Member Call Summary

August 1, 2025

Provider Self-Assessment and HCBS Settings Tracking Updates

In July 2025, the Provider Self-Assessment (PSA) Application was launched to streamline communication with HCBS Quality Oversight specialists and providers. The application is accessed within the Iowa Medicaid Portal Application (IMPA). A training was developed to communicate expectations and explain functionality of the application. You can access them here:

- Provider Self-Assessment Application Training
- Training Slides

The HCBS Provider Quality Self-Assessment is required of all providers enrolled for the services identified, regardless of whether those services are currently being provided. The self-assessment must be completed, submitted and approved at application, annually and anytime there is a change in the provider's enrollment that warrants an updated self-assessment.

Beginning August 2025, organization details, enrollment qualification details, HCBS settings, and the self-assessment questionnaire completed via the Provider Self-Assessment (PSA) Application within the Iowa Medicaid Portal Application (IMPA).

The application consists of four parts: organization contact details, program and service enrollment and qualification information, HCBS settings, and the self-assessment questionnaire. All information can be updated and reported directly within the application to your HCBS Provider Quality Specialist for review and approval.

The self-assessment questionnaire will be updated annually and released within the PSA Application.

If you have questions about the HCBS Provider Quality Self-Assessment, contact the assigned HCBS Specialist. You can also send questions via email to hcbsqi@hhs.iowa.gov

Iowa HHS Announces New Medicaid Director for State of Iowa

The Iowa Department of Health and Human Services (HHS) today announced that Lee Grossman has been appointed as the new Director of Iowa Medicaid.

Grossman, an Iowa native, brings more than 14 years of experience from the Wyoming Department of Health, where he most recently served as Medicaid Director since February 2023.

“I’m thrilled to welcome Lee back home to Iowa as he steps into this role,” said Iowa HHS Director Kelly Garcia. “His leadership and invaluable expertise make him an ideal fit to guide our Medicaid team through this critical work at this critical time. As I’ve had the pleasure of getting to know Lee, what I see is deep Medicaid knowledge, a steady hand and a clear commitment to the people this program supports. Lee’s knowledge of building rural health care access will be an attribute perfectly focused for this moment.”

The appointment follows a comprehensive nationwide search. During the interim period, HHS conducted an internal evaluation to strengthen the Medicaid team’s structure and lay the foundation for long-term success. This foundational work adds expertise in-house and deepens the agency’s commitment to strong oversight and accountability.

“It’s an honor to return to the state where I grew up and contribute in such a meaningful way,” said Grossman. “I look forward to working with this team that’s deeply committed to helping thousands of Iowans live healthier lives in the community of their choice.”

Lee will begin this new role in early September. Iowa Medicaid provides health coverage to over 700,000 Iowans each year, including children, low-income individuals, pregnant women, older adults, and people with disabilities.

Dignity Act: Bipartisan Immigration Reform Bill Introduced

Representatives María Elvira Salazar (R-FL) and Veronica Escobar (D-TX) on July 15 **introduced** the **Dignity Act of 2025**, a bipartisan immigration reform bill aimed at addressing long-standing challenges within the U.S. immigration system. The legislation seeks, among other goals, to modernize border security, streamline the asylum process, and provide legal pathways for certain undocumented individuals who have long been present in the U.S.

In its current iteration, the Dignity Act includes several provisions with potential implications for the aging services workforce:

Division A, Title IV – Mandatory E-Verify: This section would require all U.S. employers to use the federal E-Verify system to confirm the employment eligibility of new hires, phasing in the requirement over two years based on employer size. This provision could entail administrative and compliance challenges for providers—particularly small and rural organizations—while also preventing unauthorized employment.

Division B, Title I – Dream Act: This section would grant conditional permanent resident status to certain undocumented individuals who entered the U.S. as minors—commonly known as “Dreamers” and including Deferred Action for Childhood Arrival (DACA) recipients. To be eligible, an individual must have been present in the U.S. since January 1, 2021, meet certain educational requirements, and pass a criminal background check. These provisions could ensure that Dreamers and DACA recipients working in (or potentially working in) aging services have access to a more permanent status.

Division B, Title III – Dignity Program: This new seven-year program would offer long-term undocumented immigrants a chance to earn legal status, work authorization, and protection from removal if they pass background checks, pay restitution, and work or attend school for at least four of the seven years. Participants must remain in good standing and are ineligible for federal benefits during that period. Although they would be exempt from certain payroll taxes, this provision stipulates that participants in the program would pay a 1% levy on their adjusted gross income that would help fund border security. Upon successful completion of the program, participants would be able to renew their status indefinitely for additional seven-year periods. Temporary protected status holders would be eligible for this program, but only if they have been present in the U.S. since December 31, 2020. This provision could create an expanded pool of workers that LeadingAge members could draw from.

Division B, Title IV – Contribution to American Workers: This section establishes the American Worker Fund, which would be financed by restitution payments from Dignity Program participants. The fund would support workforce training and education, including apprenticeships and work-based learning programs. Grants could go to partnerships serving high-demand sectors, potentially including long-term care, to support upskilling and career advancement for American workers.

Division C, Title II, Section 3202 – Per-Country Caps Raised: This provision would double per-country caps on employment-based green cards (such as the EB-3), helping reduce visa backlogs for workers from countries with historically high demand. Although not likely to alleviate the overall wait times employment-based visas, it would likely benefit applicants from India and China to the detriment of applicants from other countries.

Division C, Title III, Section 3301 – Spouses and Minor Children of Workers: This provision would ensure that dependents of employment-based visa holders are no longer counted against annual visa caps. By removing this bottleneck, more visas would be available for actual workers, including those in direct care and nursing roles. This provision would have the potential to reduce wait times for employment-based green cards significantly.

Division C, Title III, Section 3304 – Modernizing Visas for Students: This provision would allow student visas to be issued with “dual intent,” meaning applicants would no longer have to prove they intend to return home. This change could encourage more international students to pursue long-term careers in the U.S. after completing their education.

This bill represents a serious bipartisan attempt at immigration reform that has the potential to bolster labor pools across multiple sectors, including aging services. You can read more here.

LeadingAge Joins Sen. Bernie Sanders to Oppose Devastating Medicaid Cuts

On July 30, LeadingAge President & CEO Katie Smith Sloan and the leaders of two LeadingAge-member organizations joined U.S. Sen. Bernie Sanders (I-VT) at his press conference convened to raise the alarm on Medicaid cuts totaling nearly $1 trillion.

Held on Capitol Hill in Washington, DC, the event spotlighted how these drastic funding reductions will jeopardize care for older adults and create lasting damage to the aging services infrastructure across the country.

Medicaid is the only public payer for long term services and supports in the U.S.—both for care delivered in nursing homes and through home and community-based services (HCBS). It covers 60% of older adult stays in nursing homes. LeadingAge's nonprofit and mission-driven members rely on these resources to deliver services across a range of settings—including personal and home care, assisted living, adult day services, Programs for All-Inclusive Care for the Elderly (PACE), and affordable senior housing.

"The undeniable fact is: America's infrastructure of services to support older people was inadequate and unsustainable before the passage of the 2025 Budget Reconciliation Act," said LeadingAge President and CEO Katie Smith Sloan. "The changes called for in the act—and now law—will weaken the existing system at a time when demand for services and supports is growing."

The massive cuts that will result from the 2025 Reconciliation Bill come at a time when demand for long-term care and services is growing. Americans over the age of 65 now make up nearly 20% of the total population. As this number rises, aging services providers are already stretched thin—facing persistent workforce shortages, financial pressures, and growing demand for care.

Sanders, Ranking Member of the Senate Health, Education, Labor and Pensions (HELP) Committee, warned that the bill will intensify the nation's long-term care provider crisis, noting that in 2023, 55% of nursing homes already turned away residents due to staffing or financial strain, and over 700,000 people remain on Medicaid waitlists for home and community-based services—likely an undercount of the need or desire for HCBS. Sanders underscored that forthcoming funding reductions will likely leave nursing homes with little choice but to close, downsize, or pivot away from Medicaid funded long-term care, and will force HCBS providers to reduce capacity or may even face elimination of their Medicaid-funded services since HCBS benefits are optional. These outcomes will leave older adults and families scrambling for assistance and shifting caregiving burdens primarily onto unpaid women caregivers.

This law will lead to:

- **Millions of Americans losing health insurance**, including older adults and their caregivers;
- **Potential cuts to Medicare provider payments of 4% annually for the next decade**, due to budget deficit triggers;
- **Significant reductions in federal Medicaid contributions**, forcing states to scale back eligibility, benefits, and provider payments;
- **Increased burdens on family caregivers**, who may lose access to coverage themselves while absorbing new responsibilities;
- **Threats to home and community-based services**, including home care, personal care, assisted living, and adult day programs.

The chief executives of two LeadingAge-member organizations—A.G. Rhodes' Deke Cateau and Heather Turbyne-Pollard of Circle Center Adult Day Services—shared their on-the-ground experiences providing nursing home care and services in adult day, respectively, to illustrate the drastic impact these cuts will have on real people in our country.

"Medicaid has become and is the backbone of our health care system," said Cateau. "For aging and senior services, it is the health care system. It is the only payer or the only real payer of long-term care … so any cuts, any changes, whether you disguise them as adjustments are going to have a very immediate impact. And it's an impact that I cannot imagine."

"Currently the reimbursement rate for the state of Virginia for Medicaid is $64.17. It is $150 a day for me to deliver that care," said Turbyne-Pollard. "Now when we're faced with the chance of it getting reduced or eliminated, you can see if you do the math along with me, how it may put home and community-based care folks like me out of business. … We should all be turning up the dial on all the services across our continuum that can support older adults and their caregivers caring for them as they age. It's not the time to take that away from folks."

These sweeping cuts will not just destabilize providers—they will disrupt the lives of millions of older adults and their families.

LeadingAge opposes the Medicaid policies and cuts enacted in this law as well as many other components of this law. We will continue to advocate for policies that strengthen—not dismantle—our nation's safety net, and ensure all Americans can age with dignity, health, and purpose. Read more here.

KFF Updates Analysis of State-by-State Medicaid Reductions in OBBB

In a brief published on July 23, KFF used updated scoring from the Congressional Budget Office to estimate state-level reductions in federal Medicaid spending. The estimates include allocation of provisional interactions, which account for how policies would reduce spending in multiple areas and offset double counting for policies that would result in the same outcome. KFF attributes $911 billion in federal Medicaid cuts through 2034. The analysis found that cuts applicable only to states that have undertaken Medicaid Expansion under the Affordable Care Act (ACA) account for more than half of the cuts- totaling $526 billion.

Federal funding reductions in the first five years of the budget window account for less than one quarter (24%) of the total cuts since many provisions are not effective until years out. The full $911 billion represents a 14% reduction in federal Medicaid spending over the 10-year period. States, including Louisiana, Illinois, Nevada, and Oregon, see cuts approaching 20% of their federal Medicaid funding, while all states will face significant percentage reductions in federal Medicaid spending. Iowa's Medicaid reduction is expected to be 17%. The analysis displays data in multiple easy-to-consume charts and images. A state-by-state map illustrates how individual states are anticipated to fare. Review the brief here.

CMS Increases 2026 Skilled Nursing Pay Raise to 3.2%

Nursing homes will see a 3.2% increase in their Medicare Part A payments next fiscal year, the Centers for Medicare & Medicaid Services announced late Thursday.

That's a jump from a pay rule proposed in April, in which CMS proposed a 2.8% increase for fiscal 2026. The final rate amounts to an increase in SNF PPS payments of $1.16 billion over fiscal 2025, CMS said.

It is based on final SNF market basket of 3.3%, plus a 0.6% market basket forecast error adjustment, and a negative 0.7% productivity adjustment.

The 2026 increase is still significantly less than recent years. Providers received a 4.2% pay hike ahead of this fiscal year and 4.0% the year before.

CMS acknowledged Thursday that reductions triggered by the SNF Value-Based Purchasing program would trim more than $208 million from the $1.16 billion increase.

But included in the rule's changes to the VBP program is a new reconsideration process that will allow nursing homes to appeal CMS' initial decisions for review and correction requests prior to CMS making any affected data publicly available.

CMS also is applying a previously finalized scoring methodology to the SNF Within-Stay Potentially Preventive Readmission measure beginning with the FY 2028 program year. The agency also is removing the VBP program's Health Equity Adjustment from the scoring methodology.

On the Quality Reporting side, for which nursing homes can lose 2% of their payment update for failure to provide enough data, changes are also relatively minor compared to recent years. CMS will remove four standardized patient assessment data elements

under the Social Determinant of Health category from the MDS beginning with residents admitted on Oct, 1, 2025, for the FY 2027 SNF QRP. The data elements are one item for “living situation,” two items for “food” and one item for “utilities.”

As with the VBP program, CMS is finalizing an amended reconsideration policy and process. It now will allow SNFs to request an extension to file a request for reconsideration and will update the rationales for which CMS can grant a reconsideration request. Read more here.

CMS Removes Focused Infection Control Surveys from the Survey Process

The Centers for Medicare & Medicaid Services (CMS) revised a QSO memo on Guidance for the Expiration of the COVID-19 Public Health Emergency, now listed as QSO-25-23-ALL. This memo was initially released May 1, 2023, and outlined steps upon the termination of the public health emergency and 1135 waivers. In the revised memo dated July 30, 2025, CMS added that focused infection control (FIC) surveys are no longer part of the standard survey process and that any COVID-19 or infection control concerns should be investigated through complaint investigations outside of the long-term care survey process.

QRP Non-Compliance Letters in CASPER Folders

The Centers for Medicare & Medicaid Services (CMS) is providing notification to providers that were determined to be out of compliance with Quality Reporting Program (QRP) requirements for the Calendar Year (CY) 2024, which impacts the Fiscal Year (FY) 2026 Annual Payment Update (APU). Non-compliance notifications are distributed by the Medicare Administrative Contractors (MACs) and were placed into providers CASPER folders in QIES (Hospice) and iQIES (SNF) on July 21. If you receive a letter of non-compliance, you may submit a request for reconsideration to CMS via email no later than 10:59 p.m. CT on August 26, 2025. You can find instructions on requesting a reconsideration on the appropriate QRP webpage:

- SNF Quality Reporting Reconsideration and Exception & Extension
- Hospice Quality Reporting Reconsideration Requests

QIO Programs Begin 13th Scope of Work

The Quality Improvement Organizations (QIO) Program’s 13th Scope of Work (SoW) has been approved and QIOs are once again authorized to provide training, resources, and technical support to nursing homes, hospitals, and physician’s offices. The SoW includes reassignment of QIOs into seven regions with both new state groupings and new contracts. Telligen was appointed as the QIO for Iowa and you can request assistance by visiting their website – www.telligenqiconnect.com.

Potential Medicare Claims Adjustments Due to CBSA Errors

The Centers for Medicare & Medicaid Services (CMS) announced in a MLN Connects Newsletter on July 17, that errors were identified in the Core-Based Statistical Area (CBSA) zip code files for January, April, and July 2025. The CBSAs are used to classify providers as rural or urban when determining wage indices for payment rates. CMS made corrections to files and providers may see an adjustment as the Medicare Administrative Contractors (MAC) reprocesses affected claims.

Center of Excellence for Behavioral Health Support Ending

The Center of Excellence for Behavioral Health in Nursing Facilities (COE-NF) will reach the end of its three-year funding period on September 29, 2025. After that date, technical assistance consultations and live training events will no longer be available for nursing homes. Recorded education and resources will remain accessible on the Centers for Medicare & Medicaid Services (CMS) website after the grant concludes with additional details soon. Additionally, Alliant Health Solutions will also post the recorded training and resources for at least one year after the grant funding terminates (September 2026). You can access Alliant Health Solutions website here.

LeadingAge is interested in hearing feedback on the impact terminating this funding may have on nursing homes. Have you used their 1:1 technical support or accessed resources and training? Please email Jodi Eyigor at LeadingAge with specific information.

July DIAL Updates

On July 28, the Department of Inspections, Appeals, and Licensing held their monthly association update call. During the call, DIAL provided the following updates:

AL/RCF/ADS

Assisted living recertifications are averaging approximately 29 months and the department is making progress on overdue investigations into complaints and incidents. A couple of trends were noted recently during surveys with the first being elopements and ensuring that the staff are completing checks on the functioning of door alarms and devices. For example, you should incorporate periodic testing of the door alarms and any wandering alarm devices in your policy. This helps identify if the alarm or device is malfunctioning, which would then alert the staff that repairs must be completed. Additionally, if the alarm or device is malfunctioning, you should implement safety measures to protect tenants (such as checking the tenant's location frequently or having a staff member watching the door to prevent any elopements).

Secondly, DIAL reports that significant medication errors have been noted. Upon clarification, DIAL stated that programs need to be monitoring the medication manager

staff to ensure that they are completing medication administration according to the competency training and testing programs. Recently, the medication errors were related to staff setting up multiple tenants' medications prior to medication pass and then administering the incorrect medication to the tenants. Standard of practice for medication administration always directs staff to set up the medication for one tenant at a time and at the time the medication should be administered, never before.

LTC

The long-term care unit within the department discussed the transition to iQIES and expressed that they are still trying to learn all of the reports that are available to them and how to pull certain data measures. Additionally, they expressed that processing the completed surveys from the program coordinator role has proven more challenging than anticipated which may lead to some delays in receiving your survey reports. The long-term care unit stated that they are not sure how to pull a report which identifies their current recertification average, but as of the last report in ASPEN they were averaging approximately 11.5 months between surveys. They anticipate this may increase slightly as they try to focus on reducing outstanding complaints and incident investigations.

DIAL stated that there were a couple of immediate jeopardy templates given to providers during their survey related to an electric cord that had exposed wires and when a resident went out to a courtyard but was unable to get back into the building due to the door locking and the resident was subsequently outside overnight. If you have residents that can use outdoor courtyards, ensure that you have a process for identifying when the residents are outside the building, that they are able to get back in, and that your staff periodically check on them to ensure that they are safe.

Medicare Services

Unfortunately, Hema Lindstrom was unable to be on the call, so there were not any updates provided for home health and hospice.

Misc Updates

DIAL expressed concerns during the call about the high temperatures and humidity that the state has been experiencing. They emphasized the importance of reviewing safety practices if tenants/residents are outdoors during this time such as maintaining hydration, periodic safety checks, and ensuring that they can return to the building when they desire to do so. Additionally, if your air conditioning system is having difficulty maintaining cooler temperatures, DIAL asked that you please communicate what you are doing about it to the residents/tenants, your staff, and families. They have been receiving more complaints recently about the buildings being hot and don't believe that the provider is doing anything about the building being that temperature.

During the last member call, concern was raised about a particular survey and enhanced barrier precautions (EBP). The concern included that a surveyor expressed that EBP must be implemented when a resident has a skin tear larger than what a Band-Aid can cover. This concern was raised with DIAL, and they expressed that their interpretation of the EBP memo includes chronic wounds such as pressure ulcers and not skin tears that are expected to heal without complications. However, they were going to discuss the situation with the survey team to identify if there was a specific incident that would have triggered this comment.

Finally, Iowa Health and Human Services (HHS) provided an infection control update, indicating that Measles cases across the country have started to slow and Iowa has eight identified Measles cases. Additionally, they reported that the resistant Candida auris levels have remained consistent across the State during 2025 with more cases recently identified in acute care settings as they have been conducting more screening in patients.

Best Practices – Pressure Ulcer Prevention & Repositioning

Numerous older adults are at risk of developing pressure ulcers and long-term care providers must identify this risk and implement interventions to reduce this risk in those they serve. Repositioning is an intervention that is frequently used as a prevention strategy. However, is there a best practice to determine the frequency and methods used for repositioning? When researching pressure ulcers, I found a robust guide on several topics on patient repositioning including determining the frequency that someone should be repositioned given their overall condition as well as how individuals should be repositioned.

The National Pressure Injury Advisory Panel (NPIAP) offers a free online guidance document(s) on the multiple facets of pressure ulcer prevention, identification, and treatment. To prevent information overload, lets focus on one area at a time.

The NPIAP information outlines that pressure injuries cannot form without mechanical loading acting on the tissue which includes extended periods of lying or sitting on a particular part of the body without redistributing the pressure leads to tissue deformation and ultimately damages the tissue in the form of a pressure injury. Repositioning is an essential preventative measure to reduce the occurrence of pressure injuries. To reduce your burden in researching these, I've outlined some key considerations to implementing best practice in your community.

General Repositioning:

It is good practice to reposition patients at risk for pressure ulcers, regardless of the pressure redistribution support surface being used. However, you may consider the frequency of repositioning based on the support surface. It is good practice to reposition

patients in a way that offloads pressure points and maximizes redistribution of the individual's weight. Implementation considerations include:

- The person's goals of care and priorities. For example, someone at the end of life may forego reducing the risk of pressure injury to not be disrupted by repositioning or to cause pain by repositioning. While pressure ulcers cause pain in and of themselves, the individual's goals may outline that a repositioning at a less frequent schedule is sufficient to both meet their preferences and not develop pressure ulcers.
- Look at the individual's repositioning needs over a 24-hour period. Are there times when the person will always be at meals that can be counted as a repositioning time? Additionally, there may be considerations to their preference of repositioning location (such as a bed compared to a recliner). An interdisciplinary approach should be used when developing a schedule for the patient.
- Check all pressure points when you are redistributing their weight. Areas such as the gluteal cleft, elbows, malleolus, and wrist are vulnerable areas that are frequently overlooked.
- Assess the patient's pain before, during, and after repositioning. Consider the use of pain medication before repositioning occurs if the act of repositioning causes pain.
- Assess the patient's full body when repositioning. Evaluating the person's body alignment and posture to maximize comfort and offload pressure is necessary to pressure ulcer prevention. The use of additional repositioning supports or devices may be necessary to ensure proper alignment and pressure reduction.
- Use of positioning devices can be used to maintain position, elevate and support pressure injury prone areas, promote body symmetry, posture and comfort Ensure that the patient and/or staff are well educated on positioning devices intended anatomical areas for pressure relief (for example do not position a pillow directly against the sacrum when in a lateral position). Consider using specialized repositioning devices to support specific needs or body shape such as a Z-Flo or similar device that can be molded or conformed to the patient's position and won't flatten over time like towels or blankets.
- Ensure that objects and medical devices are moved out from underneath patients to prevent device-related pressure and friction.
- If a patient can self-reposition, encourage them to do so as often as possible and staff may need to remind them to regularly do so. Assess and monitor these individuals to ensure that their self-repositioning techniques are effectively offloading pressure points and they are avoiding friction and sheer as they reposition themselves.

When repositioning patients, it is good practice to use specialized equipment designed to reduce friction and shear. If manual handling is necessary, techniques that minimize the friction and shear should be applied. Implementation considerations include:

- Identifying individual's experiences with manual handling. Fear, pain and/or discomfort may lead to difficult transfers and repositioning.
- Specialized manual handling equipment shall be easily available and in good working order. Ensure that this equipment is also safe based on age, weight, and dimensions of the individual.
- Establish procedures to support safe and appropriate transfers such as lifting rather than dragging and consider use of assistive devices such as low friction fabric transfer sheets. Also pay close attention to patient's heels during repositioning and/or transfers.
- Minimize shear once repositioning by ensuring that surface materials are not pulling on skin. Examples of this can include loosening sheets.
- Manual handling equipment should not be left under the resident unless the equipment is specifically designed for this purpose.
- Consider implementing a dedicated repositioning team who are experts in manual handling to promote optimal repositioning, adherence to schedules, and reduction of staff injuries such as ComfortGlide Turning and Repositioning System by Medline.

When positioning in bed it is not necessary to use a 30-degree lateral positioning or maintaining a 30-degree head of bed elevation as there is low certainty of evidence supporting these recommendations.

- Avoiding laying in positions that increase pressure is recommended such as a 90-degree lateral position.
- When repositioning in a lateral position, offload the sacrococcygeal area without placing pressure on the trochanter. This can be possible by positioning the upper leg forward of the lower leg with support from a pillow to promote comfort and stability.
- Ensure bony prominences such as heels, knees, and ankles are offloaded.
- Consider use of a Leaf Sensor or similar device that the patient can wear and will tell the staff if the individual needs repositioned or if they are correctly positioned with offloading of pressure injury prone areas.
- The head of the bed should be as flat as possible considering the individual's clinical needs and preferences. When possible, maintain elevation at 30 degrees or lower.
- When elevating the head of the bed, ensure that the thighs are elevated to minimize shear by sliding.
- Investigate alternatives to sitting in bed such as sitting out of bed during meals.

- Avoid slouched positions which increase pressure and shear on the sacrum and coccyx.

New Member Resources

Post this Non-Pharmacological Interventions by Behavior One-Pager for your staff to quickly identify possible interventions and reduce the use of psychotropic medications in your community.

LeadingAge Learning Hub has a new six-minute QuickCast 5 Tips for Successful PBJ Filings.

You can use this Artificial Intelligence Use policy and associated Informed Consent if you utilize AI programs.

FYI – On-site MDS

Upcoming Events

MDS Virtual Program (virtual)
August 13-15, 2025 from 11 a.m.-3 p.m.

Admit to Discharge: A Rules, Regs, & Reimbursement Blueprint Webinar Series (virtual)
August 20 & 27, 2025 from 1 - 2 p.m. & September 10, 2025 from 1 - 2:30 p.m.

Regional Networking Meeting (in-person)
August 27, 2025 from 1-3 p.m. (The Meth-Wick Community will be hosting lunch at noon for those that are able to come at that time.)
Location: The Meth-Wick Community, 1224 13th St. NW, Cedar Rapids, IA 52405