KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

# Sunflower Connection

http://www.kdads.ks.gov/AdultCareHomes/Newsletters/Newsletter_Index.html

## April 2014

## Secretary's Corner

We are at the end of the 15th month of KanCare, our fifth quarter. The state and all three managed care organizations (MCOs) have made significant improvements during this time, and we are committed to continuing to work closely with providers and consumers to assure individual issues are addressed and the program overall continues to advance.

Year one of KanCare was focused primarily on operational issues that arose out of the state's transition from the old fee-for-service model. Significant portions of the performance measures placed on the MCOs were tied directly to their timely payment of claims, credentialing of providers, appeals and grievances and other matters directly related to payment processes. We will continue to work on these operational areas, however 2014 will bring additional focus on the program goals of improving consumer outcomes, which are outlined in the KanCare pay-for-performance (P4P) measures, such as reducing the number of injury falls among nursing home residents. An overview of the P4P measures is available HERE:

While aggregate payment amounts and denials in KanCare are comparable to those under old Medicaid, we know there still are improvements that need to be made, specifically in the area of claims corrections.

All three MCOs have completed projects aimed at adjusting payments that were made based on incorrect quarterly rates through CY 2013. If you continue to have claims from 2013 which have not been adjusted correctly, please contact your MCO provider representative for assistance.

**Kansas**
Department for Aging
and Disability Services

If you have exhausted your avenues to resolve issues through the MCO, please explore the new KDADS provider issues tracking application to communicate specific claims issues to my team and the MCO leadership.

The new application is available HERE.

When submitting issues regarding claims payment, be sure to include specific details, most importantly your tax ID number, the claims numbers in question and other details to expedite in the speediest possible resolution.

While we continue to collaborate with providers and the MCOs to correct payment discrepancies, we are also working with other state agencies to address several eligibility process issues that drive many of the errors that are occurring. We are looking for ways to improve the usability of Medicaid and HCBS programs for aging-services providers as well.

# Claim Denials for Medicare Liability

The state contract with the Managed Care Organizations require the MCOs to assure KanCare is the payer of last resort. One of the ways the MCOs do this is by identifying third party liability (TPL) such as Medicare, or other insurance policies (OHI) owned by the member, and requiring claims be submitted to the third party before submitting to KanCare. The MCOs have removed the requirement for a Medicare denial for nursing home room and board from their systems. If you have outstanding claims which were denied for not billing Medicare first, please contact your provider representatives responsible for those specific claims.

A denial EOB may be required for residents with private policies, or other insurance. Please review the respective provider manuals, or contact your provider representatives for additional information on submission of denial EOB for other insurance policies.

# Facility Statistical Reports

Thank you for completing the annual statistical reports online through KDADS. This information is used by a number of individuals and organizations to inform research and public policy. Please remember there are two parts to the annual reports, which should both be completed at this time. If you have not completed both parts for the reference week of September 1-7, 2013 please log in to the KDADS Web Applications and complete the required data fields. Quick instructions for completing these reports are provided below. For questions or assistance please contact: tina.lewis@kdads.ks.gov. Thank you.

Go to our website at www.kdads.ks.gov

Click on KDADS Web Applications
- Go to your home page and log on
- If you have a problem logging on or need a password, please call our help desk at (785) 296-4987
- Scroll down until you see "Facility Statistical Reports" typed in blue letters
- Click on the button that says "Create New Report"
- Go to facility type and select your facility type
- (Note: If your facility has more than one facility type you will need to complete both reports for each facility type)
- Chose Part I and complete report then go back and complete Part II.
- The reference week and instructions are on the first page of the form.

# Enhanced PEAK 2.0 for Fiscal Year 2014-15

In the two years since release of PEAK 2.0, KDADS has learned a lot about culture change and person-centered care in Kansas nursing homes. As a result, the program is being revamped in keeping with the philosophy that culture change is a journey. Successfully reaching milestones and continuing efforts toward person-directed care will drive recognition and incentives. More details will be forthcoming.

But for now - The Kansas Department of Aging and Disability Services in partnership with the Kansas State University Center on Aging announce the release of PEAK 2.0 for fiscal year 2014-15. Among other things, the program includes some new enhanced features based on experience and feedback with homes currently enrolled in the program.

Applications are now being accepted and will continue to be accepted through April 30, 2014 for those homes that wish to participate. If your home is currently not enrolled in the program, we urge you to get involved.

Those currently enrolled in the program should continue on the PEAK 2.0 track that you are currently on. Your home will need to re-enroll in the program to continue by filling out and following the instructions on the application. Enrollment simply verifies your intent to continue with PEAK 2.0 and updates the KCCI assessment. The KSU Center on Aging (ksucoa@gmail.com or 785-532-2776) staff can address any questions you have about your standing and next steps in the program.

Here is how to apply:

Go to the following website:

http://www.he.k-state.edu/aging/outreach/peak20/

Click on the APPLY NOW link.

Follow ALL the instructions on the application.

Once you have completed all application steps, your home will receive a confirmation email that your application has been accepted.

Your incentive payment and program work will occur between July 1, 2014-June 30, 2015.

Questions: Contact the PEAK 2.0 team at (785) 532-2776 or ksucoa@gmail.com

# Nursing Home Report Card

KDADS, with input from a stakeholder group of provider and consumer representatives has been developing a state report on various elements of nursing home performance. The Kansas Nursing Home Report Card is nearly complete, and we anticipate launching the website in late April. The elements of the report card were determined by the stakeholder group and KDADS and include, state health and life safety inspection results, resident satisfaction survey results, nursing and direct care staffing levels, and clinical quality indicators. Performance in each of these measures will be rated through assignment of 1 to 5 "sunflowers," 5 being the highest possible score. Each element will have its own rating, a single composite score for each nursing home will not be calculated.

KDADS expects to launch the website publicly during the final week of April. KDADS is currently working to make detailed data, and ratings on each nursing home available through the KDADS provider application tool prior to posting the information publicly. KDADS will send information on accessing your data when it is available. Specific instruction for the rating methodology will be available at that time.

Ratings for performance on state inspections will be derived from two survey cycles of resurvey, revisit, and complaint data. Scores for the current survey cycle are weighted 70% to emphasize value of current compliance. Each nursing home begins with zero points assigned. As the overall number of deficiencies rises, points are added and the sunflower rating is reduced. G+ deficiencies are assigned additional points. State

inspection data will be updated quarterly. Cut points for each sunflower rating were determined based on criteria developed by KDADS and the stakeholder workgroup.

Clinical Quality Indicators will be displayed for each home. The measures we are looking at for year one include: pressure sores, weight loss, UTI, catheter use, and restraints. The facility scores are derived through a system developed by the University of Minnesota and modified by Meyers and Stauffer for use in Kansas. The process applies risk adjustments to reflect the acuity of residents in each home. The demographic and clinical conditions of the residents are reviewed and compared to statewide data to identify a predicted rate for each measure. The actual, risk adjusted rate for each facility is compared to the predicted rate. If a home's actual risk adjusted rate is lower than the predicted rate the home will have a positive score. If a home's actual rate exceeds the predicted rate the home's score will be negative. Overall scores are assigned based on statistical ranges between actual and predicted rates based on a rolling 12 month time period which will be updated quarterly. The risk adjustment factors used are available here: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&dDocName=dhs16_172388

Resident satisfaction is a strong measure of nursing home quality. Kansas has conducted a statewide resident satisfaction survey among Medicare/Medicaid certified nursing homes and long term care units of hospitals. The surveys were completed by independent third party interviewers trained and employed by National Research Corporation. The satisfaction survey asked residents for feedback on the following domains: autonomy, comfort, customer satisfaction, dignity, food enjoyment, individuality, meaningful activity, mood, privacy, relationships, security, and spiritual well-being.

The report card will stratify the "overall satisfaction" and "willingness to recommend" scores for assignment of comparative rankings. Individual domain scores will be available to consumers who choose to follow web links to the result details. Providers may see

the full detail of their nursing home's score through their portal with NRC. For assistance locating this information please contact:
Shirley.boltz@kdads.ks.gov.

The staffing measure reports comparative rankings based on the number of hours of nursing personnel available to each resident. The staffing levels are derived from the direct health care cost center of the annual cost report and are adjusted for CMI. Cut points for comparative rankings are set using a range from the median statewide staffing level. For example, the 3 sunflower ranking includes homes with hours within 10% above or below the median, 4 sunflower homes include those with hours 10%-20% above the median, and so forth. The scoring and cut points will be rebased annually according to data received from the cost reports. The specific cut points for each rating will be provided in April.

Information regarding this report card will be emailed to the contact address registered with KDADS for each facility. Additional information will be available in April.

# Electronic Cigarettes

Dated **November 10, 2011, CMS** issued an S&C letter, Ref: S&C: 12-04-NH. It stated; a new issue concerns the use of electronic cigarettes. These products are designed to deliver nicotine or other substances to the user in the form of a vapor. They are composed of a rechargeable, battery-operated heating element, a replaceable cartridge that may contain nicotine or other chemicals, and an atomizer that, when heated, converts the contents of the cartridge into a vapor. The vapor has a light odor that dissipates quickly. These e-cigarettes are not considered smoking devices and their heating element does not pose the same dangers as regular cigarettes.

The **FDA** states e-cigarettes have not been fully studied so consumers currently don't know:

> the potential risk of e-cigarettes when used as intended

> how much nicotine or other potentially harmful chemicals are being inhaled during use,

or
> if there are any benefits associated with using these products

Additionally, it is not known if e-cigarettes may lead young people to try other tobacco products, including conventional cigarettes, which are known to cause disease and lead to premature death.

## FDA Regulation of e-Cigarettes

Only e-cigarettes that are marketed for therapeutic purposes are currently regulated by the FDA Center for Drug Evaluation and Research (CDER). The FDA Center for Tobacco Products (CTP) currently regulates

> Cigarettes
> Cigarette tobacco
> Roll-your-own tobacco, and
> Smokeless tobacco

## Adverse Event Reports for e-Cigarettes

We regularly receive voluntary reports[31] of adverse events involving e-cigarettes from consumers, health professionals and concerned members of the public. The adverse events described in these reports include hospitalization for illnesses such as; pneumonia, congestive heart failure, disorientation, seizure, hypotension, and other health problems.

Whether e-cigarettes caused these reported adverse events is unknown. Some of the adverse events could be related to a pre-existing medical condition or to other causes that were not reported to FDA.



# Monitoring Medications

Nursing homes need to have a system to show the staff are monitoring for side effects and efficacy of all medications. The staff needs to be able to show or explain the home's system. The information does not need to be in more than one place. The care plan must cover those medications with a potential for significant impact upon the resident and those that require ongoing monitoring of their use.

A nursing home may focus the care plan on those medications that, based on a comprehensive assessment, have the potential for a clinically significant impact upon the resident or have side effects for which the resident is at particular risk. When a medication (for example, amiodarone, digoxin, or warfarin) is known to present a clinically significant risk, the nursing

home would have to justify not including it in the care plan.

The nursing home staff should be able to tell or show a surveyor the goal and objectives for medications being used and how they are monitoring the resident for efficacy and adverse consequences. The nursing home is not required to list each and every medication, but the care plan must have sufficient information to assure that the care is provided; the medication use is monitored as necessary; and that the location of the information regarding dose and duration is on the clinical record, i.e.in the physician's orders.

A drug that has a black box warning (if relevant to the resident) could have a significant impact on the resident. A nursing home should have a care plan that addresses how nursing home staff is going to monitor for or prevent an adverse reaction from that drug.

# Clostridium difficile (C-diff)

**From CDC: Frequently Asked Questions about Clostridium difficile (C-diff)**

What can I use to clean and disinfect surfaces and devices to help control C-Diff?

Surfaces should be kept clean and body substance spills should be managed promptly as outlined in CDC's "Guidelines for Environmental Infection Control in Health-Care Facilities" [PDF 1.4 MB] (/ hicpsc/pdf/guidelines/eic in HCF 03.pdf) Routine cleaning should be performed prior to disinfection. EPA-registered disinfectants with a sporicidal claim have been used with success for environmental surface disinfection in those patient-care areas where surveillance and epidemiology indicate ongoing transmission of C-diff.

CDC PRESS RELEASE – C- DIFF
March 6, 2012
Life-threatening germ poses threat across medical facilities
CDC highlights steps to prevent spread of deadly C. difficile bacteria, which impacts patients in nursing homes and outpatient care, not just hospitals

For Clinicians: 6 Steps to Prevention

1. Prescribe and use antibiotics carefully. About 50% of all antibiotics given are not needed, unnecessarily raising the risk  of C. difficile infections.

2. Test for C. difficile when patients have diarrhea while on antibiotics or within several months of taking them.

3. Isolate patients with C. difficile immediately.

4. Wear gloves and gowns when treating patients with C. difficile, even during short visits. Hand sanitizer does not kill C. difficile, and hand washing may not be sufficient.

5. Clean room surfaces with bleach or another EPA-approved, spore-killing disinfectant after a patient with C. difficile has been treated there.

When a patient transfers, notify the new facility if the patient has a C. difficile infection. All adult care home providers are encouraged to read the press release in its entirety at http://www.cdc.gov/media/releases/2012/p0306_cdiff.html. (See also Infection Control Practices… p.13.)

# CARE/PASRR Updates

**A year has passed since major changes were initiated for the CARE program.**

Some specific issues our CARE staff would like to review with you are:

**Terminal Illness Fax Memos:**
A.  Please use the FAX memo located on the Provider Resource Website at: http://www.aging.ks.gov/Forms/Assessments/CARE_Terminal_Illness_Fax_Memo.pdf  All necessary information is contained on this form.

B.    We will need ALL the blanks completed and ALL the information as requested to fill your request for a Terminal Illness letter.  When you receive the Terminal Illness Letter (TI Letter) please place it in the medical record as you would the CARE Level I Certificate as this becomes your "Proof of PASRR" for this resident.

C.    You will need to provide us with <u>actual date of admission to the nursing home</u> so we may date the letter to cover from the time of admission (only when resident admits with the 6mo.or less of life diagnosis).

D.    We CAN NOT issue a terminal illness letter back to "date of admission" UNLESS the resident actually meets "terminal illness criteria" upon admission.  In some instances a nursing home did not request a CARE assessment timely, later realized the resident now would meet criteria for "terminal illness" and attempted to capture payment for the time from admission to date by requesting a terminal illness letter dated back to admission. The physician must certify the date from which you are stating the resident meets the criteria for issuing a Terminal Illness letter.

E.    A resident DOES NOT have to be working with a HOSPICE in order to receive a terminal illness letter.  The required criterion is a diagnosis certified by a physician for "less than 6 mo. of life expectancy as defined by hospice regulation."

F.    You DO NOT NEED to have BOTH the CARE Level I assessment and a Terminal Illness Letter for the <u>same </u>resident:
1- Do not contact your ADRC for a CARE Level I if you request a TI letter of KDADS:  the purpose of the TI letter is to limit unneeded assessments.
2- If you already have a CARE Level I assessment on a resident, you will not need to request a "TI" letter if the person later meets criteria for one.

The CARE Level I and the TI Letter are both forms of "proof of PASRR". You need only the one appropriate to the admitting resident.

"30-Day Provisional" Admissions:
A.    An *appropriate 30-Day Provisional Admission* is one that admits the resident for 30 days OR LESS for the purpose of RESPITE or REHABILITATION. These (2) categories are the ONLY appropriate use of the **30-Day Provisional Admission**.
B.    The nursing home does NOT complete PASRR based on the payer source of the admitting resident: <u>PASRR is completed based on the building being licensed as a NURSING HOME and CERTIFIED for MEDICAID payment</u>.
**Many nursing homes continue to believe "in error" PASRR rules are suspended for residents admitting with "skilled orders" (i.e. Medicare payment for 20 days, etc.)**

C.    We are aware that some hospitals appear to misunderstand the **30-Day Provisional** order and issue one when not appropriate. This is not acceptable. We ask you to notify KDADS at 785-368-7323 when you encounter a hospital doing this consistently. We will call and educate their discharge planning staff regarding appropriate use of **30-Day Provisional** Orders.

D.    Nursing Homes are responsible to comply with PASRR.  Many never have any difficulty.  One "*best practice*" some have is to request the hospital fax the CARE Level I **prior** to sending the resident when the hospital plans to complete it;  in this manner there is no "surprise" when a Level I is expected but does not come with the resident.   If the admission is coming as "**30 day Provisional**" take a good look at the diagnoses and expected therapies being ordered to see if the person can actually be expected to discharge within the 30 day period.  If not, require the CARE Level I or contact the ADRC to perform it prior to or upon admission.

E.    When a resident admits "**30 Day provisional**":
1-your trained in-house NF CARE assessor completes Sections A and B of the CARE Level I assessment; fax this, along with the physician-certified 30 day or less order to KDADS at 785-291-3427;

2-Putting a "tickler file" together for "**30 day provisional**" can be helpful for remembering to contact the ADRC for the Level I by day 20 if the resident remains in the nursing home;

3-Nuring Homes have a responsibility to call timely for CARE Level I screens. The ADRC has *5 working days* to complete the assessment. Calling the ADRC on "day 30" will not keep you from missing payment days on the resident. Many times the ADRC will do everything they can to help keep you within your time frame, but their schedules are often very busy and there will be times they will need all (5) working days to get there. Calling at day 20 of the resident's stay assures you (and they) will have ample time to have the screen completed within the allowed time frame.

It is NOT appropriate to contact the ADRC for a CARE Level I PRIOR to day 20 on a "**30 day Provisional** admission." The purpose of the 30-day provisional admission order is to **prevent unneeded assessments** for residents who are in the NF for this short period of time of 30 days or less.

F.     **Please FAX  30 day provisional information to KDADS at 785-291-3427**:
        1-Section A and B of Care Level I Assessment
        2-Less than 30 day with physician signature
        3-Please include actual date of admission to NF in paperwork provided
**PLEASE  note**: A physician or physician extender must sign this order.  CMS will NOT ACCEPT a voice/phone order signed by your nursing staff, nor will they accept an order given for 30-Day Provisional AFTER the day of admission.

## Co-treatment Minutes

All MDS assessments must capture the total number of therapy co-treatment minutes provided in the seven day look-back period. However, none of these will be RUG-IV payment items, according to the RUG-IV specifications. In other words, the minutes coded for the co-treatment items will not be used by the grouper to determine RUG classification.

So how do facilities get paid for co-treatment minutes?

Judi Kulus, NHA, RN, MAT, C-NE, RAC-MT, vice president of curriculum Development, has confirmed with officials from the Centers for Medicare and Medicaid Services (CMS) that minutes delivered in co-treatment sessions still count as reimbursable therapy minutes for Medicare A patients. According to those CMS officials, providers will have to capture co-treatment minutes twice per discipline in order to be appropriately reimbursed:

• Once as appropriate in O0400A3A, O0400B3A, and/or O0400C3A for data collection, and
• A second time to capture reimbursable therapy minutes in the corresponding item for the appropriate therapy mode (e.g. O0400A1, O0400B1, or O0400C1).

Unfortunately, the coding instructions on page O-17 in Chapter 3 of the RAI Manual could be misinterpreted and lead providers to make false assumptions about how to capture co-treatment minutes. However, the OT and PT sections of the general coding example provided by CMS on pages O-28-O-30 do illustrate the need to capture the same co-treatment minutes in two separate, distinct MDS items per discipline.

In order to capture co-treatment minutes appropriately, it's first important to understand what co-treatment is and when it's allowed. CMS has not changed the definition of co-treatment. As explained on page O-21, co-treatment is not billable under Part B. Consequently, the equal capture of co-treatment minutes per discipline should only occur on the MDS Part A residents.

Here's how it works: Co-treatment involves two clinicians (which is two therapists, two therapy assistants, or combination thereof) from different therapy disciplines treating one resident at the same time with different treatments. When this type of scenario occurs under Part A, each discipline is allowed to code the full session as therapy minutes for that discipline as long as all policies regarding mode, modalities and student supervision, as well as all other federal, state, practice, and facility policies, are followed.

This information was gotten from the AANAC LTC Leader 10.10.2013 newsletter written by Caralyn Davis, Staff Writer

# Nursing Assessments

There is no one regulation/guideline listing all assessments that CMS expects will be performed. Within specific regulations, the Guidance to Surveyors addresses expectations. The following are F-Tag examples: F309 Quality of Care - pain; F323 Accidents and Supervision - smoking, choking, eloping, and more; F314 Pressure Ulcers - skin and wound assessments; and F315 Urinary incontinence - risk factors and incontinence. The RAI User's Manual in Chapter 1 p. 8 states: "Good clinical practice is an expectation of CMS .... completion of the MDS does not remove ... responsibility to document a more detailed assessment of particular issues relevant for a resident." Many assessments are completed based on standards of practice for LTC facilities. Assessment forms can be developed in-house or purchased from vendors. If you need specific assessment forms you can ask the members of this Community if anyone has one to share. Access the federal regulations from this link:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

You can also get a wealth of information from the Quality Indicator Survey (QIS) forms available at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/QIS-Survey-Forms.html

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# The Public Health Significance of *Salmonella*

In this article, KDADS underscores the importance of having in place the primary control strategies listed in the State Operations Manual (Appendix PP) to prevent a food borne outbreak caused by Salmonella.

**Question:** Why is Salmonella a public health concern and what control measures can a nursing facility kitchen(s) use to lessen the risk of an outbreak?

Salmonella is a germ that causes more hospitalizations and deaths than any other germ found in food.

The history of Salmonella dates to 1885. At the start of the 20th century, an asymptomatic carrier of Salmonella Typhi (Typhoid Mary) infected nearly 50 people during her career as a cook, three of whom died. Today, Salmonella causes approximately 1 million foodborne infections and costs $365 million in direct medical expenditures annually. More than 2,500 Salmonella serotypes have been identified. Four serotypes account for nearly half of the laboratory-confirmed human Salmonella infections reported to CDC in 2011: Enteritidis (the most common type in the U.S.), Typhimurium (or Typhi), Newport and Javiana. Only twenty serotypes account for nearly 75% of these infections.

Two on-line publications lend a current perspective on Salmonella and other pathogens.

• **FDA's Bad Bug Book** (2012 edition). This practical handbook contains scientific and technical information about the major pathogens that cause food borne illnesses. The Salmonella chapter provides a general description of this pathogen, including the characteristics, habitats and food sources, infective doses and general disease symptoms and complications. Access at: http://www.fda.gov/food/foodborneillnesscontaminants/causesofillnessbadbugbook/default.htm

• CDC's Antibiotic Resistance Threats in the United States, 2013. This a first-ever snapshot of the burden and threats posed by the antibiotic-resistant germs having the most impact on human health. Bacteria have been prioritized into one of three categories: urgent, serious, and concerning. The summaries for non-typhoidal Salmonella (caused by strains or serotypes other than Typhi, Paratyphi A, Paratyphi B, and Paratyhpi C) and Salmonella Typhi designate a Threat Level of Serious which means these "…will worsen and may become urgent without ongoing public health monitoring and prevention activities." Access at: http://www.cdc.gov/drugresistance/threat-report-2013/

Salmonella is found in nearly all foods, commonly in poultry and meat products. As stated in Appendix PP, it is *likely to be a source of contamination* in eggs (raw or unpasteurized), poultry (raw), meat (raw), and infectious food workers. Primary preventive actions to inhibit its growth are listed in Appendix PP – **and apply to all Salmonella serotypes**. The primary control strategies to prevent Salmonella infection from these sources are: time/temperature control (adequate cooking and proper holding) for Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety Food (TCS), cooking to proper temperatures, prevention of cross-contamination of ready-to-eat foods, exclusion of infectious food workers, proper hand-washing procedures, and avoiding bare-hand contact with ready-to-eat foods. According to the Bad Bug Book, cooking food to proper temperatures kill most bacteria, including Salmonella. Salmonella may also be the source of contamination as a result of adulteration of fresh fruits and vegetables. The primary control strategies to minimize the potential for Salmonella infection transmission by having good food handling practices for these sources are: washing the food prior to use (unless prewashed) and keeping cut and raw fruits or vegetables refrigerated.

Having in place evidence-based practices and control strategies for the effective control of microbiological, chemical and physical hazards in a food service operation is key to reducing the risk of foodborne illness. The FDA's 2009 Food Code establishes practical, science-based guidance and enforceable provisions for mitigating risk factors known to cause foodborne illness. It addresses controls for risk factors and establishes five key public health interventions: demonstration of knowledge, employee health controls, controlling hands as a vehicle of contamination, time and temperature parameters for controlling pathogens, and the consumer advisory. Chapters one through seven have been adopted by reference into the state's Adult Care Home Regulations. This KDADS regulation requires food employees to report a diagnosis of *Salmonella* **Typhi**, prompts the person in charge to exclude food employees with such a diagnosis, and provides conditions for reinstatement.

It is noteworthy that the 2009 Food Code and previous editions are silent about non-typhoidal Salmonella. The 2013 edition (recently released) is not. These amendments add non-typhoidal Salmonella as one of the reportable illnesses for action by the person in charge, add language to address employee health controls for the exclusion and restriction of nontyphoidal Salmonella, and add conditions for removal of exclusion and restriction of nontyphoidal Salmonella. Future revision to KDADS regulations may reflect new 2013 FDA model code amendments.

The feasibility of preventing foodborne illness has been proven, e.g., attainment of the 2010 national health objective target for STEC O157 (a dangerous type of E. coli infection) and declines in the incidence of six key foodborne infections since 1996-1998. Less progress has been made with most other infections, especially Salmonella – its incidence has not changed since surveillance started in FoodNet in 1996-1998. It is the only pathogen for which the Healthy People 2020 objective was increased compared to its 2010 target. The new target is to achieve a 25% reduction in Salmonella infections by 2020, with a projected $421 million savings in direct medical costs.

**REFERENCES**

Centers for Disease Control and Prevention. Vital Signs: Incidence and Trends of Infection with Pathogens Transmitted Commonly Through Food –

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Centers for Disease Control and Prevention. National Enteric Disease Surveillance: Salmonella Annual Report, 2011. 2013.

Food and Drug Administration. Bad Bug Book, Foodborne Pathogenic Microorganisms and Natural Toxins. Second Edition. Pathogenic Bacteria: Gram-negative bacteria: Salmonella spp., pp. 9-13.  2012.

Centers for Disease Control and Prevention. Antibiotic Resistance Threats in the United States, 2013. 2013.

State Operations Manual (SOM). Appendix PP. Guidance to Surveyors for Long Term Care Facilities. 42 CRF §483.35(i) Sanitary Conditions under Tag F371.  Pathogenic Microogganisms and Strategies for their Control.  Prevention of Foodborne Illness (chart)

FDA Food Code 2009.  Chapter 2 – Management and Personnel.  Part 2-2 Employee Health.  Subpart 2-201.11 Responsibility of Permit Holder, Person in Charge, and Conditional Employees. Subpart 2-201.12 Exclusions and Restrictions.  Subpart 2-201.13 Removal, Adjustment, or Retention of Exclusions and Restrictions.

FDA Food Code 2013.  Chapter 2 – Management and Personnel.  Part 2-2 Employee Health.  Subpart 2-201.11 Responsibility of Permit Holder, Person in Charge, and Conditional Employees. Subpart 2-201.12 Exclusions and Restrictions.  Subpart 2-201.13 Removal, Adjustment, or Retention of Exclusions and Restrictions.

U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, D.C.

# Award Letters

| Facility | City | Type | Date | Exempt | NO DEF LETTER |
|---|---|---|---|---|---|
| Clare Bridge of Wichita | Wichita | RHCF | 1/9/14 | | x |
| Vintage Park at Paola LLC | Paola | ALF | 1/14/14 | | x |
| Vintage Park at Osage City LLC | Osage City | ALF | 1/14/14 | | x |
| Twin Oaks Assisted Living | Lansing | ALF | 1/22/14 | | x |
| Meadowlark Adult Care Home 4 | Wichita | HP | 1/23/14 | | x |
| Cypress Springs - Kansas City | Overland Park | RHCF | 1/27/14 | | x |
| Reflection Living Maize Ct 1 | Wichita | HP | 1/28/14 | | x |
| Reflection Living Maize Ct 2 | Wichita | HP | 1/30/14 | | x |
| Country Living | Anthony | ALF | 2/3/14 | | x |
| Midland Care Lawrence Adult Day Health | Lawrence | ADC | 2/3/14 | | x |
| Sterling House of McPherson | McPherson | ALF | 2/3/14 | | x |
| The Homestead of Halstead | Halstead | ALF | 2/3/14 | | x |
| Vintage Park at Baldwin City LLC | Baldwin | ALF | 2/10/14 | | x |
| The Pines of Hiawatha South | Hiawatha | HP | 2/11/14 | | x |
| Arkansas City Presbyterian Manor | Arkansas City | SNF/NF | 2/18/14 | | x |
| Sterling House of Junction City | Junction City | ALF | 2/19/14 | | x |
| Marquis Place | Concordia | ALF | 2/10/14 | | x |
| Keen Boarding Care Home | Clay Center | BCH | 2/24/14 | | x |
| Rescare Home Plus | Winfield | HP | 2/27/14 | | x |
| Peggy Kelly House II | Topeka | RHCF | 3/5/14 | | x |

**SNF/NF - Skilled Nursing Facility/Nursing Facility; ALF - Assisted Living Faciltiy; BCH - Boarding Care Home; ICF/ID - Intermediate Care Facility for Intellectually Disabled; RHCF- Residential Health Care Facility; ADC- Adult Day Care; HP- Home Plus**

ROUTING SLIP
Administrator_____    Nurse Manager _____    Therapy _____    DON _____
Assist. DON _____    Social Service Director _____    Break Room _____
Activities Director _____Dietary Manager _____ Human Resources _____
MDS Coordinator _____ Other _____