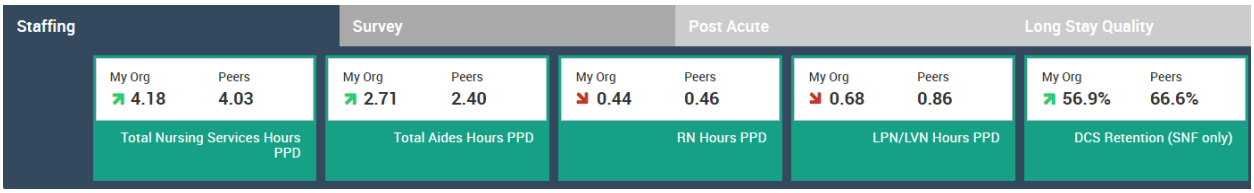
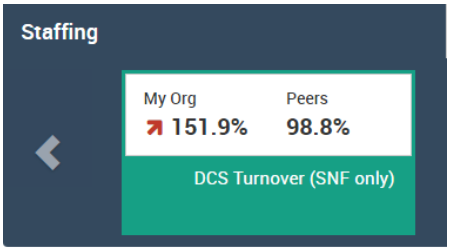
8-1-22 Weekly Clinical Update

Yesterday, August 18th, the AHCA State Affiliate Network met virtually, and I want to share a couple of items of interest from that meeting. The Public Health Emergency was extended to October 13, 2022 and we need that to be extended if possible. The good news is that the Administration has indicated they would provide 60 days' notice prior to stopping it, and that should already have happened, so it looks like it will be extended into early 2023 at the earliest. Also, the Administration doesn't want the PHE to end prior to the midterm election, so there's that.

Pam Truscott from AHCA reported that providers are pushing for updating of masking requirements for healthcare facilities. The problem is that COVID is still very active across the country. AHCA is actively tracking and advocating for clarification.

Then we got to the bad news…the staffing mandate. Pam reported that CMS folks are "committed" to minimum staffing levels of 4.1 PPD of direct care staffing. There was discussion about the definition of "direct care staff" and who could be counted into the 4.1. AHCA will be advocating for facilities during development of the final rule. AHCA is aware that CMS is "mis-guided" and providers must be active in shaping the rule. The timeline for study is set and it is likely that the rule will be issued in February, 2023. There will very likely be a grassroots call for facilities to share the impact of this potential rule. If you haven't peeked at TrendTracker lately, here is the staffing information for KHCA members.





A couple take-aways…KHCA members' staffing is higher than all other facilities in the nation for both Total Nursing Services Hours, Total Aides Hours, but look at the KHCA facilitys' direct care staff turnover rate…**151.9%!!!!!** All I can say is Holy Smoke!

Pam also emphasized the importance of this year's National AHCA Convention. With so much going on, we have to stick together to have a voice.

That's a quick synopsis of the meeting but some very important issues were covered.

Let me take a minute more to visit about a change in the Appendix PP guidance for Psychotropics in the new guidance.

In the previous guidance, antipsychotics, antidepressants, anti-anxiety medications and hypnotics were covered. In this guidance, they added the following:

Additionally, all medications which affect brain activity are included in this policy when documented use is a substitute for another psychotropic medication rather than the original or approved indication including but not limited to:

- ❖ Antihistamines
- ❖ Anti-cholinergic medications
- ❖ Central nervous system agents to treat seizures, mood disorders, pseudobulbar affect, muscle spasms, or stiffness

They also side effects, including psychosocial outcomes related to administration of psychoactive medications that should be monitored (check out the new psychosocial effects that require monitoring):

- ❖ Monitoring will including but is not limited to:
  - ➢ Behavioral symptoms
  - ➢ Presence of adverse consequences

- Potential adverse consequences include but are not limited to:
  - ❖ General:
    - ➢ Anticholinergic effects including flushing, blurred vision, dry mouth, altered mental status, difficulty urinating, falls, excessive sedation, constipation
  - ❖ Cardiovascular
    - ➢ Signs/symptoms of cardiac arrhythmias, palpitations, lightheadedness, shortness of breath, diaphoresis, chest or arm pain, increased blood pressure, orthostatic hypotension
  - ❖ Metabolic
    - ➢ Increase in total cholesterol and triglycerides, unstable or poorly control blood sugar, weight gain
  - ❖ Neurologic
    - ➢ Agitation, distress, EPS, neuroleptic malignant syndrome (NMS), parkinsonism, tardive dyskinesia, cerebrovascular event (stroke, TIA)
  - ❖ Psychosocial
    - ➢ Sedation
    - ➢ Lethargy
    - ➢ Agitation
    - ➢ Mental status changes
    - ➢ Behavior changes
    - ➢ Affecting resident's abilities to perform activities of daily living or to interact with others
    - ➢ Causing resident to withdraw or decline from usual social patterns
    - ➢ Causing resident to experience decreased engagement in activities
    - ➢ Causing diminished ability to think or concentrate

There is also a statement that is not new, but needs some added attention since there will be great emphasis placed on this in survey situations. "Report of the resident's condition from facility staff to the attending physician or prescribing practitioner does not constitute an evaluation", meaning that the physician/practitioner has to do his/her own evaluation and can't just take a report from the facility staff. Hope this information helps…