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

August 4, 2021

Many thanks, Dr. Joslin

Dr. Jeremy Joslin, Clinical Operations Officer at Upstate, has accepted a new position as the Chief Medical Officer at Central Florida Regional Hospital in Sanford, Florida. His last day at Upstate will be August 13, 2021.

I would like to congratulate Dr. Joslin on his new role and thank him for his many contributions to Upstate. As Clinical Operations Officer, Dr. Joslin has been a change agent of impressive impact with a long list of accomplishments. In collaboration with Scott Jessie, our interim Chief Nursing Officer, Dr. Joslin spearheaded the development of our Capacity & Throughput Command Center and the implementation of Teletracking software. Additionally, Dr. Joslin was instrumental in our response to the COVID-19 pandemic. He served as Incident Command Planning Section Chief, designing the plan for bed expansion and for adjustments to procedural services in response to a rapidly evolving clinical landscape. He led the expansion of Upstate's COVID-19 testing program throughout our CNY region, and was a key member of our CNY Vaccine Hub Leadership Team. His visionary leadership has also resulted in advancements in pharmacy, laboratory, and radiology services. As the Director of the Transfer Center, he established transfer policies and streamlined our transfer processes. And as the Medical Director of Transitions of Care, Dr. Joslin worked with Diane Nanno and her team to optimize transitions of care. Dr. Joslin has been a go-to subject matter expert in the areas of policy and process. In addition to serving as Clinical Operations Officer, Dr. Joslin remained an active and well-respected clinician in Emergency Medicine.

Dr. Joslin will be deeply missed. Please join me in wishing him a warm farewell and every success in his new role.

New Pulmonary Embolism Response Team (PERT) to Go-Live August 5th!

by Dr. Christopher Tanski

I am pleased to announce the formation of a Pulmonary Embolism Response Team (PERT). **Our go-live is set for this Thursday, 8/5, at 0800**. PERT is best-practice for managing patients with pulmonary embolism (PE). Our PERT is an interdisciplinary team with membership from Medical Intensive Care Unit (MICU), Cardiology, Vascular Surgery, Interventional Radiology, Cardiac Surgery and Extracorporeal Life Support (ECLS). The team will be available 24/7 for patients presenting with intermediate- and high-risk pulmonary embolism.

The PERT can be activated by paging the on-call PERT fellow, listed in AMION. Please see the attached flowchart for guidance on which patients with PE should be seen by the PERT. Low risk patients with PE are not covered by this team. There is a consult order in Epic for the team as well. Once the team is activated, the patient will be discussed in real-time and the optimal management strategy recommended.

Heparin should continue to be started on all patients with a PE unless the bleeding risk is high. Likewise, for a patient who is hemodynamically unstable, Tissue Plasminogen Activator (tPA) should also be considered. These therapies do not preclude further treatments, including invasive, by PERT. If you have a patient in whom you suspect intermediate – or high-risk PE, in addition to activating PERT, please order high-sensitivity-TNT, pro-BNP, and ***either*** chest CT with contrast or a transthoracic echocardiogram (to assess right ventricular size and function).

ALERT — IMMEDIATE ACTION REQUIRED
ADVISORY — PRIORITY BUT NOT FOR IMMEDIATE ACTION
UPDATE — FOR INFORMATION; UNLIKELY TO REQUIRE ACTION

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Please contact any of the PERT service representatives with questions or concerns:

- MICU: Dr. Manju Paul or Dr. Kartik Ramakrishna
- Vascular Surgery: Dr. Michael Costanza
- Interventional Radiology: Dr. Katsuhiro Kobayashi or Dr. Tomas Appleton-figueira
- Cardiology: Dr. Debanik Chaudhuri
- ECLS: Dr. Christopher Tanski

Welcome New Providers!

Please join me in offering a warm welcome to the following new providers at Upstate Medical University as of January 1, 2021:

ANESTHESIOLOGY
Jonathan Korets, MD
Natasha Myers, CRNA
Susan Samudre, DO
Maricela Soberanes, CRNA
Brittany St. Onge, CRNA

DENTAL SURGERY
Christyne Chmil, DDS

EMERGENCY MEDICINE
Hannah Charland, MD
Kayleigh Gifford, NP
Brett Havens, NP
Michael Keenan, MD
Nicole Mongeon, PA
Jonathan Worley, DO

GERIATRICS
Stephanie McGrath, NP
Jeffrey Owens, PA

MEDICINE
Komal Akhtar, MD
Evgenia Baranova, NP
Michelle Bernshteyn, MD
Sara Bowers, MSW
Tingyin Chee, MD
Sarah Cote, NP
Kiran Devaraj, MD
Svetlana Fomin, MD
Arianna Giruzzi-Lupo, NP
Anand Gupta, MD
Chelsea Kay-Bidinger, NP
Danna Killian, NP
Dinesh Kumar, MBBS
Madhab Lamichhane, MD
Michael Lioudis, MD
Dana Lonis, NP
Angela Love, MD
Marianne Malecki, PA
Muhammad Malik, MD
Charles Miller, MD
Cierra Omlor, PA
Samantha Page, PA
Andrew Pellecchia, MD
Patrick Riccardi, MD
Laura Senska, NP
Eman Shaban, MD
Amr Shady, MBBCH
Waseem Sous, DO
Christina Stewart, PA
Suzette Trovato, NP

NEUROLOGY
Rossella Beutler, NP
Reema Choudhry, MBBS
Ioana Medrea, MD
Carlos Muniz, MD
Angela Savage, PA
Rohit Swarnkar, MD
Zora Vidovic, NP
Claribel Wee, MD

OB/GYN
Lacresha Berger, LMSW
Tatiana Dicoby, DO
Fadi Makhlouf, MD
Jose Torrado, MD

OPHTHALMOLOGY
George Salloum, MD

OTOLARYNGOLOGY
Adetokunbo Obayemi, MD

PATHOLOGY
Oleksandr Kravtsov, MD
Yesha Sheth, MD
Alexandria Smith-Hannah, MD
Liye Suo, MD

PEDIATRICS
Fozia Bakshi, MBBS
Rachel Clarke, MD
Marissa Edwards, NP
Mariko Marium Yabe-Gill, MD

PHYSICAL MEDICINE & REHAB
Kathryn Gibbs, DO

PSYCHIATRY
Sarah Chambers, NP
Scott Daniels, MD
Robin Dean, PSYD
Alicia Franceschi, LMSW
Abigail Gleason, LMSW
Kathryn Hagen, PSYD
Ingrid Hansen, NP
Afton Kapuscinski, PhD
Jeffrey MacDaniels, MD
Gabrielle Nicolini, LMSW
Pertrina Works, LMSW

RADIATION ONCOLOGY
Nathan Goldman, MD
Shannon Opperman, NP

RADIOLOGY
Frederick Anderson, DO
Timothy Jan, DO
Markus Lammle, MD
Brett Martin, MD
Refky Nicola, DO
Mohammad Rajebi, MD
Harlan Stock, MD
Daniel Tubbs, DO
Joseph Williams, MD
Waikeong Wong, MD

SURGERY
Jacqueline Amsdell, PA
Margaret Arlington, PA
Andrea Arnaiz, PA
Katherine Getman, PA
Jennifer Knohl, LCSW
Mehdi Marvasti, MD
Margaret Terzolo, PA
Shuichi Yoshitake, MD

UROLOGY
Joshua Sterling, MD

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Masks Required in All Upstate Buildings

By Paul Suits

Masking:

Due to increased Covid-19 transmission associated with the delta variant, masks are required in all Upstate buildings regardless of vaccination status. This includes all clinical and non-clinical locations on the Upstate campus. Masks must be worn properly when entering and exiting all Upstate buildings, including the pedestrian bridge connected to Upstate University Hospital. At this time, masks are not required outdoors or in parking garages.

If masks are removed for eating and drinking, six feet of distance must be maintained.

Virtual meetings are encouraged in lieu of in-person meetings.

Daily Employee Screening:

- All staff and students must do one of the following: use the online screening tool at https://www.upstate.edu/selfscreen, scan Upstate ID badge at the kiosk, or complete the sign-in sheet daily prior to work start time in ambulatory areas.
- Do not come to work if you feel sick.
- If you are feeling sick, call 315-464-8436 and make arrangements to schedule a Covid-19 test. Symptomatic individuals must remain out of work until negative results are confirmed.

Vaccine Information:

- To schedule an appointment to be vaccinated, visit: https://vaccines.gov.
- To ensure Employee/Student Health has a record of Covid-19 vaccination status, check the personal online health portal at https://eshportal.upstate.edu/ and confirm the records on file.
- If a staff member or student does not have a Covid-19 vaccination note on file, we ask that they send the information to Employee/Student Health so that our vaccination records are up to date. For more information, contact Employee/Student Health at ESHealth@Upstate.edu or 315-464-4260.

New Clinical Decision Support Mechanism for Advanced Imaging

by Jennifer Carey

The Protecting Access to Medicare Act (PAMA) requires that physicians ordering advanced imaging exams (CT, MRI and Nuclear Medicine) consult Appropriate Use Criteria (AUC) through a qualified Clinical Decision Support Mechanism (CDSM). Upstate has contracted with Care Select to provide this clinical decision support mechanism.

Ordering providers are required to consult AUC for all Advanced Diagnostic Imaging Services (CT, MRI and Nuclear Medicine). Consultation is required in all applicable settings as outlined by the Centers for Medicare and Medicaid Services (CMS). These requirements include hospital inpatient and hospital outpatient departments (including emergency departments).

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CMS has also defined 8 Priority Clinical Areas they will be measuring for outliers. This means, if a physician is not routinely adherent to AUC in one of these areas, they will be identified as an outlier which may lead to additional prior authorization requirements.

Please see attached internal provider one-pager for more information.

Sending Information to Outside Providers

by Dr. Neal Seidberg

At the end of every inpatient stay and Emergency Department (ED) visit, we automatically send information to any outside caretaker (primary care physician and others) listed on the Care Team. Please do not manually send documents such as your notes. Doing so creates high volume, redundant documentation, that frustrates the outside providers.

Policy M-01 addresses this: patient information should be sent only by trained office staff in our clinics, using the proper release process. This ensures that the correct steps are taken and that the process is documented appropriately.

The following is a list of all documents automatically sent:

- Active Problems
- Additional Health Concerns
- Administered Meds
- Advanced Directives
- Allergies
- Current Meds
- Discharge Instructions
- Discharge Summary
- ED Notes
- Functional Status
- Goals
- H&P Notes
- Immunizations
- Insurance
- Plan of Treatment
- Procedure Notes
- Progress Notes
- Reason for Referral
- Reason for Visit
- Resolved Problems
- Results
- Social History
- Visit Diagnosis
- Vital Signs

2021 Physician Sunshine Payment Act Education

by Loretta Harris Stickane

Attached please find education regarding the expansion of the Physician Sunshine Act.

The Physician Payment Sunshine Act is part of the Affordable Care Act (ACA) 2010 (enacted in 2013) and requires medical product manufacturers, pharmaceutical companies, biologic manufacturers and medical supply companies to disclose to the Centers for Medicare and Medicaid Services (CMS) any payments or other transfers of value made to physicians or teaching hospitals. It also requires certain manufacturers and group purchasing organizations (GPOs) to disclose any physician ownership or investment interests held in those companies.

If you have any questions, please contact Loretta Harris Stickane, Chief Ethics and Compliance Officer, at 315-464-4789 or HarrisLo@upstate.edu.

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New/Revised/Deleted COVID-19 Policies of Special Interest for Clinicians

REVISED:

- **COVID-19: Bed Management and Throughput (COV B-03):** Change to symptom-based COVID testing for patients. Separated COVID patient placement into routine and surge level procedures. Removed appendix D.
- **COVID-19 Testing at Upstate University Hospital Locations (COV T-08):** Made changes to accommodate symptom-based COVID testing.
- **COVID-19/SARS-CoV-2 Testing Results Delivery Responsibilities (COV T-11):** Updated Addendum A table, including testing site.
- **Visitor Restriction During Prevalence of COVID-19 (COV V-08):** Revised ED visitation and updated FBC visitation.

DELETED:

- **Decontamination of N95 Mask and Storage Process (COV D-03)**: Archived and retired in MCN (7/28); policy no longer applicable.
- **Transportation of the COVID Positive and COVID R/O Patients to the 5 EAST OR (COV T-06):** Archived and retired in MCN (7/28); policy no longer applicable.

Clinical Documentation Improvement (CDI)

by Dr. Emily Albert and Dr. Ali Khan, Co-Directors, CDI

Acute Respiratory Failure must always include documentation by a provider of the underlying cause with symptoms to match. Please include subjective and/or objective clinical indicators used to formulate the diagnosis in your diagnostic statement. Please see attached tip sheets 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:

Adult Hematology Oncology: **Dr. Abirami Sivapiragasam** – gentle, kind, and non-judgemental.

ENT at Community Hospital: **Dr. Brian Nicholas** came highly recommended and has been great on all my visits. **Dr. Brian Nicholas** has always treated us kindly and professionally. He is knowledgeable, confident, and caring; great qualities that make us feel at ease when he cares for our son.

EU at Community Hospital: **Dr. Victoria Titoff** – amazingly helpful and kind. **Dr. Xiangping Zhou** attended as often as possible.

Joslin Center for Diabetes: **Dr. J Kurt Concilla** is fantastic. He was my doctor before he came to Joslin and I followed him because I like him so much. **Dr. J Kurt Concilla** – excellent, caring, friendly.

Multidisciplinary Programs Cancer Center: **Dr. Jason Wallen** explained why there was a need to do a lung biopsy and explained the procedure answering any questions I had in a way that eased my anxiety. He presented my case to other doctors while at a conference that afternoon. At my appointment, he told me that he would call at the end of the day with the results of their

discussions of my case. He called, as he had promised, and explained the plan of care going forward. I feel like my care is in good hands.

Nephrology Clinic: I was admitted to the hospital and they cancelled my appointment with **Dr. William Elliott** but he saw me anyway. **Dr. Harris Mobeen** was very thorough and explained everything and answered all my questions. **Dr. Harris Mobeen** was wonderful! **Dr. Harris Mobeen** was very courteous and went through everything with me. I left feeling very good about my visit.

Pediatric Multispecialty Clinic: Our experience with **Dr. Christopher Fortner** was outstanding as always. From beginning to end, we were treated courteously and professionally.

Regional Perinatal Center: **Dr. Robert Silverman** – very knowledgeable and likable!

Rheumatology Clinic: **Dr. Hiroshi Kato** is one of the best doctors I have seen – very caring and knowledgeable. **Dr. Hom Neupane** is worth the wait.

SUNY Upstate – Virtual: **Dr. Andrea Berg** was early to open video appointment and was clear with no technical difficulties. **Dr. Andrea Berg** was compassionate and understanding.

Surgical Specialties at Community Hospital: **Dr. Kristina Go** was very easy to talk to and very approachable. **Dr. Michael McGrattan** took time to explain my situation and potential treatment options and complications.

Surgery – UHLL022: **Dr. Jeffrey Albright** – extremely professional, thorough with explanations, and compassionate with concerns.

The Surgery Center – CG: **Dr. Eric Quilty** – dream team! I felt safe and taken care of at each step. **Dr. Ranjna Sharma**, of course, was her usual warm wonderful self.

UHCC – Neurology: **Dr. Deborah Bradshaw** is incredible. She is always very patient and understanding. She explains everything easily and she genuinely cares for her patients. **Dr. Deborah Bradshaw** came in minutes after the triage nurse was finished. I was impressed! **Dr. Anuradha Duleep** is working very hard, not only with my doctors, but also with doctors she plans on referring me to. I have already recommended **Dr. Anuradha Duleep** to everyone I know, including my own daughter. I have required a great deal of medical care, and **Dr. Anuradha Duleep** is surely the kindest, gentlest, most patient doctor I have had the pleasure to work with over the last 20 years. The minute she walks into the room, you feel calm and unworried about what is going on. I highly recommend her to everyone I know. **Dr. Corey McGraw** seems like a very knowledgeable doctor and it didn't take long for him to diagnose me. I'm very thankful. **Dr. Corey McGraw** spoke to me and explained everything very well. **Dr. Luis Mejico** was superb! **Dr. Awss Zidan** – nice!

University Cardiology: **Dr. Kwabena Boahene** dedicated his full attention to me and gave me all the time I needed to discuss my condition. **Dr. Kwabena Boahene** explained my problem very well and made changes. **Dr. Robert Carhart** is the best! **Dr. Robert Carhart** is an excellent doctor. He takes the time to inform you of any issues and explains them to you clearly. If it isn't clear and you don't understand, he will answer all of your questions and make sure you understand before ending the appointment. **Dr. Robert Carhart** because of his sensitivity and his experience, and his willingness to explain everything.

University Center for Vision Care: I am very pleased by the care provided to me by **Dr. Robert Fechtner**. He is pleasant, knowledgeable and offers multiple options for treatment. **Dr. Robert Fechtner** continues to provide outstanding care. He's one of the very best doctors I've ever had and I've had a lot!

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University Geriatricians: **Dr. Andrea Berg** is exceptional! She has amazing skills! **Dr. Vikrant Tambe** is very conscientious of all my medical needs and provided options I could consider.

University Internists: **Dr. Tingyin Chee** took the time to listen to me. **Dr. Tingyin Chee** went over all health issues I have. This was my first time meeting **Dr. Tingyin Chee**, and I already think she's terrific! I always recommend **Dr. Vincent Frechette** to everyone looking for a new physician. **Dr. George Gluz** was thorough and patient, provided good information about the Delta variant which I appreciated. **Dr. Sarah Lappin**, as always, is so wonderful It seems that **Dr. Sarah Lappin** reviews charts prior to coming in to see the patient or remembers patient issues from the past. **Dr. Catherine White** for her attention to detail, her care, and empathy. **Dr. Catherine White** is exceptional. **Dr. Catherine White** spent ample time with me explaining my problems. Very satisfied. I especially commend **Dr. Catherine White**.

Upstate Pediatrics: **Dr. Jaclyn Sisskind** is hands down the best doctor I have ever met. Her kindness is unmatched, she has always listened to us and provided us with plans when there have been health issues, and she makes us feel so incredibly special! **Dr. Jaclyn Sisskind** has always made us feel so important and cared for. We look forward to our visits and she remembers things about my daughters' lives and asks about them. She says she loves when we have appointments and she is so gentle both with physical interaction and verbal communication. She's just the best!

Upstate Urology: **Dr. Gennady Bratslavsky** – great! **Dr. Gennady Bratslavsky** was very charming, caring and intelligent. He addressed our concerns to our satisfaction. **Dr. Oleg Shapiro** made a scary thing not so scary. He put things in perspective! **Dr. Oleg Shapiro** – impressed, attentive, and showed concern about resolving my issues. **Dr. Oleg Shapiro** is the best.

4North at Community Hospital: **Dr. Emily Albert** was wonderful. I thoroughly enjoyed working with **Dr. Mitchell Brodey** and **Dr. Brian Changlai**. **Dr. Brian Changlai** took lots of time with me to discuss the issue that led me to needing emergency care and how I could hopefully avoid the issue going forward. **Dr. Andres Madissoo** is the best! He always spends time to go over everything in detail and he cares.

05A: **Dr. Ebosi Mbame** explained problems so you could understand. **Dr. Jason Wallen** saved my life. **Dr. Jason Wallen** – thank you!

05B: **Dr. Gennady Bratslavsky** - skilled, informative, and excellent bedside manner. **Dr. Elizabeth Ferry** was exceptional explaining every detail about my operation.

07A: **Dr. Richard Tallarico** – people person.

07C: **Dr. David Duggan** talked with my RN daughter. **Dr. Matthew Hess** – updated us and explained tests. **Dr. Anupa Mandava** – thorough and informative.

08G: **Dr. Michael Archer** and his team did an excellent job. **Dr. Michael Archer** talked with me before and after my surgery plus while inpatient. Very compassionate doctor, and I would recommend him to my friends and family.

10G: **Dr. Riaz Syed** – instrumental in identifying underlying pathology (benzo withdrawal) and safely removed me from harm. **Dr. Thomas Vandermeer** was very patient, positive, and compassionate.

11G: **Dr. Karen Teelin** – so kind and knowledgeable.

I hope you all are having a wonderful summer! Thank you for all of the fantastic work you do! Amy

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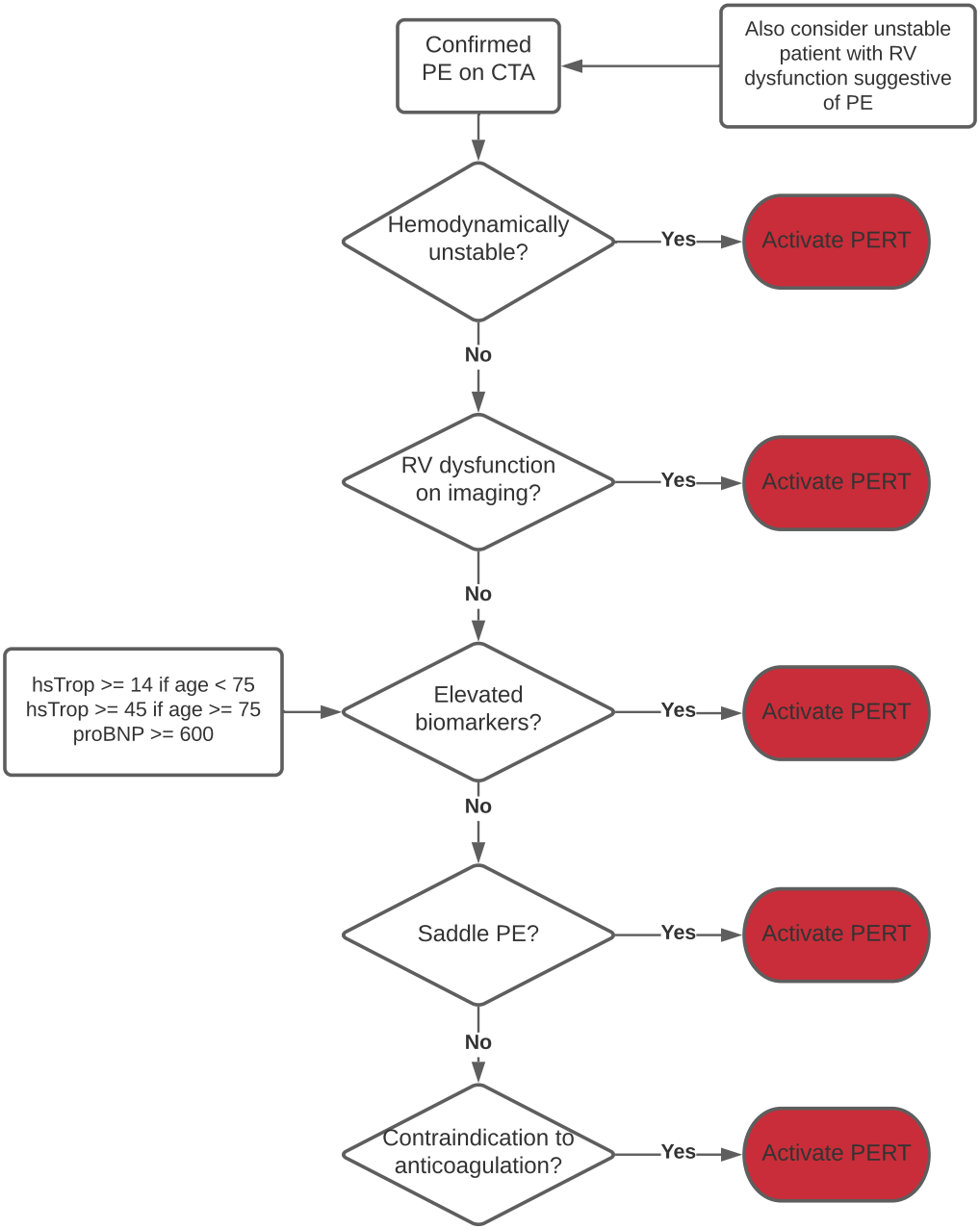

Confirmed PE on CTA
Also consider unstable patient with RV dysfunction suggestive of PE
Hemodynamically unstable?
Yes
Activate PERT
No
RV dysfunction on imaging?
Yes
Activate PERT
No
hsTrop >= 14 if age < 75
hsTrop >= 45 if age >= 75
proBNP >= 600
Elevated biomarkers?
Yes
Activate PERT
No
Saddle PE?
Yes
Activate PERT
No
Contraindication to anticoagulation?
Yes
Activate PERT

CareSelect™ imaging

Connecting Compliance, Quality & Savings to Clinical Decision Support

Benefits

Quality
- ✓Reduce unnecessary exposure to radiation
- ✓Correct exam for the indication

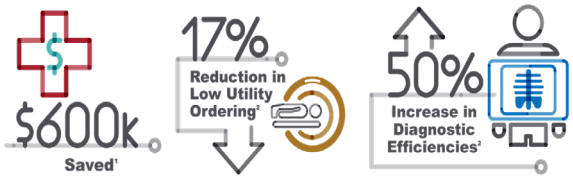
Patient Safety
- ✓Correct exam is ordered the first time
- ✓Exams are supported by evidence based practice

Potential Cost Savings
- ✓Appropriate utilization of resources
- ✓Reduced prior auths for imaging exams

Regulatory Compliance
- ✓Meet Jan 1, 2022, mandate

NDSC'S CARESELECT PLATFORM, in close partnership with leading EHR vendors and content sources, offers a proven enterprise solution with seamless workflow integrations. CareSelect® Imaging offers point of order guidance to physicians and radiologists by integrating expert panel education on overutilized and high value imaging exams.

VALUE



Go Live 09/07/21

Q: How will CareSelect® integration impact me?
A: High tech imaging exams for CT, MRI, NM, PET and SPECT modalities will now trigger integrated clinical decision support (CDS).

Q: As a physician, am I required to adhere to the recommendations presented in the CDS?
A: No – CareSelect® supplies point of care guidance and does not force or prevent decision-making by the provider.

Q: What if I cannot find an appropriate reason for exam within the structured list provided by CareSelect®?
A: You can select 'I can't find a match' and add a free text reason for exam. If you would like to recommend an adjustment to the content, we ask that you provide feedback to Jennifer Caldwell – Director of Radiology.

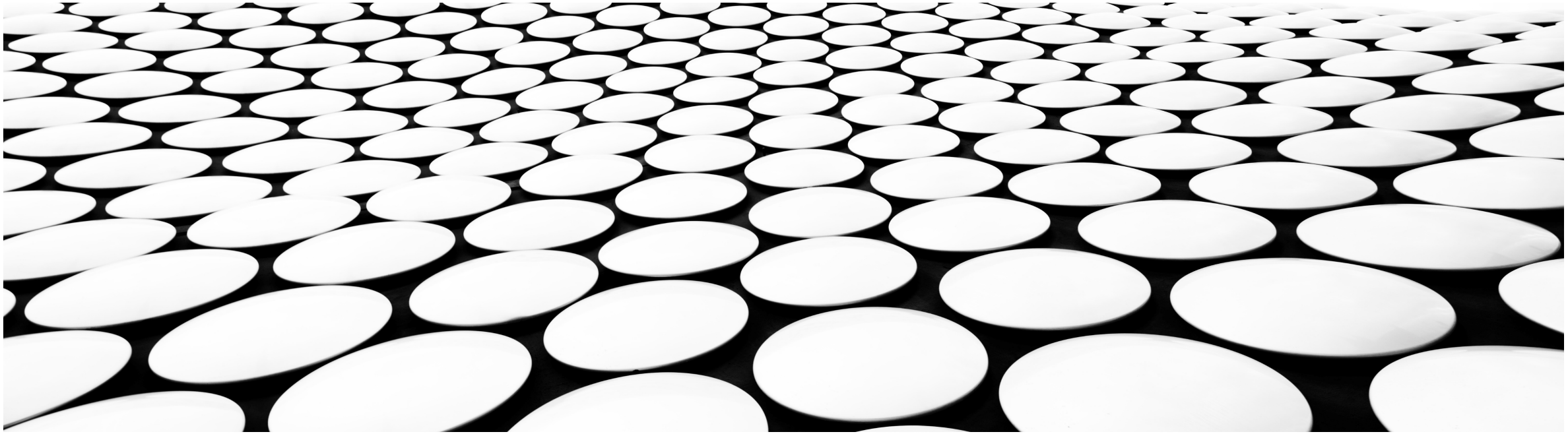
Q: Who can I contact with questions about CareSelect®?
A: IMT Help Desk – 315-464-4115

PHYSICIAN PAYMENT SUNSHINE ACT (OPEN PAYMENTS)

PRESENTED BY LORETTA HARRIS STICKANE, MBA, CHC, CCEP, CHPC

CHIEF ETHICS & COMPLIANCE OFFICER, CONFLICT OF INTEREST & INTEGRITY OFFICER

SUNY UPSTATE MEDICAL UNIVERSITY



BACKGROUND

- The Physician Payment Sunshine Act is a part of ACA 2010 (enacted in 2013) and requires medical product manufacturers, pharmaceutical companies, biologic manufacturers and medical supply companies to disclose to the Centers for Medicare and Medicaid Services (CMS) any payments or other transfers of value made to physicians or teaching hospitals. It also requires certain manufacturers and group purchasing organizations (GPOs) to disclose any physician ownership or investment interests held in those companies.
- This information is available on their public website and is published annually.

WHO IS REPORTED TO OPEN PAYMENTS?

- 2013-2021- Covered recipients are any physicians (excluding medical residents); or teaching hospitals that receive payment for Medicare direct graduate medical education (GME), inpatient prospective payment system (IPPS) indirect medical education (IME), or psychiatric hospital IME programs during the last calendar year for which such information is available. (See 42 CFR 403.902)
- 2022- Open Payments expanded in January 2021 (data collection to be reported in 2022) to include five new provider types: ***physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists & anesthesiologist assistants, and certified nurse-midwives.***

WHAT'S REPORTED

Natures of payment categories are categories that must be used to describe why a payment or other transfer of value was made (See 42 CFR 403.904(e)(2)). The categories are:

- Consulting fees
- Compensation for services other than consulting, including serving as faculty or as a speaker at an event, other than a continuing education program
- Honoraria
- Gifts
- Entertainment
- Food and beverage
- Travel and lodging
- Education
- Research charitable contributions
- Royalty or license
- Current or prospective ownership or investment interest
- Compensation for serving as faculty or as a speaker for an unaccredited and non-certified continuing education program
- Compensation for serving as faculty or as a speaker for an accredited or certified continuing education program
- Grants
- Space rental or facility fees (teaching hospital only)

WHY IT MATTERS

As State employees you are held to the standards of New York State Public Officers Law, including the restrictions on gift acceptance and avoiding conflicts of interest. Accepting any type of renumeration has the potential to violate both state law and our own internal policies. Additionally, this information is available to the public, who also have the ability to search their providers names to see whom they accept money or reimbursements from. This information has the potential to corrode public trust if proper disclosures and management plans are not implemented. Transparency is the key to ensuring that all know we are operating in an ethical manner.

https://jcope.ny.gov/ethics-laws-and-regulations-0 – New York State Public Officers Law

https://upstate.ellucid.com/documents/view/2981 - Policy on Relations with Industry

https://upstate.ellucid.com/documents/view/418 - Conflict of Interest Policy

HOW TO AVOID COMPLIANCE ISSUES

- Check with the Compliance & Ethics office **PRIOR** to accepting any reimbursement from an outside entity that could potentially cause a conflict of interest
- Ensure that you have the appropriate approvals for outside activities/honorarium. Forms can be located on the compliance website in under the ethics tab: https://www.upstate.edu/compliance/ethics.php
- When in doubt, check it out!

SEARCH FOR YOUR NAME/INSTITUTION

- https://openpaymentsdata.cms.gov/

COMPLIANCE & ETHICS RESOURCES

Loretta Harris Stickane, MBA, CHC, CCEP, CHPC

Chief Ethics & Compliance Officer

Conflict of Interest & Integrity Officer

harrislo@upstate.edu, compliance@upstate.edu, https://www.upstate.edu/compliance

315-464-4789

External Resources:

https://www.cms.gov/OpenPayments

https://jcope.ny.gov/

UPSTATE
UNIVERSITY HOSPITAL

Clinical Documentation Improvement
Tip of the Month –Respiratory Failure

Applies to all providers

Acute Respiratory Failure must always include documentation by a provider of the underlying cause, with symptoms to match. Please include subjective and/or objective clinical indicators used to formulate the diagnosis in your diagnostic statement.

Hypoxic Respiratory Failure

OBJECTIVE	pO2 < 60 mmHg on room air, or SpO2 < 91% on room air, or P/F ratio (pO2/FIO2) < 300 on oxygen, or Baseline pO2 decrease by > 10.
SUBJECTIVE	cyanosis, dusky appearance, respiratory distress, airway occlusion, apnea, respiratory arrest, shortness of breath, dyspnea, stridor, tripoding, inability to speak in complete sentences

Hypercapnic Respiratory Failure

OBJECTIVE	pH <7.35, pCO2 >50, serum bicarb >30 in absence of other metabolic cause
SUBJECTIVE	Somnolence, hyper or hypoventilation, anxiety, encephalopathy, low GCS, asterixis, myoclonus, seizure, papilledema, superficial venous dilation

Acute pulmonary insufficiency

- *Please document this diagnosis when the patient's condition is not severe enough to be deemed respiratory failure.*

Mechanical ventilation following surgery and/or anesthetic (must be less than 48 hours following end of the operation)
Need for pulmonary toilet to prevent deterioration
Need for supplemental low-flow oxygen (more than baseline)
Use of frequent nebulizers (more than baseline)
Need frequent monitoring of respiratory status but does not meet criteria for acute respiratory failure

Documentation Examples

Patient presented from OSH intubated for acute hypoxic respiratory failure – intubated and sedated, maintain on vent

- *Acute hypoxic respiratory failure secondary to airway obstruction – respiratory distress, tachypnea, and stridor present prior to intubation. No desaturations noted, reported perioral cyanosis indicates presumed hypoxia from upper airway obstruction. Maintaining oxygen saturations >92% on 30% FiO2.*

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Intubated for airway protection secondary to alcohol intoxication - *must make the distinction if this is for prevention or due to acute failure and the patient has lost the ability to maintain their airway*

- *Acute respiratory failure secondary acute toxic encephalopathy causing CNS depression – patient with persistent hypoventilation, periods of apnea, snoring respirations. Intubated for airway protection because the patient lost the ability to maintain their airway GCS 6. No hypoxia noted. Possible component of hypercapnia, will check ABG.*

Patient intubated during RRT, transferred to ICU for respiratory failure and vent management

- *Acute hypercapnic respiratory failure secondary to presumed opiate overdose – patient initially with GCS of 9, and lost their airway, no hypoxia. Asterixis present, minimal response to sternal rub prior to intubation. Per nursing, patient was agitated, encephalopathic prior to becoming obtunded. Serum bicarb 47 with no identifiable metabolic cause. No ABG prior to intubation, ordered.*

Acute pulmonary insufficiency due to weakness from Parkinson Disease and being ill

- *Acute pulmonary insufficiency due to weakness from Parkinson Disease and being ill - patient has some atelectasis with some desats to 88%, placed on 2LNC in the setting of weakness from Parkinson's disease.*

Acute Respiratory Failure is one of the most common diagnoses for insurance denial due to the lack of documented clinical support, or evidence, by providers. Clinical indicators documented by nursing cannot be assumed as clinical evidence, or support, for any diagnosis unless you state it as such. The clinical criteria must be clearly outlined in the diagnostic statement by the provider formulating the diagnosis and treatment plan.

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Clinical Documentation Improvement (CDI)
Tip of the Month –Respiratory Failure

Applies to Pediatrics

Acute Respiratory Failure must always include documentation by a provider of the underlying cause, with symptoms to match. Please include subjective and/or objective clinical indicators used to formulate the diagnosis in your diagnostic statement.

Pediatric Respiratory Failure

There is **NOT** a universally accepted definition for respiratory failure in the pediatric population. Respiratory failure is the inability to provide O_2 and remove CO_2 at a rate that meets metabolic demands.

Respiratory Failure Compared to Respiratory Distress:

- Respiratory insufficiency or respiratory distress is sometimes documented when the child clinically meets criteria for respiratory failure. These are lower-weighted, therefore use ***respiratory failure*** when the child meets criteria.

Acute Respiratory Failure

- Not all patients with acute respiratory failure require intubation and mechanical ventilation.
- Any of the following interventions meet the criteria for acute respiratory failure.
  - Supplemental oxygen with a FiO_2 > 30-35% to maintain oxygenation ($SpO_2 \geq$ 90%)
    - Nasal cannula 2-4 LPM in children and adolescents
    - Nasal cannula ½ -2 LPM in infants and toddlers
    - Simple face masks 5-7 LPM
  - High-flow nasal cannula, vapotherm or non-rebreather mask oxygen, CPAP or BiPAP
  - Increased work of breathing, retractions – nasal flaring, subcostal, supraclavicular, substernal with RA sats <88%

Chronic Respiratory Failure

- **Continuous** home oxygen or ventilator support (mechanical vent or nasal BiPAP) **or**
- Having baseline SaO_2 < 88% on room air or pCO_2 > 50 with a normal pH due to a respiratory condition

Acute on Chronic Respiratory Failure

- Chronic respiratory failure is worsening of SaO_2 and/or pCO_2 with symptoms

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Documentation Example:

Upon initial presentation to the Pediatric ED, 8 year old patient was in respiratory distress, noted to have increased work of breathing with retractions both subcostal and intercostal requires 6 L NC. Continued to have respiratory distress with prolonged expirations, tachypnea, not responsive to albuterol. HFNC was started, increased to a max of 30 LPM.

Principal Diagnosis:
Severe Asthma with acute exacerbation
Secondary Diagnosis:

Acute respiratory distress
Severity of Illness – **1, Minor**
Risk of mortality = **1, Minor**
CMS DRG Weight **0.4736**

Principal Diagnosis:
Severe Asthma with acute exacerbation
Secondary Diagnosis:

Acute respiratory failure
Severity of Illness – **3, Major**
Risk of mortality = **2, Moderate**
CMS DRG Weight **0.9377**

- ✓ **Most accurately reflects severity of illness and risk of mortality – you do hard work, take credit for it!**