporting them.
4) Involve your pharmacy consultant in the process of reviewing documentation of medication administration for accuracy and ensuring doses were not missed.
5) Periodically interview residents receiving narcotic pain medications and others to ensure their pain is being managed and they are receiving their medications.
6) Ensure staff are aware of the need to report to keep residents safe and assist the staff member taking the medications.

New OSHA Injury, Illness Data Reporting Requirements in Effect and Include Nursing Homes

Long-term care and other employers are now required to complete updated reporting requirements for injury and illness data through the Occupational Safety and Health Administration's (OSHAs) injury tracking application (Injury Tracking Application | Occupational Safety and Health Administration (osha.gov).

The requirements went into effect in 2024 for employers of certain sizes and in certain industries. Among the affected employers are assisted living, residential care facilities, continuing care retirement communities and skilled nursing facilities (NAICS 6231 and 6233, for example).

Under a rule finalized in July (Federal Register :: Improve Tracking of Workplace Injuries and Illnesses), OSHA amended its regulation to require companies with 100 or more employees in certain industries to electronically submit information from their Forms 300 and 301 (Recordkeeping - Recordkeeping Forms | Occupational Safety and Health Administration (osha.gov) to the agency once a year.

The new requirement is an expansion of what employers must send to OSHA and will allow OSHA to obtain and publish to third parties, the specific injury and illness records that each senior living and skilled nursing operator maintains.

Among other requirements (Recordkeeping - Detailed Guidance for OSHA's Injury and Illness Recordkeeping Rule | Occupational Safety and Health Administration), records must be maintained at the worksite for at least five years. Each February through April, employers must post a summary of the injuries and illnesses recorded the previous year. Also, if requested, copies of the records must be provided to current and former employees, or their representatives.

OSHA says that the new reporting requirement will allow the agency to keep closer tabs on illness and injuries in workplaces as well as make the information publicly available. The agency will publish some of the data collected on its website to allow employers, employees, potential employees, employee representatives, current and potential customers, researchers and the general public to use information about a company's workplace safety and health record to make informed decisions.

Avoiding Legal Risks of Admissions of Residents With Substance Abuse Disorder

The rising prevalence of substance abuse disorders has placed a growing demand on skilled nursing operators to provide comprehensive care within the continuum of healthcare services. There are complex legal considerations that operators must grapple with when it comes to admitting individuals residents. For SNFs, admitting such residents can be problematic, since these individuals often don't adhere to treatment for substance abuse disorders, according to legal experts and nursing home executives.

Federal and state enforcement agencies, armed with anti-discrimination laws, have issued warnings and taken actions against SNFs refusing admission to individuals in treatment for substance abuse disorders. On the federal level, the pressure to admit has been compounded by Centers for Medicare & Medicaid Services' (CMS) recent ruling on the matter, which threatens enforcement action in some cases. On the state level, many recent actions have forced SNFs to admit such patients or face dire consequences. In some states, the state legislature has stepped in where operators have refused admission due to substance abuse or opioid addiction.

In Pennsylvania, Attorney General Michelle Henry's office announced that 38 nursing homes in the state have committed to complying with state and federal disability laws. These laws prohibit nursing facilities from refusing residents based on their previous history of opioid drug use, unless the resident is currently engaged in illegal drug use.

The initiative was prompted by a complaint from a 76-year-old man with opioid addiction. After hospitalization, surgery, and medical interventions related to Covid, the man faced multiple denials from facilities due to his opioid use history, despite having a hospital referral.

Attorney General Henry's office said it would be enforcing penalties on skilled nursing operators not in compliance. "Opioid dependency impacts every Pennsylvania community, and those receiving medication that enables recovery should not be discriminated against," Attorney General Henry said. "These settlements highlight how people in recovery deserve to be treated with dignity and respect. In fact, the law requires it."

Howard L. Sollins, a health care regulatory attorney, said that it is crucial for skilled nursing operators to recognize the legal repercussions of such refusals and work towards compliance with anti-discrimination laws. He said that SNFs are obligated to conduct annual facility-wide assessments, ensuring they have the necessary resources to competently care for residents.

"Such assessments can prompt a SNF to question whether it has the resources to safely and effectively provide services to individuals with substance abuse disorders," he said. "By the same token, there are also SNFs that not only admit such individuals, but they also develop focused programming around individuals with such needs."

Sollins pointed out that not all individuals seeking admission to SNFs adhere to treatment for substance abuse disorders. This challenge is further complicated by recent language in the CMS' State Operations Manual, which threatens enforcement action against SNFs for resident rights violations.

Sollins warned that facilities should not try to act as law enforcement when they find potentially illicit substances, and consider referring cases to local law enforcement if necessary. "Advance working relationships with local law enforcement are encouraged to ensure a timely response to potential illegal drug use within SNFs," he noted. Sollins said that in order to safeguard the well-being of residents, it may be necessary for facilities to enhance their monitoring and supervision efforts. Should facility personnel discover items or substances that present potential risks to residents' health and safety and are easily visible, they have the authority to confiscate such items. However, he noted that it is important for facility staff to refrain from conducting searches on a resident or their personal belongings unless the resident or their representative willingly consents to a voluntary search and comprehends the purpose behind it.

CMS Takes Tougher Antipsychotic View After Hundreds Audited for Schizophrenia Diagnosis

Half the nursing homes audited in a new process admitted to misdiagnosing schizophrenia, the Centers for Medicare & Medicaid Services (CMS) is extending its drive to reduce the use of certain drugs intended to treat schizophrenia, psychosis and other behavioral health conditions. CMS also stated that it will continue the audits.

Last January, CMS announced it would review diagnoses among the nursing home population because it had observed a rise in rates of schizophrenia, which is most commonly diagnosed when a person is in their 20s. Regulators said they suspected that some diagnoses were unfounded and potentially being given to mask dependence on medications to treat symptoms of other diseases or disorders.

Schizophrenia and antipsychotics are closely linked, and especially so in nursing homes. Facilities receive a quality rating connected to their patients' use of antipsychotics such as the commonly prescribed aripiprazole, clozapine, haloperidol and risperidone. But residents taking those drugs for schizophrenia, Tourette syndrome and Huntington's disease are excluded from the measure, which makes the overall rate of use appear lower.

While CMS did not release information about how it chose its audit targets, two clinical and compliance experts have said even a single diagnosis could qualify a provider for additional review. However, the audits appeared to focus on a group of facilities that diagnosed residents most often. CMS began contacting selected providers a year ago, asking for MDS assessments (Nursing Homes' Use Of Antipsychotic Drugs To Be Audited By CMS - KFF Health News); behavioral health records; medication orders and administration records; and other associated information that could support residents' schizophrenia diagnoses.

"Approximately half of the facilities that have been contacted have attested to having erroneous schizophrenia diagnoses and committed to correcting their information," CMS said. "For the remaining facilities that have been audited and have had erroneous schizophrenia diagnoses, we have generally found an absence of comprehensive psychiatric evaluations, medical evaluations, and behavioral documentation to support a diagnosis of schizophrenia, following professional standards of practice of the DSM-5-TR [Diagnostic and Statistical Manual of Mental Disorders]."

Facilities that fail an audit have their star rating reduced for six months and are required to correct the issues identified (Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System: Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding, and Posting Citations Under Dispute | CMS).

Providers that opted to do the audit did not do well; they ended up with the penalty. Many facilities did opt not to go through with the audit. These providers had to provide a corrective action plan and now CMS is coming back to those providers and they are being audited to see if their corrective action plan was effective. You cannot opt out of this audit.

CMS provided specific attestation language that required providers to say they had misdiagnosed schizophrenia on their MDS. There was no ability to explain a higher-than-expected rate due to, for instance, a resident population with extensive behavioral health needs whose charts would indeed support those diagnoses and related antipsychotic prescribing.

The main reason for audit failure was a lack of documentation for six months of symptoms and behaviors like delusions or hallucinations before a new diagnosis of schizophrenia was coded in the MDS. Those diagnoses of nursing homes residents that happened after admission also drew CMS attention.

Additionally, providers have often noted that residents come to them with existing, possibly decades-old diagnoses that they are unable to substantiate with recent paperwork. Those residents can still be included in the current audit process.

An expert panel was convened in February 2023 to discuss concerns about and possible changes to the measure. Its findings weren't published by CMS until September (Technical Expert Panel (TEP) for Refinement of the Nursing Home (NH) Antipsychotic Medication Measures (cms.gov).

Advocates want CMS to "get rid of the drugs," which was the reason for the expert panel exploring different mathematical ways of calculating the measures using new data sets. It also queried members, including pharmacists, about adding other drugs to the antipsychotics list. A physician member said that a measure that somehow took into account "appropriate" use could be more effective for consumers, given that more nursing home residents today have behavioral health diagnoses for which an antipsychotic may be appropriate, if not formally FDA-approved. The physician said the agency's focus on driving down use, regardless of indicated need, leaves providers grappling with an impossible choice of doing the right thing by patients whose doctors indicate they need medications or taking a possible hit on their quality rating.

The number of antipsychotic drugs with indications for non-schizophrenia related conditions is also growing, offering a new pathway to treat behaviors associated with Alzheimer's and other diseases. There's no clear timeline for adoption of a refined antipsychotic measure or any specifics on how audit findings might be used to inform that.

But at the conclusion of the TEP report, CMS contractor Acumen said it planned to conduct further analyses to understand antipsychotic use and schizophrenia diagnosis reporting. It also said it wants to refine the antipsychotic medication list and schizophrenia ICD-10 codes, as well as explore including Medicaid and Medicare Advantage data in the antipsychotic medication measure re-specification.

PADONA Posts Position Openings to Website

PADONA can assist with your recruitment efforts. As a PADONA member, one of your benefits is that PADONA will post your ads for open positions on our website without cost. If you need posting a staffing ad, please send the written ad to Sophie Campbell at scampbell@padona.com and it will be posted on the PADONA website.

The PADONA website is where Pennsylvania nurses and nurse leaders go to look for available positions. We are here to help you fill those needed positions.

Nursing Home Provider Must Issue Back Pay After Abruptly Ending Shift-Differential Benefit

(Article includes Pennsylvania facility)

The National Labor Relations Board (NLRB) sided with a union's request to have shift-differential pay reinstated and back pay issued after a nursing home's new owner unilaterally ended the incentive practice in August 2023. The ruling illustrates a key potential pitfall providers need to avoid amid a surge of labor activity in nursing homes.

Care workers at Twinbrook Healthcare and Rehabilitation Center had been paid an additional $1 per hour for second shift work and $0.50 per hour for third-shift shifts when owned by Guardian Elder Care. After taking over operations of the Erie, PA facility in April, Twinbrook OpCo continued to pay this differential rate for several months, according to the Dec. 28 NLRB ruling (Board Decisions | National Labor Relations Board (nlrb.gov).

In May 2023, these rates were doubled and a further $2 per hour differential rate was added for weekend shifts. But in mid-August, Twinbrook OpCo informed employees that licensed practical nurses and certified nursing assistants would no longer receive the additional pay going forward.

Twinbrook OpCo had previously negotiated a bargaining agreement with the care workers' union. While that agreement did not specifically mention differential pay, the NLRB agreed with the union's complaint that the unilateral pay change was not permissible.

"The Respondent gave employees every expectation that the shift differentials would continue by including the payments in each paycheck from the time it purchased the facility until negotiations concluded and the Agreement went into effect," the ruling stated. "The Respondent violated the Act when it abruptly ended the shift differentials without affording the Union notice or an opportunity to bargain."

The ruling orders Twinbrook to reinstate the differential rates, give back pay for time missed, and make employees whole for any additional costs they may have incurred as a result.

The NLRB ruling comes at a time of increased labor activity across the country and in the healthcare sector specifically. Only 16% of nursing homes are unionized currently, but that number is likely to increase if current labor market trends hold.

Twinbrook had argued that ending differential pay had not violated its bargaining with the union because the differential rate was not explicitly codified in the final agreement. The NLRB's ultimate disagreement illustrates the caution operators should use when potential cost-saving measures run the risk of drawing union complaints.

CMS Focuses on Resident Mood Interviews in Recent Nursing Home MDS Draft Version

The Centers for Medicare & Medicaid Services (CMS) issued the draft Minimum Data Set (MDS) — earlier than the federal agency's typical timeline and with less sweeping changes compared to past years.

CMS said in a memo that changes, effective October 1, 2024 include an update to the list of state RAI coordinators, MDS automation coordinators, CMS locations and contacts, the agency. Revisions were also made to provide clarity and additional guidance for Section D and Chapter 6 – dealing with resident mood interviews. Specifically, additional guidance was added around the question, "Should Resident Mood Interview be Conducted?" which serves as a gateway item for the resident mood interview, or PHQ-2 to 9 and D0500, or staff assessment of resident mood.

Minor corrections were also made to care area assessment requirements, and on guidance for combining Omnibus Budget Reconciliation Act (OBRA) discharge assessments. CMS updated an Internet Quality Improvement & Evaluation System (iQIES) warning error message in Chapter 5 of the MDS, and updated screenshots in Section A and O along with the MDS Item Matrix. The revised RAI (Resident Assessment Instrument) manual has not been released yet.

Anticonvulsants will be added to the high risk drug class in Section N, since such medications are being administered to residents, CMS officials said in December. The self-care and mobility discharge goal column in Section GG – GG-0130 and GG-0170, column two – will be removed as well.

A new item will be added to collect Covid vaccination status among residents, agency officials said in December. The data will be used to inform the "Covid vaccine percent of residents who are up-to-date" measure for the SNF Quality Reporting Program (QRP).

The last two changes are the result of policies finalized last year in the fiscal year 2024 Skilled Nursing Facility Prospective Payment System Final Rule.

On a more technical note, CMS health insurance specialist, Ellen Berry, said in December that the iQIES MDS user interface has been replaced by jRAVEN software. The new interface doesn't allow for completion of MDS assessments for other insurance payers including Medicare Advantage and private insurance, or for other purposes.

"The take home message is that providers who need to complete assessments for other purposes, other than federal and state, should use vendor software. Providers are not to submit these assessments to IQIES," said Berry.

Safeguarding Senior Care: Avoid 3 Key Mistakes in Employee Screenings

Background checks substantially help mitigate risk by evaluating various sources to confirm that candidates are who they claim to be, that who they claim to be is indeed a fit for the role they are interviewing for, and that they pose no threat to the seniors living in the community. But other dangers exist, too; the process of hiring can consume substantial amounts of time and resources. Failing to identify unsuitable candidates in a timely manner will result in malinvestment, even if the candidate is never hired.

1. Lack of Knowledge-induced legal risks

Litigation is a top concern for any senior living employer conducting background checks. Employers should ensure full understanding and compliance with both local and federal legislation before even designing their policy, And before running an actual check.

Laws governing the hiring process will vary widely based on location and the nature of the position. They tend to specify certain aspects of the procedure, such as information that must be communicated to candidates throughout the screening process. Restrictions and regulations on using acquired data also are common, with consideration of marijuana use or criminal backgrounds being notable examples. Failure to adhere to such legislation may expose a company to potential lawsuits, which can easily cost millions of dollars in settlements and legal fees.

2. Flexibility without framework

Often, approaching the screening process on a case-by-case basis is the path of least resistance. Although each position should be given unique consideration, improvisation always will result in concerns. The underlying factor here is that lack of consistency increases the likelihood of legal negligence. Without a pre-decided policy, it is much easier for an employer to disregard certain legal guidelines or restrictions that otherwise might be detailed in a well-prepared plan. Once such a policy has been created, staying aligned with the law is merely a matter of ensuring that it remains up to date.

Another concern is that an unorganized background check will lack the efficiency of a carefully designed workflow. Organizing how screenings and communications, will take place ensures that a company's background check does not waste resources.

3. Using unclear criteria

Finally, senior living organizations often try to speed up the screening process by sending all candidates through a single filter. The faults with such an approach, however, are obvious. Unclear criteria consistently will deny competent workers where parameters are too strict and allow unsuitable workers where parameters are too loose. For this reason, providers must establish job-specific criteria.

The first criteria to consider are criminal backgrounds, because — yet again — the law must be considered first and foremost. Legislation often will regulate which workers can be employed in certain fields, such as working with older adults, based on criminal records. Although background checks in this industry are more extensive than in most other industries, some offenses should not disqualify candidates for certain positions. Non-criminal criteria like work experience, licensing, references, and referrals should also be job specific. While there is not much flexibility here, organizations must decide for themselves where to set the bar for each position — something that may change with the job market.

FOR IMMEDIATE RELEASE
January 18, 2024

Contact: CMS Media Relations
(202) 690-6145 | CMS Media Inquiries

CMS Announces New Model to Advance Integration in Behavioral Health

New model seeks to improve quality of care, access, and outcomes for people with mental health conditions and substance use disorders in Medicaid and Medicare

Today, the U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services (CMS), is announcing a new model to test approaches for addressing the behavioral and physical health, as well as health-related social needs, of people with Medicaid and Medicare. The Innovation in Behavioral Health (IBH) Model's goal is to improve the overall quality of care and outcomes for adults with mental health conditions and/or substance use disorder by connecting them with the physical, behavioral, and social supports needed to manage their care. The model will also promote health information technology (health IT) capacity building through infrastructure payments and other activities.

The IBH Model will be tested by the Center for Medicare and Medicaid Innovation (CMS Innovation Center). Under IBH, community-based behavioral health practices will form interprofessional care teams consisting of behavioral and physical health providers, as well as community-based supports. This new model supports the President's mental health strategy and implements an action item in the HHS Roadmap for BH integration.

"I am proud of all the work we have done to change the way mental health is treated in this country for the better. This new behavioral health model released today will help states to advance this goal, in line with the President's Unity Agenda priority to tackle the mental health crisis," said HHS Secretary Xavier Becerra. "The Biden-Harris Administration will continue to explore innovative ways to help people with mental health conditions and/or substance use disorder. Put simply, mental health is health—and by expanding access to the high-quality care that people need, we are changing lives."

Through the interprofessional care teams, people will experience an integration of services that will bridge the gaps between physical and behavioral health. The model enables a "no wrong door" approach, meaning that regardless of how patients enter care, they will have access to all available services. Through this practice, IBH also aims to reduce overall program expenditures.

“The Biden-Harris Administration believes that treating mental health and substance use disorder requires a “no wrong door” approach. This new model ensures that anyone can get access to the services they need, regardless of how they enter care,” said HHS Deputy Secretary Andrea Palm. “We will continue to test approaches that close the gaps between how behavioral and physical health are treated. Our goal is always to improve the overall quality of care and outcomes for patients and this model brings us one step closer.”

“Addressing the nation’s behavioral health crisis remains a key priority for CMS,” said CMS Administrator Chiquita Brooks-LaSure. “Through this model, CMS will support behavioral health practices to provide integrated care and help meet people’s behavioral and physical health and health-related social needs, like housing, food, and transportation, all of which can negatively impact a person’s ability to manage their care.”

“The IBH Model will help improve the quality of care and health outcomes for people with moderate to severe behavioral health conditions,” said HHS Assistant Secretary for Mental Health and Substance Use and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), Dr. Miriam E. Delphin-Rittmon. “Additionally, this model will enhance the behavioral health system infrastructure and the staffing to support it.”

The impact of behavioral health conditions is significant among the Medicare and Medicaid populations, with 25% of people with Medicare experiencing mental illness and 40% of adult people with Medicaid experiencing mental illness or substance use disorder (SUD).[1] High out-of-pocket costs for care, lack of access to quality behavioral health treatment in some areas, and often fragmented systems of care can make it difficult for people to obtain the care they need. This is particularly true for historically marginalized racial and ethnic groups, low-income populations, and individuals living in rural areas.

“The systems of care to address physical and behavioral health conditions have historically been siloed, but there is a direct correlation between people with mental health conditions or substance use disorder and poor physical health,” said CMS Deputy Administrator and Innovation Center Director Liz Fowler. “This model will bring historically siloed parts of the health system together to provide whole-person care – designed to keep people out of the emergency department, ensuring better care management and coordination, and improving their overall health.”

Practice participants in the IBH Model will be community-based behavioral health organizations and providers, including Community Mental Health Centers, public or private practices, opioid treatment programs, and safety net providers where individuals can receive outpatient mental health and SUD services. The model will incentivize these practice participants to work collaboratively to screen, assess, and coordinate between individuals’ physical and behavioral health needs. Practice participants will be equipped with the necessary resources to facilitate integrated care, including infrastructure payments to support health IT capacity building, electronic health records, and practice transformation; technical assistance; and a predictable value-based payment model.

The IBH Model builds upon earlier Innovation Center efforts to include community-based behavioral health practices, including both mental health providers and substance use disorder providers, in value-based care. The IBH Model is based on the lessons learned from previous Innovation Center models, such as the Maternal Opioid Misuse Model, Integrated Care for Kids Model, and the Value in Opioid Use Disorder Treatment Demonstration.

The model will launch in Fall 2024 and is anticipated to operate for eight years in up to eight states. CMS will release a Notice of Funding Opportunity for the model in Spring 2024.

Please visit the IBH Model webpage for more information:
https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model

COVID-19 Survivors Have Higher Risk for Digestive Diseases

People who survived COVID-19 — including some older adults — have a higher risk for digestive diseases, a new study finds (Digestive System Diseases, Genetic Risk, and Incident Dementia: A Prospective Cohort Study - American Journal of Preventive Medicine (ajpmonline.org).

Digestive diseases include gastrointestinal (GI) dysfunction, peptic ulcers, gastroesophageal reflux disease (GERD), gallbladder disease, nonalcoholic liver disease and pancreatic disease. Data was derived from adults ages 3 to 73 in the UK Biobank, according to the study published Jan. 10 in *BMC Medicine (*Risks of digestive diseases in long COVID: evidence from a population-based cohort study | BMC Medicine | Full Text (biomedcentral.com).

The researchers compared the rates of digestive diseases among 112,311 COVID-19 survivors 30 or more days after infection, 359,671 people in a comparison group and data from a control group of 359,671 people from 2017 to 2019 (before COVID-19 occurred). All of the people were located in the United Kingdom. The researchers followed up on people for a median of 8.4 months. People with COVID-19 were infected between January 2020 and October 2022.

Compared to the controls, COVID-19 survivors had a 38% higher risk for GI dysfunction, 23% higher risk for peptic ulcers, 41% for GERD, 21% for gallbladder disease, 35% for severe liver disease, 27% for nonalcoholic liver disease and 36% for pancreatic disease. The risk for developing GERD, specifically, went up the more severe the case of COVID-19. The risk for having GI dysfunction or GERD didn't go down after a one-year follow-up. People who had COVID once and were later reinfected had a higher chance of having pancreatic disease.

"We found that even in people with mild COVID-19 symptoms who did not receive hospitalization treatment, the risks of GI dysfunction, peptic ulcer disease, GERD and nonalcoholic fatty liver disease were evident, while the risks of severe liver disease, IBD and biliopancreatic diseases were not," the authors wrote.

What causes the increased risk for the GI ailments? It may be fecal-oral viral transmission, interactions between the SARS-CoV-2 spike protein and angiotensin-converting enzyme 2 (ACE2) receptors in the digestive tract, or inflammation associated with the virus.

"This underscores the significance of ensuring that healthcare systems are equipped to provide appropriate care to this population of mild cases, as well as varying degrees of COVID-19 severity," the authors wrote.

REMINDER REGARDING THE STATE CHANGE IN STAFFING RATIO METHODOLOGY CALCULATION

December 13, 2023

Dear Providers,

This message provides an update to nursing care facilities regarding the methodology for calculating the staffing ratios for LPNs and Nurse Aides. The new regulations requiring minimum staffing ratios were implemented on July 1, 2023. After several months of surveying facilities, and feedback from provider associations and other stakeholders, DOH is clarifying the ratio calculations.

With the initial implementation of the new regulations, DOH calculated the staffing ratios for LPNs and Nurse Aides by rounding up as the facility's census changed. For example, if a facility had 24 residents and increased the census to 25, the facility would be required to have a 3rd Nurse Aide on duty for the day and evening shift.

After much analysis and feedback from the providers, DOH determined that it would be more effective to calculate the staffing ratios based on the full-time equivalent (FTE) required as a facility's census changes. In the same example as above, this facility would be in compliance if they have 2.08 FTE Nurse Aides on duty for the day and evening shift and will not be required to have 3 full-time Nurse Aides until they are serving 36 residents.

There are no changes to the PPD requirement and calculation. As a result, facilities may need to have additional staff to reach the PPD requirement even if they are in compliance with the LPN and Nurse Aide ratio requirements. In the same example, the PPD would remain 2.87.

The new method of how DOH surveyors calculate for LPNs and Nurse Aides will go into effect January 1, 2024 and surveyors will continue to calculate by rounding up to a full FTE until that date. DOH will update the Interpretive Guidance and FAQs relating to the regulations implemented July 1, 2023 and provide training to its staff before January 1, 2024. Facilities surveyed between now and January 1, 2024, or with inspections in the plan of correction phase, will need to be in compliance based on the current methodology. If the staffing ratio would be within compliance using the revised methodology, facilities can note that in their plan of correction. Thank you for your continued dedication to quality care.

Please send any questions to RA-DHLTCREGS@pa.gov

Until December 31, 2023				
Census	24	25	30	100
Day Shift				
RN	1.00	1.00	1.00	1.00
LPN	1.00	1.00	2.00	4.00
NA	2.00	3.00	3.00	9.00
Evening Shift				
RN	1.00	1.00	1.00	1.00
LPN	1.00	1.00	1.00	4.00
NA	2.00	3.00	3.00	9.00
Night Shift				
RN	1.00	1.00	1.00	1.00
LPN	1.00	1.00	1.00	3.00
NA	2.00	2.00	2.00	5.00
Hours Worked	96	112	120	296
PPD Required 2.87	4.00	4.48	4.00	2.96

Effective January 1, 2024				
Census	24	25	30	100
Day Shift				
RN	1.00	1.00	1.00	1.00
LPN	0.96	1.00	1.20	4.00
NA	2.00	2.08	2.50	8.33
Evening Shift				
RN	1.00	1.00	1.00	1.00
LPN	0.80	0.83	1.00	3.33
NA	2.00	2.08	2.50	8.33
Night Shift				
RN	1.00	1.00	1.00	1.00
LPN	0.60	0.63	0.75	2.50
NA	1.20	1.25	1.50	5.00
Hours Worked	84.48	87.00	99.60	276.00
PPD Required 2.87	3.52	3.48	3.32	2.76

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