CMO REPORT

FROM THE DESK OF
Amy Tucker, MD, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine
Vice President, Ambulatory Services and Population Health, Upstate Medical University

UPSTATE UNIVERSITY HOSPITAL

May 18, 2020

Reopening and Recovery

On April 29, 2020, the NYS DOH issued Executive Order 202.25, allowing resumption of elective outpatient surgeries and procedures in hospitals located in counties with low COVID-19 burden, including Upstate. On May 11, 2020 we transitioned from our Incident Command response to our Recovery process. During Recovery, we will gradually introduce incremental surgical and procedural volumes, while maintaining social distancing and universal masking. Patients will be tested for COVID by PCR no more than 72 hours prior to their procedures and will be counseled to adhere to strict social distancing and public masking for the 14 days prior to their procedures (see attached for specifics). We are also introducing more in-clinic ambulatory visits to provide care not amenable to telemedicine. During the Recovery Phase, we will be carefully monitoring for:

- New regulatory directives from NYSDOH,
- COVID prevalence in the community
- COVID admissions
- Bed capacity—ICU and med/surg
- Availability of PPE and other supplies
- Testing supplies
- Staffing

Should any one of these become limiting, we will pull back. The current versions of the Recovery Team Overview and the Reopening Plan are attached. These are living documents and will be updated frequently as we progress and/or conditions change.

VTE Anticoagulation Guidance in COVID-19 Patients by Chris Miller PharmD and Rishi Kumar MD

Background: There is an increased incidence of thrombosis in patients with severe novel coronavirus pneumonia (COVID-19). Increase in markers such as D-dimer, prothrombin time (PT) & activated partial thromboplastin time (aPTT) in these patients are positive predictors of VTE. Anticoagulant treatment using chemical VTE prophylaxis was found to decrease 28-day mortality in patients with D-dimer > 6x upper limit of normal. A subset of patients' display worsening hypoxemic respiratory failure with increasing D-dimer in spite of VTE prophylaxis, suggesting increased risk for micro-thrombus.

Recommendation/Action: The following guidance has been developed to provide direction for anticoagulation management among patients with COVID infection. This guidance can be found on the Upstate policy webpage at: https://upstate.ellucid.com/documents/view/10645/active. Due to heightened thrombosis risks, higher anticoagulation doses and/or extended therapy should be considered among COVID-positive patients, particularly in patients with a D-dimer ≥3 (see table 1). It is recommended that patients be counselled about the risks and benefits of anticoagulation during the hospital stay and at the time of hospital discharge. When possible, the inpatient provider should consider a 'warm handoff,' i.e. phone call to the patient's primary care provider to relay information about any new anticoagulants that will be continued after hospital discharge.

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	GROUP 1	GROUP 2	GROUP 3
Criteria	D-Dimer < 3 mcg/mL	D-Dimer >= 3 mcg/mL	Confirmed VTE **OR** Unexplained worsening hypoxemia and suspected VTE with D-Dimer >= 3 mcg/mL
Treatment	**Stable Renal Function eCrCl>30 mL/min** Enoxaparin • 40mg sq daily (BMI <40) • 40mg sq q12hr (BMI 40-49.9) • 50mg sq q12 hr (BMI >=50) **Stable Renal Function eCrCl<=30 mL/min** Enoxaparin • 30mg sq daily (BMI <40) • BMI >= 40 use heparin, see below **Any GFR or Acute Kidney Injury** Heparin • 5000 U sq q8 hours (BMI <40) • 7500 U sq q 8 hours (BMI >=40)	**Stable Renal Function eCrCl>30 mL/min** Enoxaparin 0.5mg/kg sq q12 hrs **Stable Renal Function eCrCl<=30 mL/min** Enoxaparin 0.5mg/kg subQ daily Or **Any GFR or Acute Kidney Injury** Adult heparin infusion low dose protocol (anti-Xa target range 0.3-0.5) If anticipated procedures and/or high risk bleeding utilize heparin infusion	**Stable Renal Function eCrCl>30 mL/min** Enoxaparin 1mg/kg subQ q12hrs **Stable Renal Function eCrCl<=30 mL/min** Enoxaparin 1mg/kg subQ daily Or **Any GFR or Acute Kidney Injury** Adult heparin infusion high dose protocol (anti-Xa target range 0.3-0.7) If anticipated procedures and/or high risk bleeding utilize heparin infusion
Monitoring	Check daily CBC with diff, D-Dimer and Fibrinogen. PTT, PT/INR. Can consider Hematology consult		
Precautions	Active bleeding Platelet count < 50,000 Decreased renal function (GFR<30) and/or BUN > 80	Active bleeding Severe bleeding diathesis Platelet count < 50,000 Decreased renal function (GFR<30) and/or BUN > 80 If clinician assesses bleeding risk is too high (age, multiple organ failure, significant co-morbidities, previous bleeding, recent surgery), can move to Group 1	Active bleeding Severe bleeding diathesis Platelet count < 50,000 Decreased renal function (GFR<30) and/or BUN > 80
Discharge	If D-Dimer > 0.5mcg/mL and/or patient has decreased mobility Apixiban 2.5mg BID x 14 days OR Rivaroxaban 10mg daily x 14 days	Apixiban 2.5mg BID OR Rivaroxaban 10mg daily x 4 total weeks of anticoagulation	Apixiban 5mg BID x 3 total months of anticoagulation OR Rivaroxaban 15mg BID for 21 days then 20mg daily for total 3 months of anticoagulation
	For discharge patients with ESRD or HD consider dose reduction as necessary or alternative agent		
Notes	Physician should assess for bleeding daily and can stop anticoagulation if suspected. Physician should complete necessary work up for suspected DVT or pulmonary embolism if clinically appropriate and deemed safe for patient.		

Table 1: Anticoagulation guidance for COVID -19 patients

Instructions for Surgical Companions from Barbara Walczyk MSN RN CCSM

As part of a directive from the CDC regarding COVID, we have a new protocol in place for the individual who will be accompanying patients to their procedure.

On arrival, a patient's ride/companion will drop them off at the entrance to the hospital lobby. They are not required to stay at the hospital during the patient's procedure. Companions who live within 30 miles of Upstate are invited to return to their homes after dropping the patient off. Patients are asked to have their ride/companion's phone number readily available as a nurse will call them to return to the hospital lobby entrance when the patient is ready for discharge.

A ride/companion who chooses to stay at the hospital during a patient's outpatient procedure, are welcome to park in the visitor garage. There is currently no valet parking available. We do have a companion waiting room available which is primarily reserved for companions who live more than 30 miles away. If a ride/companion needs to use the restroom or have more space, they are welcome to use our companion waiting space located in the Campus Activities Building

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(CAB) on Elizabeth Blackwell Street at the Downtown Campus and the Centering Room at the Community Campus. Rooms are available for use Monday-Friday 7am-6pm. Please know the rooms are arranged for social distancing and no food or drink is allowed.

Anyone who chooses to use the companion waiting space will be screened for COVID symptoms (fever, new cough, shortness of breath, sore throat, loss of taste of smell), including a temperature check, at the entrance to the building.

To get to the Downtown companion waiting space, companions can park in the East garage and exit on the first level on Elizabeth Blackwell Street. The CAB is directly across the street, to the left of Jacobsen Hall. Rooms 120 and 122 on the first floor are available for use with proper social distancing. The restroom is located to the left when entering the building.

The Centering Room at the Community Campus is located in the POB south building. Parking is available in the Visitor Garage. After entering the hospital, use the elevators to the left, go to the 2nd Floor, and follow signs to the Centering Room.

Information Blocking Epic Changes Slated to Go-Live May 26 from Laura Cuff BSN RN

On Tuesday, May 26th, the approved changes for information blocking will go-live in Epic. These changes include:

- Ambulatory Pathology and Radiology reports will be released to MyChart 48 hours after resulting instead of 7 days. This does not impact inpatient Pathology and Radiology reports which were already released 24 hours after resulting and discharge.
- Ambulatory, ED and Inpatient providers will see a “share note” option for all procedure notes, discharge summaries, consult notes, progress notes and H&Ps when in Epic. This will allow them to send the patient notes to MyChart. Only Physicians, Nurse Practitioners and Physician Assistants will have this option to start.

These changes were previously approved by the EMR Advisory, the UUMAS Governing Board, and the Clinical Governance Committee. They will help to ensure Upstate is not inadvertently information blocking which is something each provider and MSG attests to for MIPS and Meaningful Use reporting. There is no change to any providers regular workflow with these changes, it simply allows providers to send notes to MyChart for patients if they would like to or if the patient asks them to.

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Exposure Scenario	Patient's PPE	Staff PPE	Staff Action after Contact / Potential Exposure
No Known Exposure	None Recommended	None Recommended	No action
COVID Ruleout Patient	Appropriate PPE* for Patient	Appropriate PPE for Staff**	No action
	Patient without PPE	Appropriate PPE for staff	No action
	Patient without PPE	Inappropriate PPE for staff	***Continue to work, wear a mask, monitor symptoms and temperature for 14 days or until symptoms develop. For symptoms, seek medical care
COVID Positive Patient	Appropriate PPE* for Patient	Appropriate PPE **	No action
	Patient without PPE	Appropriate PPE for staff	No action
	Patient without PPE	Inappropriate PPE for staff	***Continue to work, wear a mask, monitor symptoms and temperature for 14 days or until symptoms develop. For symptoms, seek medical care
COVID Positive Patient having a High Risk Procedure. (e.g., FOB/BAL, NP swab collection, Intubation, Surgical procedures which could aerosolize)	N/A	Appropriate PPE **	No action
	N/A	inappropriate PPE for staff	***Continue to work, wear a surgical mask, monitor symptoms and temperature, continue monitoring for 14 days or until symptoms develop. For symptoms, seek medical care
Staff member positive for COVID			Should not work for at least 7 consecutive days. Contact Infection Control and Employee Health. Must contact Employee Health again prior to returning to work.
Staff member awaiting COVID result			Symptomatic staff or known exposure self-quarantine at home until results are available. For symptoms seek medical care. Surveillance testing of asymptomatic staff with no known exposure may continue to work while awaiting test results. EX staff requiring testing on the TCU
Staff member returning from domestic **travel without known COVID+ contact**			***Continue to work, monitor symptoms and temperature, continue monitoring for 14 days or until symptoms develop. For symptoms, seek medical care
Patient reports that they are positive for COVID after being seen at one of our ambulatory sites	None at time of exposure	None at time of exposure	Identify employees in direct contact with patient during the time of encounter and identify Infection Control for appropriate tracking and guidance.
Exposure Scenario	**Patient's PPE**	**Staff PPE**	**Staff Action after Contact / Potential Exposure**
Staff positive for COVID-19	None at time of exposure	None at time of exposure	COVID positive staff should not work for at least 7 consecutive days. Contact Infection Control and Employee Health. Must contact Employee Health again prior to returning to work. Staff (w/o ear loop mask) exposed to the positive staff member for more than 10 minutes and less than 6 feet apart and patients exposed to positive staff member within 2 days from onset of symptoms: wear mask and monitor symptoms for 14 days. If symptomatic visit employee testing site. Inpatients exposed to staff: moved to a private room with mask if tolerated and monitor symptoms for 14 days. Outpatients exposed to staff: will be contacted by Infection Control, self-quarantine at home with a mask for 14 days and monitor symptoms. Do not share living spaces, bathrooms or bedrooms with family. If symptoms develop call the triage line 464-EZPZ for instructions on how to get tested.
	None at time of exposure	Ear loop mask	No exposure to staff or patient
	Ear loop mask	None at time of exposure	Staff (w/o ear loop mask) exposed to the positive staff member for more than 10 minutes and less than 6 feet apart: wear mask and monitor symptoms for 14 days. If symptomatic, visit employee testing site. Patient exposed to staff: no exposure.
	Patient tested positive	Roommate of positive pt	
Patient shared room with patient that tested positive	Ear loop mask	Ear loop mask	No exposure to roommate of postive patient, the roommate of the positive patient shall be moved to a new room to clean the current room. Positive patient is moved to a covid unit.
	No mask	Wearing a mask	Exposed patient placed in new private room quarantined on droplet precautions for 14 days. Patient will wear ear loop mask. Monitor symptoms. Staff will wear eye protection during any close face to face contact.

Notes
* Appropriate patient PPE = surgical mask
** Appropriate provider PPE = N95 mask or PAPR for clinician OR both patient & provder wearing surgical mask; goggles or shield; gloves; gown
*** Incubation period from time of exposure to time of symptoms ~5 days; Earliest time from exposure to time of potential infectiousness estimated at 2.5 days; Current time from sample collection **to COVID test results < 48 hours**

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Clinical Documentation Improvement (CDI) from Dr. Emily Albert and Dr. Ali Khan, Co-Directors, CDI

Why does your documentation matter?

Not only are you using it to communicate your patients' conditions, your plan for their care and their response to it, but it represents corresponding codes in the ICD system which are used for Quality / Risk adjustment. Thankfully, you don't need to know these know these codes, that's why you have CDI specialists.

We work closely with all of you and our hospital coding department to ensure accurate and complete code assignment. Be sure to answer queries and continue complete documentation throughout the hospital record into the discharge summary – it's one of the most important documents in the medical record.

Please refer to the attached tip sheet for more information and contact the CDI Hotline with questions at 315-464-5455.

Outstanding Physician Comments

Comments from grateful patients receiving care on the units and clinics at Upstate:

Breast Care Center: **Dr. Ranjna Sharma** was excellent!

Gamma Knife: My heart felt thank you to **Dr. Satish Krishnamurthy** and **Dr. Karna Sura**.

GEM: **Dr. Christian Knutsen** – amazing!

Joslin Center for Diabetes: **Dr. Barbara Feuerstein** explains everything so I can understand it.

Multidisiplinary Programs – Cancer Center: **Dr. Mark Crye** has been very accessible. So very fortunate to have **Dr. Mashaal Dhir** as my doctor. I can't say enough good stuff about him. He explains everything and answers our questions.

Pediatric Cancer Center: As always, **Dr. Jody Sima** was great. She always takes time to explain things, the appointment never feels rushed, and you can tell she really cares.

Rheumatology Clinic: **Dr. Sheetal Rayancha** was very patient and made our appointment together work great. She is a great doctor.

UHCC – Neurology: I was very pleased with **Dr. Arayamparambil Anilkumar**. It was our first time using telemedicine and he made it a great experience. I would highly recommend him. **Dr. Robert Beach** is a wonderful doctor. He is very professional. **Dr. Luis Mejico** – very good!

Upstate Urology: **Dr. Zahi Makhuli** – always very good!

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Post COVID-19 Reopening Plan
May 13, 2020

Revised Date	Change Description
May 13, 2020	Removed Appendix A to become a separate document
May 12, 2020	Amended Table 8 (patient testing requirements)
May 11, 2020	Added updated Appendix A
May 8, 2020	Updated Tables 2, 3, 4, 5, and 6, temporarily removed Appendix A
May 7, 2020	Updated volumes in Tables 3, 4, 5, and 6, updated test requirements in Table 7
May 6, 2020	Updated Tables 1, 3, 4, 5, and 6, added Appendix A, clarified testing requirement for patients having only a diagnostic test performed, added governor's healthcare criteria for reopening NYS
May 5, 2020	Updated neurophysiology and diagnostic CV volumes, updated elective surgery algorithm

Introduction

New York State Governor Cuomo outlined a plan to reopen New York State, with a focus on individuals returning to work and easing social isolation without triggering renewed spread of the virus or overwhelming the hospital system. New York will reopen on a regional basis as each region meets necessary criteria.

Healthcare specific criteria for the governor's plan to reopen include:

- New infections
    - Based on guidelines from the CDC, regions must have at least 14 days of decline in total net hospitalizations and deaths on a 3-day rolling average.
    - In regions with few COVID cases, the region cannot exceed 15 net new total hospitalizations or 5 new deaths on a 3-day rolling average.
    - In order to monitor the potential spread of infection in a region, a region must have fewer than 2 new COVID patients admitted per 100,000 residents per day.
- Healthcare capacity
    - Regions must have at least 30% total hospital and ICU beds available.
    - Hospitals must have at least 90 days of personal protective equipment stockpiled.
- Diagnostic testing capacity
    - Each region must have the capacity to conduct 30 diagnostic tests for every 1,000 residents per month.
- Contact tracing capacity
    - Regions must have a baseline of 30 contact tracers for every 100,000 residents, and additional tracers based on the projected number of cases in the region.

On March 23, 2020, the New York State Department of Health issued the *COVID-19 Directive to Increase Availability of Beds by a Minimum of 50% And Provide Necessary Staffing and Equipment* (Executive Order 202.10), which required that all general hospitals, among others, suspend all non-essential elective surgeries and non-urgent procedures.

On April 29, 2020, the New York State Department of Health issued the *COVID-19 Directive Regarding the Resumption of Elective Outpatient Surgeries and Procedures in General Hospitals in Counties and Facilities Without a Significant Risk of COVID-19 Surge* (Executive Order 202.25), which provides guidance regarding the resumption of elective outpatient surgeries and non-urgent procedures in general hospitals in counties and facilities without a significant risk of a COVID-19 surge. This directive will be amended after a two-week period to account for new data and determine eligibility.

Eligibility Determination

Non-essential outpatient elective surgeries and non-urgent procedures can resume on April 29, 2020 if the following criteria are met:

- County Eligibility
  In order for a general hospital in a county to be eligible, the county in which that hospital is physically located must have:
  - An available county hospital inpatient capacity of over 30% for the county, AND
  - An available county hospital ICU capacity of over 30%, AND
  - There must have been a change of fewer than 10 hospitalizations of COVID-19 patients in the 10-day lookback period for COVID-19 hospitalizations
- Eligible Eligibility
  A general hospital within an eligible county must also have:
  - An available hospital inpatient capacity of over 30%, AND
  - An available hospital ICU capacity of over 30%, AND
  - There must have been a change of fewer than 10 hospitalizations of COVID-19 patients at the hospital in the 10-day lookback period for COVID-19 hospitalizations

Eligibility Definitions

County Hospital Inpatient Capacity

The total number of staffed beds (including Intensive Care Units/Psychiatric Units, etc.) that are currently available in the county, divided by the total number of staffed beds (including ICU, Psych, etc.) in the county, as reported by each general hospital in the April 27, 2020 daily *HERDS COVID-19 Patient and Bed Summary* survey.

County Hospital ICU Capacity

The total number of staffed ICU beds that are currently available in the county, divided by the total number of staffed ICU beds in the county, as reported by each general hospital in the April 27, 2020 daily *HERDS COVID-19 Patient and Bed Summary* survey.

COVID-19 Hospitalizations in a County

The total number of COVID-19 patients hospitalized in a county as reported by general hospitals within that county in the daily HERDS COVID-19 Patient and Bed Summary.

Hospital Inpatient Capacity

The total number of staffed beds (including ICU, Psych, etc.) that are currently available, divided by the total number of staffed beds (including ICU, Psych, etc.), as reported by the hospital in the April 27, 2020 daily HERDS COVID-19 Patient and Bed Summary survey.

Hospital ICU Capacity

The total number of staffed ICU beds that are currently available, divided by the total number of staffed ICU beds, as reported by the hospital in the April 27, 2020 daily HERDS COVID-19 Patient and Bed Summary survey.

10-Day Lookback Period for COVID-19 Hospitalizations

The change in the number of hospitalized COVID-19 patients from April 17, 2020 to April 27, 2020 as reported in the daily HERDS COVID-19 Patient and Bed Summary survey.

Requirements for Resuming

- Prioritization Policy Committee
  Hospitals should establish a prioritization policy committee to develop a prioritization strategy appropriate to the immediate patient needs.
- Patient Testing
  Hospitals must test all patients receiving outpatient elective surgeries and non-urgent procedures for COVID-19. Patients must test negative for COVID-19 using a molecular assay for detection of SARS-CoV-2 RNA prior to any surgery or procedures. The test must be administered no more than 3 days prior to the surgery or procedure.
- Patient Counseling
  Hospitals should counsel patients to do the following for the 14 days before the surgery or procedure:
    - Maintain current social distancing recommendations
    - Follow other preventative measures, such as wearing a cloth face covering in public when social distancing might not be possible
    - Minimize trips away from the home as much as possible
    - Inform the healthcare provider performing the surgery or procedure if there is any contact with a suspected or confirmed case of COVID-19 or a person with symptoms consistent with COVID-19
    - Inform the healthcare provider of any symptoms consistent with COVID-19 or a positive test results for COVID-19
- PPE and Medical Surgical Supplies
  Hospitals must have adequate PPE and medial surgical supplies appropriate to the number and type of procedures to be performed, including all stages of care (pre-operative and post-discharge) associated with the procedure and the needs of the patient and health care personnel. Adequate PPE means that a hospital has at least a 7-day supply of PPE on hand, and the hospital's supply chain can maintain that level without resorting to contingency or crisis capacity strategies.
- Staffing
  Hospitals must ensure sufficient staffing appropriate to the surgery or procedure and must take into consideration the time needed to repatriate staff to ambulatory and non-urgent care settings, including the needs of staff for downtime and emotional support.
- CEO Attestation
  Prior to resuming non-essential elective surgeries and non-urgent procedures, the Chief Executive Office or equivalent official of the hospital will execute and submit an attestation.
- Monthly Reporting
  Hospitals resuming non-essential elective surgeries and non-urgent procedures should submit the information below to the Department of Health on a monthly basis:
    - Number of non-essential surgeries and non-urgent procedures performed, categorized by the appropriate tier in accordance with the surgery acuity scale in Attachment A
    - Procedure type (e.g. cosmetic, orthopedic, colon/rectal, obstetrics/gynecology, neurological, ophthalmic, oral/maxillofacial, otolaryngological, general surgery, other)
    - Number of procedures requiring admission to an ICU
    - Number of procedures requiring admission to an ICU and intubation
    - Number of procedures requiring the post-operative transfer of a patient to a skilled nursing facility or inpatient rehabilitation

This document outlines the Upstate University Health system's approach to resuming elective procedures, as well as any allowable exceptions to inpatient elective cases. Upstate will:

- Take steps to optimize the safety of staff and patients;
- Reopen to elective cases as appropriate to deliver healthcare to the community and the region; and
- Take a measured, step-wise approach to reopening.

Timeline for Reopening

Ambulatory and perioperative/procedure reopening will follow a measured approach to rollout.

Table 1. Timeline for Reopening

	Phase I	Phase II	DOH Guidance	Phase III	DOH Guidance	Phase IV
Decision Date	4/29/2020	5/7/2020	Expected 5/13/2020	5/21/2020	Expected 5/27/2020	6/8/2020
Activation	5/1/2020	5/11/2020		5/25/2020		6/4/2020

Table 2. Ambulatory Reopening

	Phase I Pre-Operative Clearances, Consults, and Ambulatory Procedures that can no Longer be Delayed		Phase II Additional Acute / High Priority Visits		Phase III Remaining Visit Types Added	
	Opening	**Pull-Back***	**Opening**	**Pull-Back***	**Opening**	**Pull-Back***
Visits	▪ Open to visits related to necessary surgeries and Ambulatory procedures that can no longer be delayed. Also open to urgent visits (medically necessary, time sensitive visits that cannot be completed via telemedicine). Urgent visits or procedures can be further defined as ones that cannot be postponed for 2 weeks. ▪ Prioritize current in-person visit slots for these patients.	▪ Revert to allowing only emergent visits.	▪ Open to all acute patients and other types of visits identified as high priority (will differ by clinic). High priority visits can be defined as visits that cannot be postponed for a month. ▪ Also open to Ambulatory procedures that cannot be postponed for a month.	▪ Acute patient visits only that cannot be assessed/ treated via telemedicine.	▪ Fully open to patients with new telemedicine plans in place. This phase includes bringing back patients whose visits have been postponed >1 month, routine follow-ups, well visits, and annual exams.	▪ All acute patients and other types of visits identified as high priority (will differ by clinic).
Staff	▪ No change, essential vs. non-essential practices remain in place.		▪ Non-essential staff working from home begin to return to accommodate new in-person visit volume.	▪ Identify non-essential staff; all others work from home.	▪ All employees, including non-essential staff, return.	▪ Non-essential staff working from home return to accommodate in-person volume.
Visitors	▪ Refer to current institutional visitor policy.	▪ Refer to current institutional visitor policy.	▪ Refer to current institutional visitor policy.	▪ Refer to current institutional visitor policy.	▪ Refer to current institutional visitor policy.	▪ Refer to current institutional visitor policy.

*Upstate will pull back on cases if Upstate and/or Onondaga County no longer meet the requirements for resuming elective procedures.

Perioperative/Procedural Phases

Phase I

This phase includes urgent inpatient or outpatient cases that can no longer be delayed.

No additional COVID-19 testing for patients is required; continue testing patients only as clinically indicated.

Table 3. Phase I Additional Daily Case Volume Allowance

(Volumes include both campuses, unless otherwise noted)

Location	Current Daily Average	Additional Daily Case Volume Allowance	Total Phase I Volume
5E	10	5	15
3N	0	5	5
IR	20	10	30
Neurophysiology	0	1	1
Diagnostic CV Imaging	1	2	3
Pulmonary Testing	1	0	1
Outpatient Imaging Exams*	30	29	59
Cancer Center**	1	2	3
Endoscopy	7	5	12
Heart & Vascular Center	4	2	6
EMU (total beds, not daily volume)	0	1	1
Community OR	2	10	12
550 Harrison	1	10	11
	77	**82**	**159**

*Does not includes Women's Imaging, Wellspring, or UHCC. These are included in the Ambulatory reopening plan.

**Coordinated with 5E and 3N totals by Dr. Marx and Barb Walczyk.

Phase II

This phase includes all of Phase I plus elective outpatient surgeries and non-urgent procedures. Patients must test negative for COVID-19 using PCR assay prior to surgery or procedure. The test must be administered no more than 3 days prior to the surgery or procedure. If a patient tests positive, the surgery or procedure should be postponed for 28 days.

Table 4. Phase II Additional Daily Case Volume Allowance

(Volumes include both campuses, unless otherwise noted)

Location	Additional Daily Case Volume Allowance	Total Phase II Volume
5E	10	25
3N	5	10
IR	15	45
Neurophysiology	8	9
Diagnostic CV Imaging	4	7
Pulmonary Testing	4	5
Outpatient Imaging Exams*	48	107
Cancer Center**	5	8
Endoscopy	5	17
Heart & Vascular Center	6	12
EMU (total beds, not daily volume)	1	2
Community OR	15	27
550 Harrison	15	26
	141	**300**

*Does not includes Women's Imaging, Wellspring, or UHCC. These are included in the Ambulatory reopening plan.

**Coordinated with 5E and 3N totals by Dr. Marx and Barb Walczyk.

Phase III

This phase includes all Phase I and Phase II cases and increases volumes in a measured approach. Patients must test negative for COVID-19 using PCR assay prior to surgery or procedure. The test must be administered no more than 3 days prior to the surgery or procedure. If a patient tests positive, the surgery or procedure should be postponed for 28 days.

Table 5. Phase III Additional Daily Case Volume Allowance

(Volumes include both campuses, unless otherwise noted)

Location	Additional Daily Case Volume Allowance	Total Phase III Volume
5E	TBD	TBD
3N	TBD	TBD
IR	TBD	TBD
Neurophysiology	TBD	TBD
Diagnostic CV Imaging	TBD	TBD
Pulmonary Testing	TBD	TBD
Outpatient Diagnostic Imaging*	TBD	TBD
Cancer Center**	TBD	TBD
Endoscopy	TBD	TBD
Heart & Vascular Center	TBD	TBD
EMU (total beds, not daily volume)	TBD	TBD
Community OR	TBD	TBD
550 Harrison	TBD	TBD
	TBD	**TBD**

*Does not includes Women's Imaging, Wellspring, or UHCC. These are included in the Ambulatory reopening plan.

**Coordinated with 5E and 3N totals by Dr. Marx and Barb Walczyk.

Phase IV

This phase includes all of Phase I, Phase II, and Phase III cases and increases volumes in a measured approach. Patients must test negative for COVID-19 using PCR assay prior to surgery or procedure. The test must be administered no more than 3 days prior to the surgery or procedure. If a patient tests positive, the surgery or procedure should be postponed for 28 days.

Table 6. Phase IV Additional Daily Case Volume Allowance

(Volumes include both campuses, unless otherwise noted)

Location	Additional Daily Case Volume Allowance	Total Phase IV Volume
5E	TBD	TBD
3N	TBD	TBD
IR	TBD	TBD
Neurophysiology	TBD	TBD
Diagnostic CV Testing	TBD	TBD
Pulmonary Testing	TBD	TBD
Outpatient Diagnostic Imaging*	TBD	TBD
Cancer Center **	TBD	TBD
Endoscopy	TBD	TBD
Heart & Vascular Center	TBD	TBD
EMU (total beds, not daily volume)	TBD	TBD
Community OR	TBD	TBD
550 Harrison	TBD	TBD
	TBD	**TBD**

*Does not includes Women's Imaging, Wellspring, or UHCC. These are included in the Ambulatory reopening plan.
**Coordinated with 5E and 3N totals by Dr. Marx and Barb Walczyk.

Appendix A includes reopening plans as submitted by the heart and vascular, radiology, perioperative, and ambulatory areas.

Considerations for Case Classification

Recovery Team

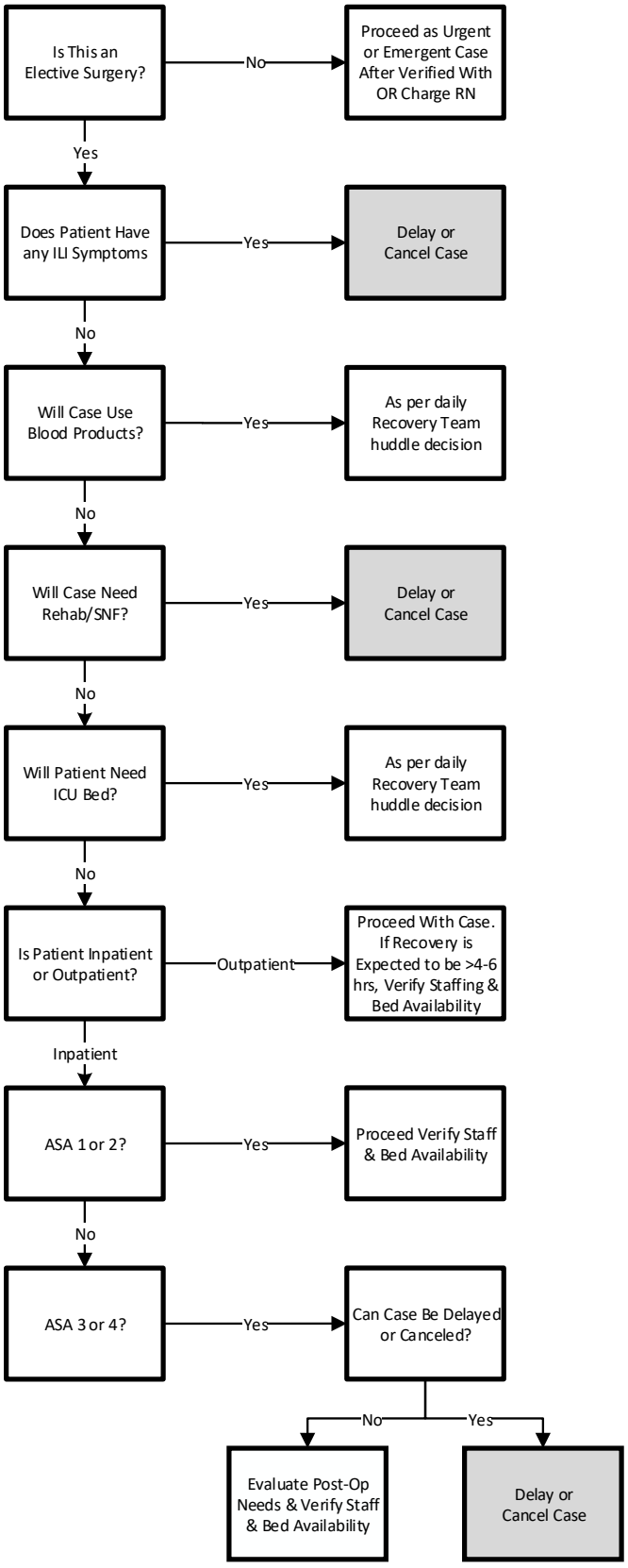
The Recovery Team will assess conditions daily. The Moonshot Team has created a PPE Projection Tool in Tableau to analyze PPE availability and aid in decision making around reopening. Condition assessment will take the following into consideration:

- New York State Department of Health criteria as stated in the Eligibility Determination section earlier in this document
- Upstate University Health criteria
    - Availability of personal protective equipment
    - COVID-19 test availability
    - Bed availability
    - Availability of necessary supplies
    - Administrative discretion

The Recovery Team operational huddle will determine the hospital's status on a daily basis (see Figure 1 for the elective surgery algorithm). Operational status definitions include:

- Green – no restrictions in place
- Yellow – proceed under caution as per rules outlined in this plan
- Red – cases are on hold

Figure 1. Elective Surgery Algorithm



Nursing Operations
Nursing operations will facilitate the logistics and care for the additional number of cases allotted per day at each location.

Department Chairs, in Collaboration with the Director of Surgical Services
Department Chairs, or Division Chief designees, will determine the patients to be scheduled for elective procedures based on the number of cases allotted per day in accordance with criteria listed in Table 7.

Backlogged and new cases will be prioritized as per below:

Table 7. Case Priority and Approvals Needed

Case priority	Phase	Incident Command Approval	Action	Some Examples
Emergent or Urgent	I	Not needed	May be booked any time	-Transplants -Trauma -Cardiac w/symptoms -Limb threatening vascular surgery -Most cancers -Neurosurgery -Highly symptomatic patients
Can No Longer be Delayed (outpatient or inpatient)	I	Needed	May be booked if condition yellow or green for the day	-Low risk cancer -Non-urgent spine & Ortho: including hip, knee replacement and elective spine surgery -Stable ureteral colic -Elective angioplasty
Elective outpatient	II and III	Needed	May be booked if condition yellow or green for the day	-Carpal tunnel release -ESG -Colonoscopy -Cataracts -Endoscopies

Language taken from a letter sent to hospitals March 23, 2020, titled "COVID-19 Directive to Increase Bed Availability by a Minimum of 50% And Provide Necessary Staffing and Equipment" and Attachment A.

Testing Strategy
A testing site will be identified for pre-operative testing for patients. The testing site should have the ability to handle the additional case volume. Patient testing requirements are listed in Table 8.

Patients who require testing should follow the direction given by their provider as to the location where the test will be performed.

Patients who cannot have a required test completed by a UHCC provider should be assisted in arranging for a test to be completed via the preadmission laboratory testing process.

Patients who are having a diagnostic test performed, and are not having a procedure or surgical intervention, are not required to be tested for COVID-19.

Patients should be counseled per the Patient Counseling section earlier in this document. If a patient tests positive, the surgery or procedure should be postponed for 28 days.

Table 8. Patient Testing Requirements

Case Priority	Phase	Testing Requirements	Testing Priority
Emergent or Urgent	I	Patients may be tested at the discretion of the proceduralist or surgeon.	Routine
Can No Longer Be Delayed	I	Patients may be tested at the discretion of the proceduralist or surgeon.	Routine
Elective Outpatient	II and III	All patients, even if asymptomatic, must be tested no more than 3 days prior to the surgery or procedure.	Routine

At this time, only staff and providers who are symptomatic or who have come in contact with an individual with confirmed COVID-19 will be tested.

Considerations for Reopening

- Patient/staff safety and infection control
    - Remove all magazines, newspapers, toys, etc. from waiting areas
    - Arrange waiting area seating to keep patients at least 6 feet apart
    - Mark floor area with tape to indicate a distance of 6 feet between patients waiting to register or check out
    - Post signage in appropriate languages at the entrances and inside the office to alert all patients with respiratory symptoms and fever to notify staff immediately
    - Post signage in appropriate languages with pictures to teach/remind patients about correct respiratory hygiene and cough etiquette
    - Provide tissues, alcohol-based hand rub, no-touch trash cans in waiting areas and exam rooms
    - Develop a protocol to disinfect waiting room chairs, reception counters, elevator buttons, door handles, railings, etc. several times a day
    - Create separate spaces in waiting areas for sick and well patients
- Patient flow pattern
    - Ask patients if they are symptomatic during reminder calls
    - Recommend that patients with symptoms and fever call the office before arrival
    - Consider arranging a separate entrance/exit for symptomatic patients, if possible
    - Implement procedures to quickly triage and separate sick patients
    - Place sick patients in exam rooms as quickly as possible
    - Designate certain offices to solely see patients with suspected COVID, if possible
    - Designate certain times of day on particular days for older at-risk noninfectious patients
    - Invite patients to wait in their cars until they receive a text when the exam room is available
    - Discuss advanced directives with patients, especially patients who are older adults, frail or post-COVID-19
    - Consider telehealth options for follow up
- Exam rooms and equipment
    - Institute a designated exam room with designated equipment (stethoscopes, thermometers) for patients with symptoms
    - Disinfect exam rooms after each patient

- Staffing
    - Account for office staff illness, absences, and quarantine in reopening planning
    - Cross-train staff for all essential office functions
    - Assess presence of nonessential personnel, including students
    - Ensure staff have received training on how to put on, use, and take off PPE correctly
    - Maintain records of staff-patient contact in a log or medical record for contact tracing
    - Send staff home if they are/become symptomatic

Innovations for Possible Implementation

- Virtual visits for pre-op classroom education and discharge instructions
- Epic My Chart eCheck-in and Hello Patient to speed up registration and arrival process and text patients when the exam room is ready
- Epic team to set up MyChart Self Triage

Threats Analysis

PPE burn

As outlined in the Requirements for Resuming section of this plan, adequate PPE means the hospital has at least a 7-day supply of PPE on hand, and supply chain can maintain that level without resorting to contingency or crisis capacity strategies. Projected increases in patient volumes will be supplied to the Moonshot Team, who will analyze based on assumptions provided by the Planning Section, Logistics Section, and Infectious Disease Section. Analysis and decisions on continuation of operations will be promulgated by the Recovery Team.

PPE burn is being analyzed for the following scenarios:

1. Surge to "contingency operations," which is the Next 100 Beds Surge Plan/Wave 2.
2. Phase I of this plan (Post COVID-19 Reopening Plan).
3. A surge (up to Wave 2) of patients after reopening Phase I occurs.
4. Phase II reopening.
5. A surge (up to Wave 2) of patients after reopening Phase II occurs.
6. Phase III reopening.
7. A surge (up to Wave 2) of patients after reopening Phase III occurs.

Test availability and timing

The availability of testing, when required by DOH regulations, will impact decisions on continuation of operations and will be promulgated by the Recovery Team.

Patient safety/infection control

Procedural and surgical areas will put into place appropriate social distancing processes and continue with standard infection precautions. Patient logistics (appointment, parking, registration, visitors, waiting room configuration) planning will be done at the area/local level taking institutional standards into account.

Staffing availability

Labor pool and managers will need to account for any temporary changes in staffing and repatriate as required to affect this plan.

Patient selection

Patients should be prioritized as per an objective methodology, such as the MeNTS score. The MeNTS scoring system includes 21 factors that are scored on a scale of 1 to 5, and the total score, which ranges from 21 to 105, is computed

for each case. The higher the score, the greater chance of poorer patient outcomes, the higher the use of hospital resources, and the higher the risk of COVID-19 transmission to the healthcare team. The DOH has required the formation of a committee to oversee this, as well.

Supplies (ET tubes, etc.)
The monitoring of supplies will be performed by the Logistics Section. At this time there are no plans for reuse of procedural supplies, such as ET tubes.

Blood Product Availability
Blood product availability will be monitored by the Recovery Team and discussed during the daily operational huddles.

SNF/Rehab
The number of available SNF and rehab beds will continue to be monitored to guide reopening decisions.

Informed consent from patient (patient opting for elective treatment, acknowledges risk of COVID)
Proceduralists and surgeons should take this into account during their standard informed consent process.

Overview

The Recovery Team will leverage principles and experiences of Upstate's Incident Command structure to orchestrate a meaningful reopening and recovery effort.

The basic functions of the Recovery Team will comprise:

- **Tuning** of the measured approach to reopening operations
- **Review** of the effects of the operational decisions
- **Communication** of real-time status to stakeholders
- **Engagement** of task force efforts

The basic outputs of the Recovery Team will comprise:

- Daily operational huddles to escalate and evaluate information that serves the above functions
- Offline stakeholder engagement to ensure that the work product cycles of the various task forces are maintained

Huddle Detail

The huddle will occur at 09:00 each day, including weekends, and move at a brisk pace to cover the agenda detailed in Table 3. Daily huddles will result in a decision regarding activity for the next day, regardless of phase. Each section leader will report as per the Report Out Detail in Table 3. Additional information should be held for offline discussion and dissemination by email after discussion with daily huddle leader. Huddle leadership will rotate every 14 days.

Table 1. Components for Decision Making

SURGICAL TEMPLATE			
Regulatory	Go or No Go		
ID	Exponential	Linear	Declining
Testing	Critical	Low	Available
PPE	<30	<90	Available
Supplies	Critical	Low	Available
Blood	Critical	Low	Available
Staffing	Red	Yellow	Green
Physicians	Red	Yellow	Green
Beds	<30%	<30%	
ICU Beds	<30%	<30%	

AMBULATORY			
COVID	Exponential	Linear	Decreasing
Staffing	Red	Yellow	Green
Physicians	Red	Yellow	Green
PPE	<30%	<90%	>90%
Pause			
Phase I			
Phase II			
Phase III			
Unrestricted			

Every other Thursday, beginning May 7, 2020, the output of the huddle will be a decision regarding movement along the timeline for reopening (advance to next phase, stay in current phase, pull back to last phase). Phases of operation will be set for two weeks, beginning May 11, 2020 (see Table 2).

Table 2. Timeline for Reopening

	Phase I	Phase II	DOH Guidance	Phase III	DOH Guidance	Phase IV
Decision Date	4/29/2020	5/7/2020	Expected 5/13/2020	5/21/2020	Expected 5/27/2020	6/8/2020
Activation	5/1/2020	5/11/2020		5/25/2020		6/4/2020

The following describes participants and organization of the daily huddle organized by functions described above.

Tuning

Tuning is an executive activity. By the end of each huddle, decisions will be made by the day's team leader on the following:

- Procedural status:
  - *Green* – Continue activity without restriction
  - *Yellow* – Continue activity as described in the Reopening Plan for the specific phase of recovery
  - *Red* – Pause/re-pause on procedural activity not deemed emergent
- Specific requests of data, action, or documentation by a task force

Review of Operations

Review is an operational activity. During huddles, each operational section will report on the status of their areas and the effects of clinical activity on important metrics such as capacity of beds, availability of PPE, unintended consequences, etc.

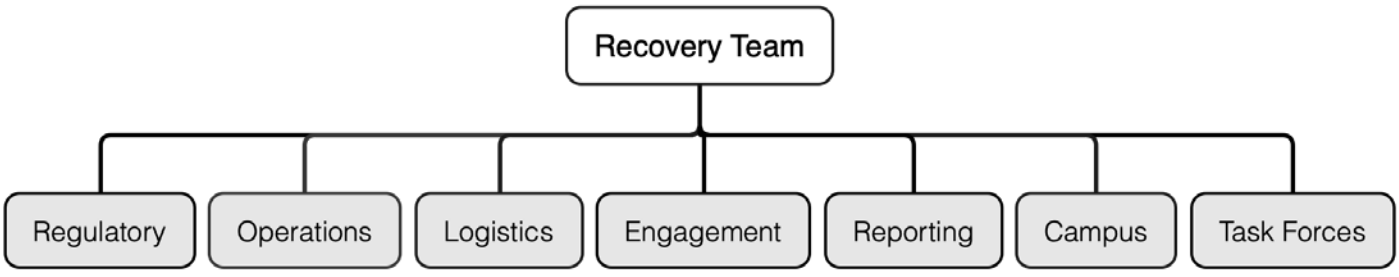
Communication

Communication is a reporting activity. During each huddle, various groups will be observing reports, synthesizing information, and planning on dissemination of vital information to different stakeholders. This function is integral to ensuring situational awareness to both internal and external constituents.

Engagement

Engagement is a collaborative and development activity that occurs offline continuously. This function encapsulates the need for a broad range of stakeholders to be engaged in the recovery efforts. This engagement is most likely to occur in task forces which will be developed and tasked with specific projects throughout the efforts. They may spring up, complete a project, and then dissolve. They may also be continuous and perpetual. Their work products will be reported through operational reporting agenda, and direct to leadership as needed.

Figure 1. Recovery Team



Communications

Information flow regarding reopening and recovery will follow a two-way process.

Questions from medical staff regarding reopening and recovery should be brought to the attention of Division Chiefs and Department Chairs. Chiefs and Chairs may elevate questions, if necessary, to the Recovery Team Chairs Section for information and clarification. Information regarding decisions made by the Recovery Team should then be disseminated to all Chiefs and Chairs by the Recovery Team Chair Section leaders as appropriate. The Chiefs and Chairs may elect to send to all in their department or only as appropriate.

Questions from hospital staff regarding reopening and recovery should be brought to the attention of their manager or director. Directors may elevate questions, if necessary, to their administrator; administrators may elevate to the appropriate Recovery Team Section Leader. Information regarding decisions made by the Recovery Team should be disseminated by the Section Leader to the administrator or director who made the inquiry. That director or administrator should then disseminate that information as broadly as appropriate.

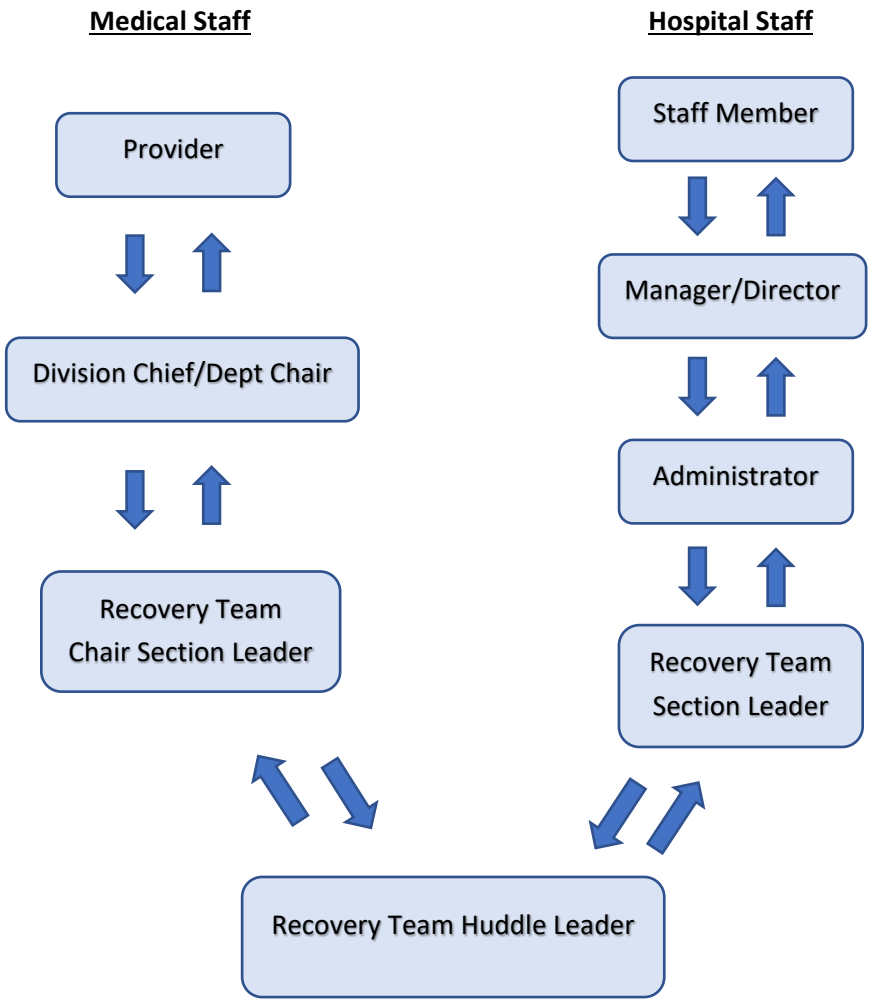


Table 3. Huddle Agenda

Function	Section	Section Leads	Responsibility	Report Out Detail
Tuning	Huddle Leader	*Leads:* Amy Tucker Jeremy Joslin Scott Jessie *Alt Leads:* Nancy Page Jen Speicher Peggy Thomas	1. Opening Remarks 2. Leadership Message	Decisions on system readiness and how to proceed for the day
Regulatory	Inbound Reporting	*Lead:* Joyce Mackessy *Alt Lead:* Aimee Goulette	1. Situational awareness of inbound regulations	
Review of Operations	Hospital Status (system)	*Lead*: Becky Dwyer *Alt Lead:* Kyle Choquette	1. COVID ADT 2. Capacity and system status	Census (combined and broken out by campus) Total COVID admits and R/Os & any related bed challenges specific to COVID Hospital system status (R, Y, G/diversion status) Nurse staffing issues
	COVID Information	*Lead:* Katie Anderson *Alt Lead:* Jana Shaw Telisa Stewart	1. Epidemiology & Public Health situational report	Landscape update (trends, R rate, etc.) SEIRS predictions Other analyses
	OR Areas (system)	*Lead:* Barb Walczyk *Alt Lead:* Bill Marx	1. OR areas utilization & situational report	OR cases scheduled and IP bed needs (both campuses, adults and peds) for today and tomorrow Daily challenges (staffing, sterile processing, anesthesia)

Function	Section	Section Leads	Responsibility	Report Out Detail
	Diagnostic and Procedural Areas (system)	*Lead:* Jen Carey	1. Procedural areas	Procedural cases scheduled and IP bed needs for today and tomorrow (both campuses, adults and peds)
		Alt Lead: Steven McClintic		Daily challenges (staffing, sterile processing, anesthesia)
	Emergency Departments (system)	*Lead:* Michelle Zoanetti	1. ED utilization & situational report	All 3 EDs: 24 hr lookback (visits, admits/obs)
		Alt Lead: Bill Paolo		7-day volume trend (increase, decrease, steady state)
	Ambulatory Areas (system)	*Lead:* Juliann Axton	1. Ambulatory areas utilization & situational report	Daily visit volume
				Cancel/no-show rate
		Alt Lead: Tiffany Bell		PPE concerns
				Staffing
	Transitions of Care	*Lead:* Diane Nanno	1. Difficult to place report 2. Situational report	Today's anticipated discharges by campus
				SNF discharge delays today and tomorrow
				# of COVID patients on comfort care
		Alt Lead: Kelly Mussi		Difficult to place weekly trend
	COVID Testing	*Lead:* Scott Riddell	1. PCR capacity 2. Serology capacity	Daily availability (rapid vs PCR)
		Alt Lead: Sylva Bem		Antibody testing
	COVID Medical	*Lead:* Stephen Thomas	1. Infection control situational report 2. ID science report	Educational needs
				Policy briefs
				Infection control challenges and changes
		Alt Lead: Mitchell Brodey		Novel disease phenomenon
				New therapeutics
				Issues with current therapeutic pipeline
	Quality & Safety	*Lead:* Dinesh John	1. Situational report 2. Hazards report	Safety or quality events in last 24 hrs
		Alt Leads: Julie Briggs Sally Ramsden		Practices or policies to be refined/changed to improve patient safety

Function	Section	Section Leads	Responsibility	Report Out Detail
	Clinical Integration Team	*Lead:* Zac Shepherd	1. Provider staffing	
		Alt Lead: Bill Paolo		
	Learner Operations	*Lead:* Danielle Katz	1. Workforce situational report	Update on J1 VISAs (weekly)
		Alt Lead: Stephen Knohl		# COVID+ residents or fellows (weekly)
	Labor Pool	*Lead:* Jen Speicher	1. Nursing and other staffing	
		Alt Lead: Kelly Dolan		
	Administrative supervisor	Per Schedule	1. Situational report last 24 hours	
	Physical Plant & Support Services	*Lead:* Marylin Galimi	1. Situational report and 24-hour outlook	EVS
		Alt Lead: Nancy Daoust		Space modifications/room closures
				Parking
				Construction/Maintenance Issues
	Clinical Policies	*Lead:* Denise Letourneau	1. New policies 2. Important reminders	New policies that are needed
		Alt Lead: Joyce Mackessy		In process and outstanding policies
Logistics	Supplies & Logistics	*Lead:* Mark Kearsing	1. PPE supply 2. Pulmonary supplies 3. Blood products 4. Ventilators	
		Alt Lead: Mike Fegley		
	Finance	*Lead:* Robert Seabury	1. Situational report	
		Alt Lead:		

Function	Section	Section Leads	Responsibility	Report Out Detail
		Stuart Wright		
Engagement	Chairs	*Leads:* Gregory Conners Robert Cooney		
		Alt Leads: Luis Mejico Sri Narsipur		
	Communications	*Lead:* Darryl Geddes	1. Communications	Media asks:
		Alt Lead: Kathleen Paice Froio		Media Trends:
	Marketing and Resilience	*Lead:* Leah Caldwell	1. Marketing	
		Alt Lead: Darcy DiBiase		
		Resilience Team Liaison: Leah Caldwell		
Reporting	Outbound Reporting	*Lead:* Jim Legault	1. Situational report	
		Alt Lead: Pam Farabee		
Campus	Campus Collaboration	*Lead:* Lynn Cleary	1. Situational report	
		Alt Lead: Linda Veit		
Daily Decisions	Huddle Leader		1. Decision on next day status	Surgery status for next day
				Ambulatory status for next day

Task Forces

Task forces will create innovations and solutions around specific issues or topic areas. Each task force is mapped to a particular section; task forces will report to their section lead by 8:45am for inclusion in the 9:00am huddle.

Table 4. Task Forces

Task Force	Responsible Section	Mission	Lead	Work Product
Project Mgmt & Administration	Huddle Leader		Shawna Craigmile Amy Wagner	
Emergency Mgmt	Huddle Leader		Brad Marmon	
Employee Health	Huddle Leader		Jarrod Bagatell	
Human Resources	Huddle Leader		Eric Frost	
Staff Resilience	Huddle Leader		Mark Buttiglieri	
Wellness	Huddle Leader		Kaushal Nanavati CWO (TBD)	
Community Hospital Inpatient	Hospital Status		Matt Glidden	
Dashboard	Hospital Status		Mary Ann Gross	
IMT Support	Hospital Status		David Hanson	
Pediatric Inpatient	Hospital Status		Angela Wratney	
University Hospital Inpatient	Hospital Status		Housam Hegazy	
Virtual Visits	Hospital Status		Josh Onyan	
Chatbot	COVID Information		Susan Furtney	
Public Health	COVID Information		Telisa Stewart	
Pre-Operative Testing	OR Areas		Peggy Thomas	
Cancer Center	Procedural Areas		Jeffrey Bogart	
Diagnostic Radiology	Procedural Areas		Jennifer Caldwell	
Endoscopy	Procedural Areas		Anne Snowdon	
Heart & Vascular Center	Procedural Areas		Amy Tetrault Debanik Chaudhuri	
Interventional Radiology	Procedural Areas		Mohammed Jawed	
Neurophysiology	Procedural Areas		Jennifer Carey	

Task Force	Responsible Section	Mission	Lead	Work Product
Pulmonary Testing & Services	Procedural Areas		Jennifer Carey Robert Lenox	
SNF Placement	Transitions of Care	Coordinate the return of COVID+ SNF patients to the SNF.	Diane Nanno	Evolving plan to discharge COVID+ patients
COVID Testing Capacity / Strategy	COVID Testing		Nancy Daoust	
Infection Control	COVID Medical		Paul Suits	
Credentialing	Clinical Integration Team		Beth Erwin	
Resident & Fellow Learners	Leaner Operations		Danielle Katz	
Donning & Doffing Coaching	Labor Pool		Kelly Dolan	
Entrance Screening	Labor Pool		Nancy Walklett	
Volunteer	Labor Pool		Kristin Bruce	
Safe Patient & Companion Flow	Physical Plant & Support Services		Peggy Thomas	
Space Readiness	Physical Plant & Support Services		Marilyn Galimi	
Parking	Physical Plant & Support Services		Peter Marthia	
Visitation	Clinical Policies	Plan and coordinate for the phased return of visitors to all areas of the hospital, including inpatient, ambulatory, and periop.	Tina Passett	
Oversight OR	Outbound Reporting		Bill Marx	
Research & Innovation	Campus Collaboration		David Amberg Chris Morley	
Student Learners	Campus Collaboration	Coordinate with campus on return of students and residents.	Julie White	Student and resident return plan dates and contingencies.

UPSTATE
UNIVERSITY HOSPITAL

Clinical Documentation Improvement
Tip of the Month – Why Documentation Matters
Applies to all providers

Many organizations provide quality rankings for physicians and hospital systems—determined after risk adjustment is applied. Risk adjustment is based on clinician documentation. Only coded diagnoses are included in the risk adjustment.

Did You Know?

There are no ICD-10 codes for the organ-system approach to medical record documentation. You must document specific diagnoses for which there are corresponding codes in the ICD system, and validate each diagnosis, if you hope to receive the credit you deserve for the work you do.

You don't need to know the codes – that's why you have CDI Specialists!

ICD-10 specific documentation is paramount to demonstrating quality!

Quality Measures impacted by risk adjustment based on clinical documentation include:

Mortality Rate/Scoring	Hospital Rankings
Readmission Rates	Length of Stay

Unintentionally downgrading the severity of a patient's clinical condition in the medical record can lead to insurance company denial opportunities.

Physician Queries serve many purposes and can come from Coders and CDI professionals.
During the patient's hospitalization - queries come from CDI
After discharge - queries come from Coding:

To support documentation of conditions that are evident clinically but without complete documentation of corresponding diagnoses or condition.	To clarify diagnoses documented without documentation of clinical validation.
To clarify procedure objectives and details	To support appropriate Present on Admission (POA) code indicator assignment.
To establish acuity and specificity of documented diagnoses, whenever possible	To establish relevance and diagnostic status, "history of" vs. chronic conditions, active or ruled out diagnoses
To resolve conflicting documentation	To establish clear cause-and-effect relationship between medical conditions

Be sure to continue complete documentation & carry all diagnoses through the Discharge Summary! It's one of the most important documents in the medical record and is:

The first document hospital coders review when they start coding any given hospitalization
Considered the final diagnostic statement for the entire hospitalization
The first document Recovery Auditors review in their efforts to deny any given hospitalization and remove important diagnoses