MORNING CMO REPORT

12.06.2017

FROM THE DESK OF:
Anthony P. Weiss, MD, Chief Medical Officer,
Associate Dean for Clinical Affairs,
Upstate University Hospital

UPSTATE UNIVERSITY HOSPITAL

THANK YOU

Applies to All Physicians

Over the past week we saw unprecedented volumes of patients within our ED's and our census across both campuses was the highest I've seen in four years here. Yet, we did not go on diversion. We remained open to transfers and emergencies around the region, saving lives as a direct result, lives that would have been lost if they were forced to travel across the state because our doors were closed. To do this has required an incredible multi-disciplinary team effort. I would like to express my particular thanks to all of the medical staff and residents for their work during this time.

Private Encounter/Alias Name Brand

Applies to All Physicians

Upstate is standardizing colors for alert wristbands in a partnership with local hospitals and national American Hospital Association initiatives. According to the American Hospital Association, when hospitals use different colors for alert wristbands, caregivers working in more than one facility may have difficulty always responding in the appropriate manner.

Standardizing the colors of the wristbands used in hospitals is the sensible approach to improving patient safety, and many state hospital associations have already engaged their hospitals in this effort.

The first wrist band color change is effective January 2, 2018 is the Private Encounter/Alias Name band. The color will change from green to gray.

ALERT-Highest priority emergency communication; warrants immediate action or attention by the recipient.
HIGH ADVISORY-High priority does not warrant immediate action but recipients should be aware.
ADVISORY-Provides very important information for a specific incident or situation that does not require immediate action.
UPDATES TO ALERTS AND ADVISORIES-Provides updated information regarding an incident or situation; unlikely to require immediate action.
INFORMATIONAL MESSAGE-Provides timely information, important for review or serves as a reminder for an action that should be taken.

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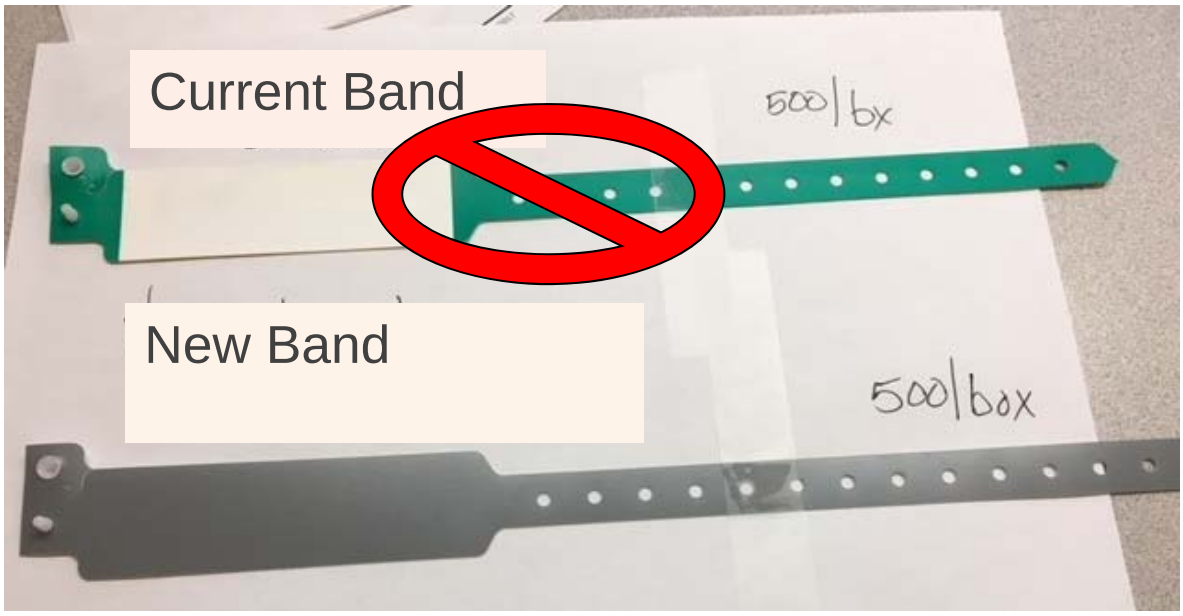

A private encounter designation protects the identity of a patient in the Hospital Information System for safety or privacy reasons. After receiving the Private Encounter form, Patient Access staff will make up the five (5) gray ID bands, which includes one for the patient. The visitor gray bands will be labeled with the patient MRN, patient DOB and the visitor's name. The patient band will be labeled with their MRN and DOB.

PUREWICK Female External Catheter

Applies to All Physicians

This is a product which is available in the hospital that may be used in incontinent females. It is non-invasive and can decrease the use of invasive Foley Catheters.

Nurses and/or providers can make the decision to use this device. Please see the attached PowerPoint on this product. Urine output is obtained in a collection jar and can be measured.

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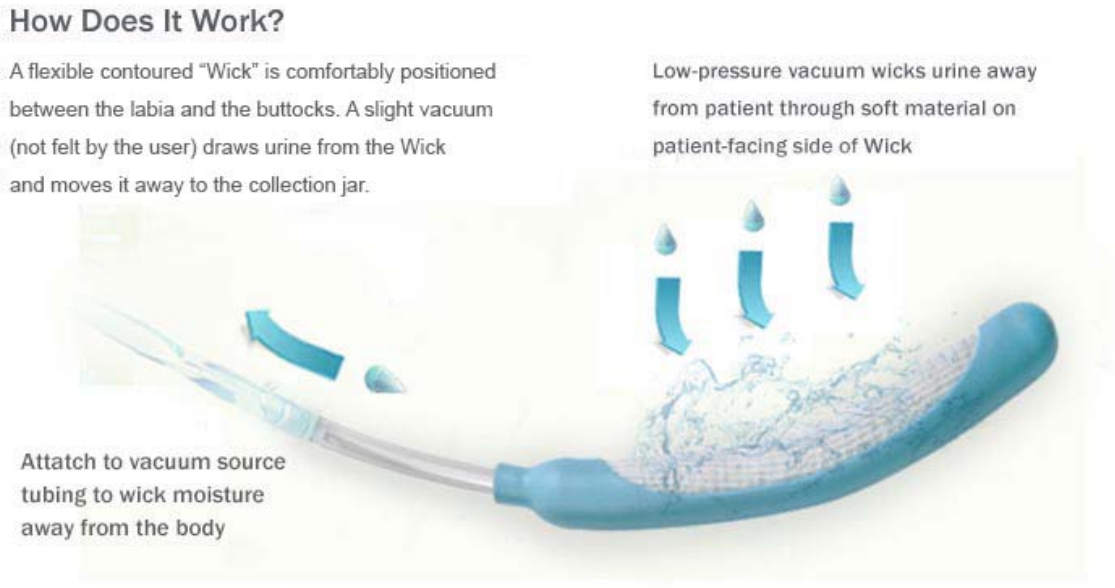

Expected Date of Discharge

Applies to All Physicians

As we are developing a new process to better manage our capacity and throughput within the Hospital, we have identified a need for a more accurate list of patients who are expected to go home on any given day. To that end, the document attached to this Report outlines a new process by which the expected date of discharge entered as part of the admission orders will be used to create such a roster. This process will largely be managed by Case Management but does rely on the initial date entered on the admission order, and ongoing conversations with physicians, to be sure that date is accurate. This is a new process which may encounter some bumps in the road, but I am hopeful it will help us gain a better understanding of the inflows and outflows into our organization.

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Upstate University Hospital

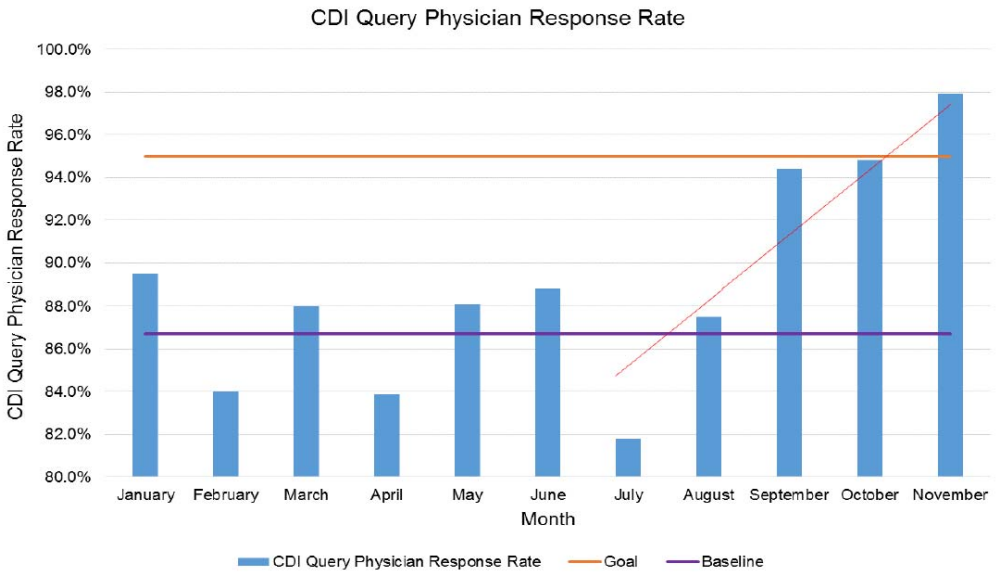
UPSTATE UNIVERSITY HOSPITAL

CDI Query Physician Response Rate

Applies to All Physicians

We see incredibly sick patients here at Upstate, patients transferred in from around the region. Yet our documentation does not always reflect this level of acuity. Our Clinical Documentation Improvement (CDI) team is here to assist us in being sure we are accurately documenting co-morbid conditions. For their work to benefit us, physicians must respond to their queries. Over the past five months, we have seen a tremendous improvement in physician query response rates, as reflected in this chart. Thank you!

CDI Query Physician Response Rate-2017



Source-3M: 09F Physician Query Detail Listing Report (Based on Discharge Date & Re-Cast of Queries)
Note: Baseline represents response rate from January to July; Goal represents industry standard

1

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UPSTATE UNIVERSITY HOSPITAL

Schwartz Center Rounds

Applies to All Physicians

Tuesday, December 12, 2018 at 3:45 pm, East Tower 11405 A/B. See attached flyer.

Declaration of Geneva

Applies to All Physicians

The Declaration of Geneva is an important ethical touchstone for physicians and was recently updated to keep it current. I thought I would take this opportunity share this document with you as recently published in JAMA.

Outstanding Physician Comments

Applies to All Physicians

Each week we receive written comments from our patients regarding the care we provide within the Hospital. Below are this week's comments from grateful patients receiving care on the units and clinics at Upstate:

11G - **Dr. Sima** - amazing.

10E - **Dr. Zachary Shepherd** was excellent as was **Dr. Dorothy Pan**.
Dr. Zachary Shepherd is excellent. His knowledge of my condition was impressive, his bedside manner is wonderful and he seems to really care about his patients. He even stopped up on the oncology floor to visit me after my transfer! I wish more doctors were like him.

Radiation Oncology – **Dr. Paul Aridgides** - WONDERFUL!

Adolescent Medicine - **Dr. Teelin** is amazing and so sweet.

AP1 - **Dr. Scalzetti** was very caring and kind. He explained everything that was going to happen and made me feel at ease.

Center for Children's Surgery – **Dr. Tatum** was a fabulous surgeon.
Dr. Riddell always goes above and beyond.
Dr. Ahmed is an amazing doctor and very great with our child.

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ODS - **Dr. Anghel** impressed me as he was extremely considerate of explaining my procedure as he was actually engaged in doing my ablation and placing my monitor. He is a patient friendly doctor.

Upstate Pediatric & Adolescent Center – **Dr. Black** is very nice, and he's a good doctor.

Vascular Surgery Clinic – **Dr. Surowiec**- Professional

VIEWPOINT

The Revised Declaration of Geneva
A Modern-Day Physician's Pledge

Ramin Walter Parsa-Parsi, MD, MPH
German Medical Association, Berlin, Germany; and Chair of the World Medical Association Declaration of Geneva Workgroup; member of the WMA Medical Ethics Committee; and member of the WMA Council.

Supplemental content

Corresponding Author: Ramin Walter Parsa-Parsi, MD, MPH, German Medical Association, Herbert-Lewin-Platz 1, 10623 Berlin, Germany (rparsi@baek.de).

A newly revised version of the Declaration of Geneva was adopted by the World Medical Association (WMA) General Assembly on October 14, 2017, in Chicago.

As the contemporary successor to the 2500-year-old Hippocratic Oath, the Declaration of Geneva, which was adopted by the World Medical Association (WMA) at its second General Assembly in 1948,[1] outlines in concise terms the professional duties of physicians and affirms the ethical principles of the global medical profession. The current version of the Declaration, which had to this point been amended only minimally in the nearly 70 years since its adoption, addresses a number of key ethical parameters relating to the patient-physician relationship, medical confidentiality, respect for teachers and colleagues, and other issues. A newly revised version adopted by the WMA General Assembly on October 14, 2017, includes several important changes and additions (Supplement).

It is standard practice for the WMA to circulate its policy papers for review every 10 years to reevaluate the accuracy, essentiality, and relevance of the documents. The Declaration of Geneva is no exception. In 2016 (10 years following the most recent editorial revision of the Declaration), the WMA established an international workgroup to assess the Declaration of Geneva's content, structure, audience, and implementation and to determine whether any amendments were necessary. Given the crucial nature of this document, the assigned workgroup charted a generous timeline of nearly 2 years to allow ample opportunity to gather feedback and suggestions not only from member national medical associations, but also from external experts. The goal in doing so was to ensure that the revision was as transparent and collaborative an effort as possible.

Chaired by the German Medical Association and composed of workgroup members of different cultural, religious, and racial backgrounds, the workgroup tasked with determining the need for a revision carefully considered the Declaration in light of modern developments in medicine and medical ethics, as well as in the context of other important WMA policies and respected international literature. The workgroup also based its recommendations on comments solicited from WMA members on several occasions (most recently in July and August 2017), as well as a 3-week public consultation carried out in May and June 2017, during which the draft version of the revised Declaration was published on the WMA website and distributed to an international network of experts and stakeholders for comment. Each comment received over the course of the revision process was carefully reviewed

World Medical Association Declaration of Geneva

The Physician's Pledge

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948
and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968
and the 35th World Medical Assembly, Venice, Italy, October 1983
and the 46th WMA General Assembly, Stockholm, Sweden, September 1994
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006
and the WMA General Assembly, Chicago, United States, October 2017

AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.

by workgroup members and considered for inclusion in the revised draft.

The most notable difference between the Declaration of Geneva and other key ethical documents, such as the WMA's Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects[2] and the Declaration of Taipei on Ethical Considerations Regarding Health Databases and Biobanks,[3] was determined to be the lack of overt recognition of patient autonomy, despite references to the physician's obligation to exercise respect, beneficence, and medical confidentiality toward his or her patient(s). To address this difference, the workgroup, informed by other WMA members, ethical advisors, and other experts, recommended adding the following clause: "I WILL RESPECT the autonomy and dignity of my patient." In addition, to highlight the importance of patient self-determination as one of the key cornerstones of medical ethics, the workgroup also recommended shifting all new and existing paragraphs focused on patients' rights to the beginning of the document, followed by clauses relating to other professional obligations.

To more explicitly invoke the standards of ethical and professional conduct expected of physicians by their patients and peers, the clause "I WILL PRACTISE my profession with conscience and dignity" was augmented to include the wording "and in accordance with good medical practice."

A reevaluation of how the professional obligations of physicians are represented in the Declaration of Geneva would not be complete without considering increasing workload, occupational stress, and the potential adverse effects these factors can have on physicians, their health, and their ability to provide care of the highest standard. In light of feedback received in the survey of WMA members, along with the recommendations outlined in the recently adopted WMA Statement on Physician Well-Being,[4] workgroup members incorporated the concept of physician well-being into the revised Declaration as follows: "I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard." This clause reflects not only the humanity of physicians, but also the role physician self-care can play in improving patient care.

With regard to professional relationships, previous versions of the Declaration called for students to respect their teachers, but deviated from the Hippocratic Oath, which calls for mutual respect between teachers and students. The workgroup agreed to integrate this idea of reciprocity of respect and to add a reference to respect for colleagues—"I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due"—to replace the line "MY COLLEAGUES will be my sisters and brothers," which has been removed in the current draft because the tone was considered outdated. To complement this principle, the workgroup also added a clause referring more explicitly to the obligation to teach and forward knowledge to the next generation of physicians.

These and other editorial amendments, including the addition of a subtitle identifying the Declaration as a "Physician's Pledge," have enabled this pivotal document to more accurately reflect the challenges and needs of the modern medical profession. It is the hope of the World Medical Association that this thorough revision process and follow-up advocacy efforts will lead to more widespread adoption of the Declaration of Geneva on a global scale.

ARTICLE INFORMATION

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Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and reported nonfinancial support from the World Medical Association.

Additional Contributions: I thank the Declaration of Geneva workgroup members, advisors, and observers for their commitment and valuable contributions throughout the revision process.

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1. World Medical Association Declaration of Geneva. https://www.wma.net/policies-post/wma-declaration-of-geneva/. Published May 2006. Accessed October 5, 2017.

2. World Medical Association. World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. *JAMA*. 2013;310(20):2191-2194.

3. World Medical Association Declaration of Taipei on Ethical Considerations Regarding Health Databases and Biobanks. https://www.wma.net/policies-post/wma-declaration-of-taipei-on-ethical-considerations-regarding-health-databases-and-biobanks/. Published October 2016. Accessed October 2, 2017.

4. World Medical Association Statement on Physician Well-Being. https://www.wma.net/policies-post/wma-statement-on-physicians-well-being/. Published October 2015. Accessed October 5, 2017.

UPSTATE Medical University

Discharge Policy Updates

FAST FACTS

Deadline to be included in Monthly "One Time Required Education" – education content and review process must be complete at least 5 business days prior to education start date. Otherwise, the education will move to the next month.

Plan Submitted by: Diane Nanno CNS, MS, RN

Target Audience: Licensed and Unlicensed staff-Adult and Pediatric Inpatient units, Adult and Peds ED, 5E Pre/Post-op, Procedural areas, Family Birth Center, Administrative Supervisors, Social Work, Case Management, PM&R, Pharmacy. Does not include OR.

Target Date: Education to go on Bb 12/7/17

Method of Education: Blackboard FAST FACTS Course

Time to Complete: 5 min

Reason for education (e.g. policy, corrective action, high risk/low volume):
Policy Change

Does this involve EPIC: Yes

Include Names of Staff who developed/reviewed the education content:

Susan Mulcahey MS, RN, Clinical Educator

Tracker Code: EXPECTDOD

How Will New hires be trained:

1. New hires will receive this education via unit orientation
2. This change in practice will be communicated via management forum, inpatient leadership, CMO newsletter, nursing newsletter, and added to the admission packet.

Fast Facts

There will be a change in practice related to Expected Date of Discharge (EDD):

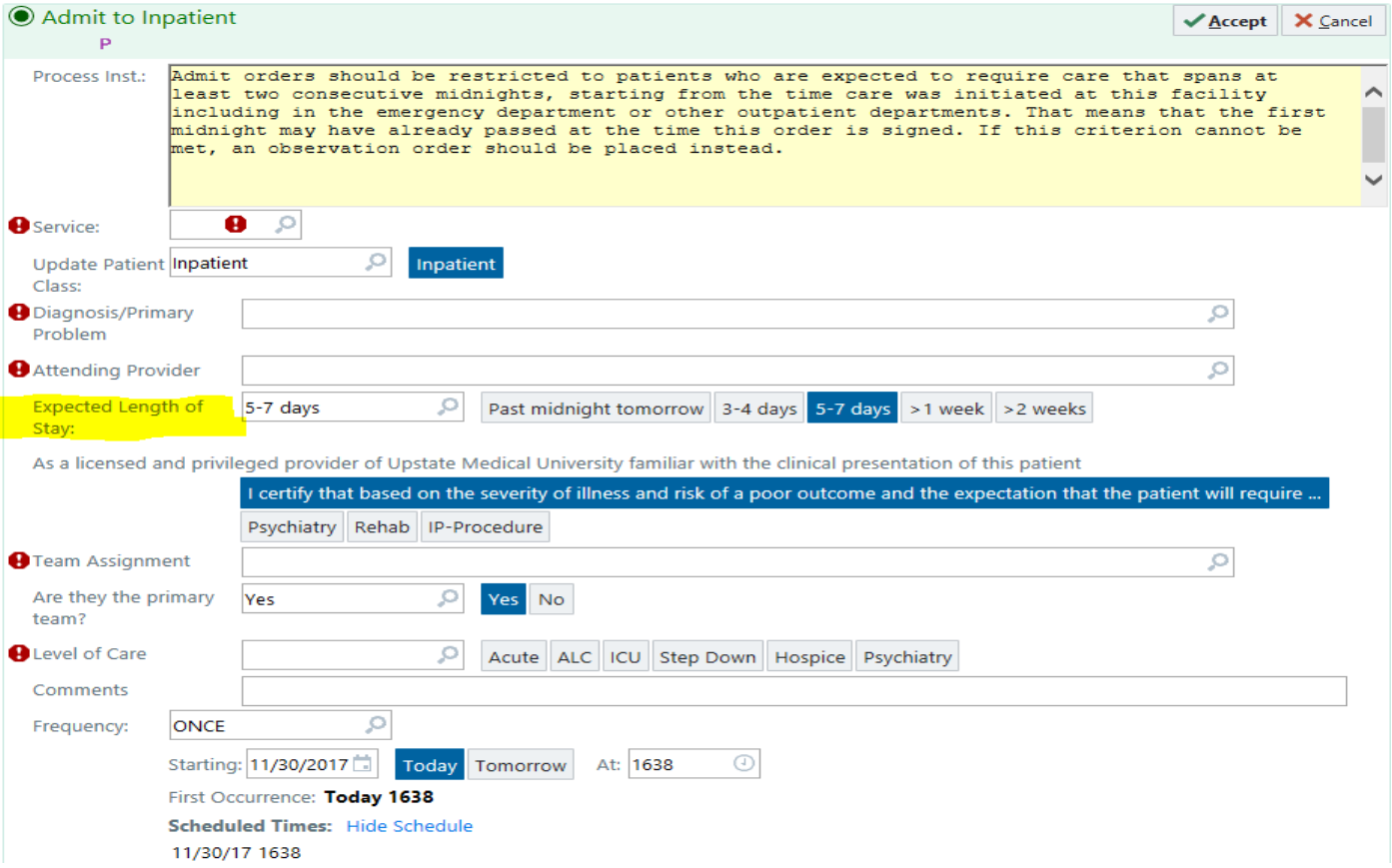
1. The medical provider will include the expected date of discharge range in the epic electronic medical record in the provider admission assessment. The provider, based on the admitting diagnosis, will select the expected date range for discharge.

2. The Case Manager will use the low range of the identified dates to plan discharge.

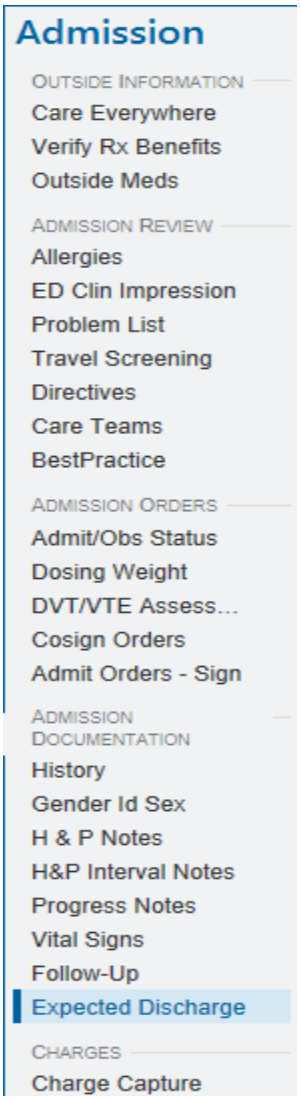
3. The Case Manager will add the expected date of discharge to the whiteboards in the inpatient areas (excluding Psychiatric and ICU areas) and in the Expected Discharge Date field which will be visible to all disciplines.

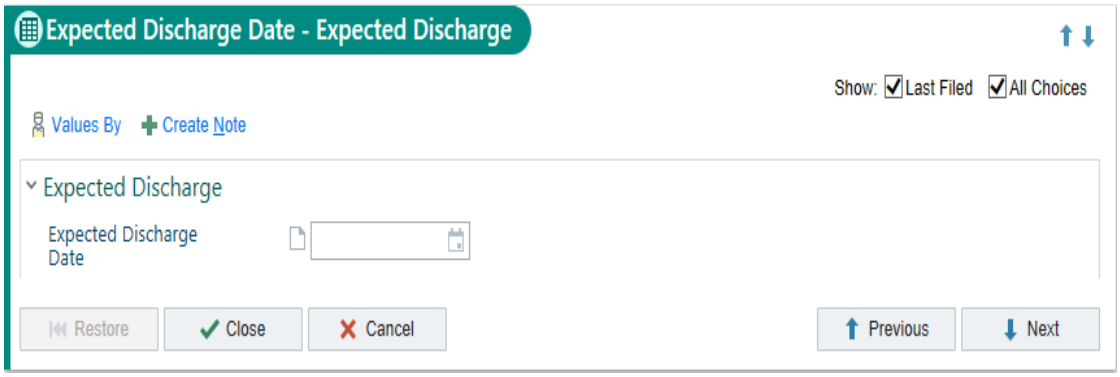
4. Discharge date will be re-evaluated daily at multidisciplinary rounds and may be adjusted based on clinical findings and or contributing factors. Any member of the team may adjust the discharge date in the Epic electronic medical record

Physician-Initial Expected Date of Discharge will be driven by the Length of Stay question on the "Admit to Inpatient" order. For observation, a value of 2 days will be assigned.

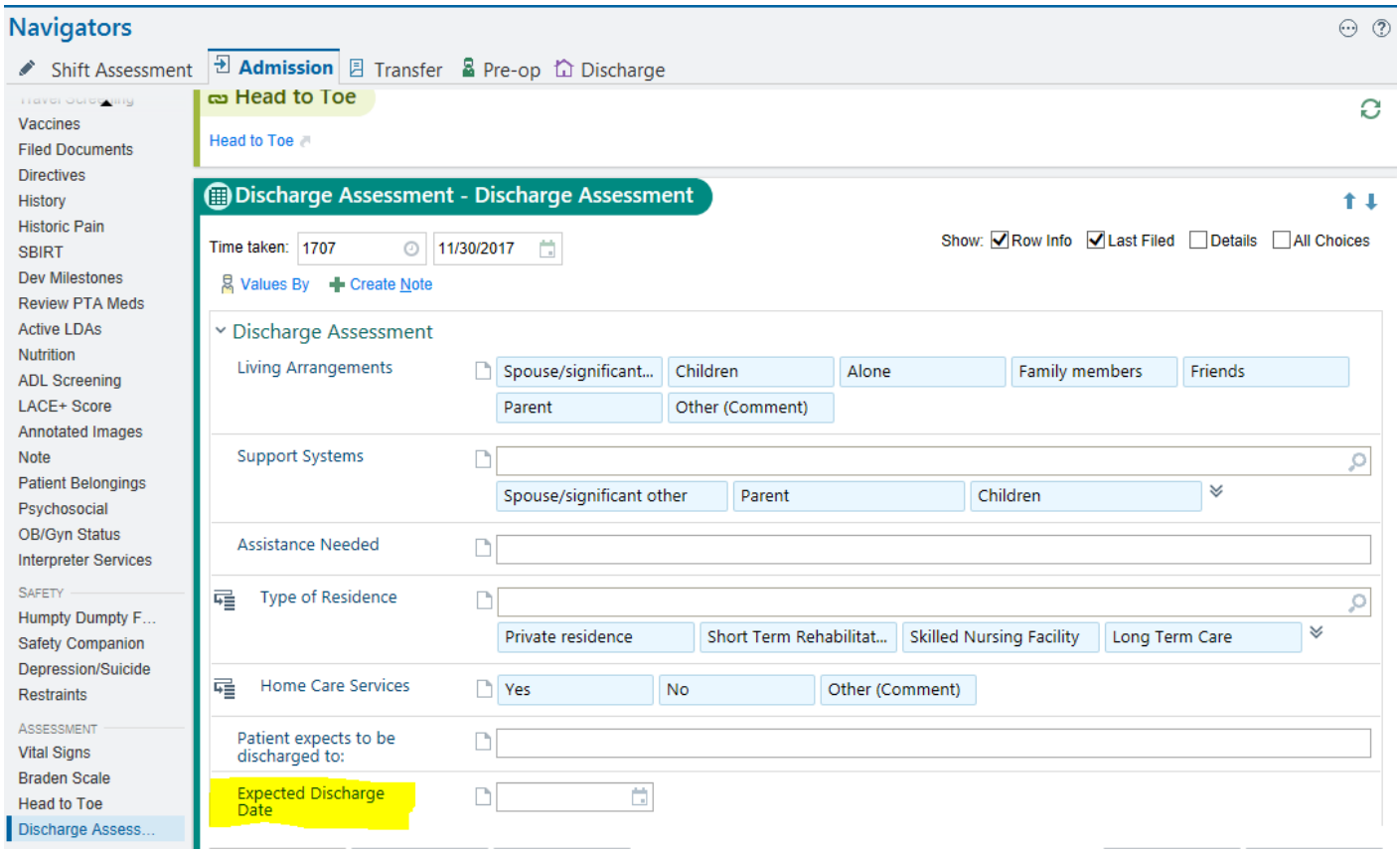


Providers have access to document and update the EDD in their Admission navigator, in the "Expected Discharge Date" section:

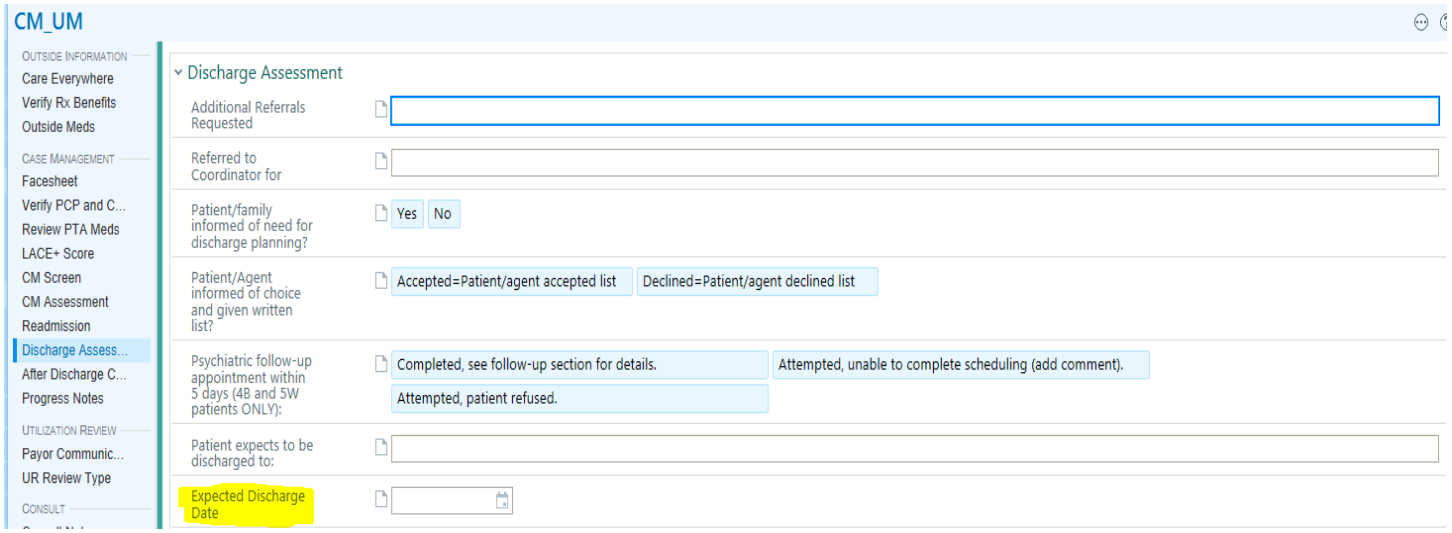




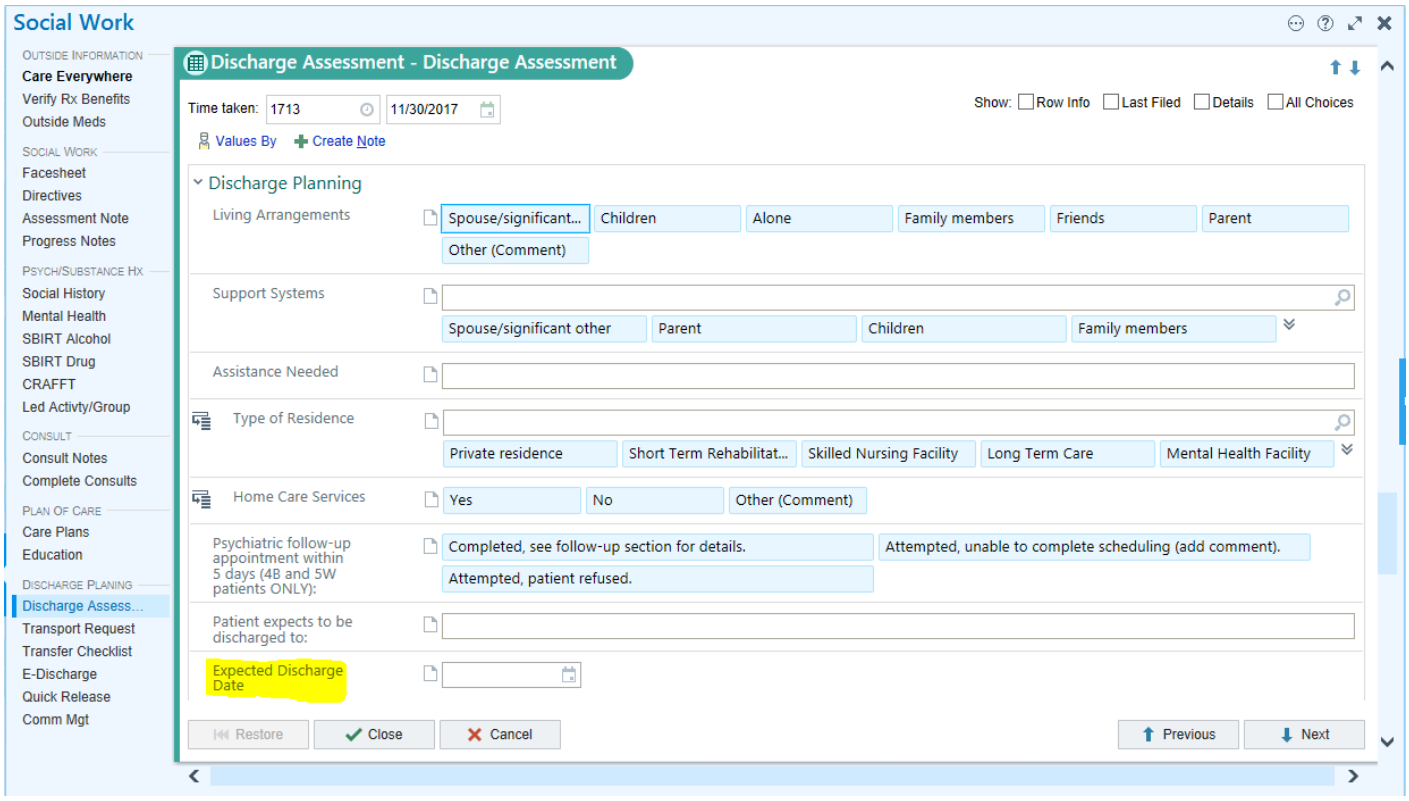
Nursing Staff have access to document and update the EDD in their Admission navigator, as well as in the Screenings flowsheet.



Case Managers and Utilization Management have access to document and update the EDD in their CM_UM navigator.



Social Workers have access to document and update the EDD in their CM_UM navigator.



Test Questions:

1. Where will the patient's expected date of discharge be documented?

   A. Electronic Medical Record
   B. Inpatient whiteboards (excluding Psychiatric and ICU areas)
   C. On the patient's ID band
   D. Only A and B above (correct answer)
   E. All of the above

True/False

2. Only the provider can change the expected date of discharge in the EPIC electronic medical record

   Answer: False

The Schwartz Center Rounds®

A multidisciplinary forum where caregivers discuss social and emotional issues that arise in caring for patients

More than 13 Reasons:

the impact of teen and young adult suicide on the healthcare team

Tuesday, December 12, 3:45 p.m.
East Tower 11405 A & B

Jay Brenner, MD
Sue Karl, CCLS
Angela Pugliese, RN
Jennifer Zucarro, MD

Continuing Medical Education (CME) Credits available

For more information:
Rev. Bill Reynolds, Department of Spiritual Care
reynoldw@upstate.edu

The Schwartz Center Rounds program was initiated by the Dr. Daniel Burdick Compassionate Care Fund, established in 2013 by a generous founding gift from the children of Daniel and Billie Burdick. The gift honors Dr. Burdick's compassion for both patients and caregivers throughout his medical career as a surgical oncologist and general surgeon, and his foresight in recognizing the emotional toll of serious illness on care providers.

UPSTATE
UNIVERSITY HOSPITAL

The Schwartz Center Rounds®

A multidisciplinary forum where caregivers discuss social and emotional issues that arise in caring for patients

The Schwartz Rounds 3:45 PM – 4:45 December 12, 2017 East Tower 11405 A & B

Q. What are The Schwartz Rounds?
A. The Schwartz Rounds are multi-disciplinary case presentations and discussions that involve difficult ethical or emotional situations encountered with patients and families. The Schwartz Rounds are presented as opportunities for the staff of University Hospital to share emotions and feelings and to learn from their experiences.

Q. How are The Schwartz Rounds different from clinical case presentations?
A. The Schwartz Rounds are not 'root cause' rounds. Rather, they are multidiscipline and hospital-wide forums where clinical care givers can share their experiences, thoughts and feelings around specific health care topics. The purpose of the Rounds is to support caregivers and focus on their relationships with patients. This is done by looking at the case from a social and emotional perspective

The result (substantiated by independent research) is that caregivers will be better equipped to provide compassionate care for patients and better able to maintain their own sense of well-being by gaining insight into themselves, co-workers and difficult situations. Rounds lessen the stress by lessening the sense of isolation among staff members.

Q. Who should attend The Schwartz Rounds?
A. Any caregiver or member of the support team who is concerned about giving the best care and support in cases that are complex, confusing or ethically problematic; has been troubled by a difficult case that engaged your emotions or challenged your composure; has seen fellow caregivers wrestle with the personal impact of problem cases and situations.

Q. What do The Rounds entail?
A. Each Rounds involves a brief (3 to 5 min) presentation by those involved in a patient's care, followed by an open discussion that welcomes personal observations, shared experiences, and strategies for understanding and managing difficult situations or cases.

The Schwartz Rounds are a one-hour, safe place "to talk about it."

Q. Are CME credits offered?
A. Yes, Continuing Medical Education (CME) credits are available.

Q. What is the Dr. Daniel Burdick Compassionate Care Fund?
The Schwartz Center Rounds program is supported by the ***Dr. Daniel Burdick Compassionate Care Fund,*** which honors the compassion of Dr. Burdick for both patients and caregivers. It recognizes Dr. Burdick's foresight in recognizing the emotional toll of serious illness on care providers.

In a 1987 manuscript, Caring for the Cancer Patient, Dr. Burdick counseled his colleagues to "share experiences. It is often helpful to share personal feelings and experiences with other professionals. This will enable the physician to understand that other physicians are facing the same daily struggles. In addition, it is usually helpful for all professionals (physicians, nurses, social workers and others) to share feelings and emotional problems experienced in caring for cancer patients. To provide support in these areas, some hospitals have developed informal discussion groups."

Dr. Burdick joined the faculty of the Health Science Center as a clinical instructor of surgery in 1948. In 1969 he was named a clinical professor of surgery, and he served as director of University Hospital's Tumor Clinic. He served as the director of the Central New York Cancer Registry for 20 years, and he was a member of the medical staffs of other Syracuse hospitals. A role model for colleagues and students, Dr. Burdick died in 2012 at the age of 96. The ***Dr. Daniel Burdick Compassionate Care Fund*** was established in 2013 by a generous founding gift from the children of Daniel and Billie Burdick.

For additional information about Schwartz Compassionate Care and short videos: go to web page www.theschwartzcenter.org. To view the 8 minute video of a Schwartz Rounds experience: 1. Click on link 'Schwartz Center Rounds' 2. Click on the link 'The Schwartz Center Rounds: *Voices of Caregivers*

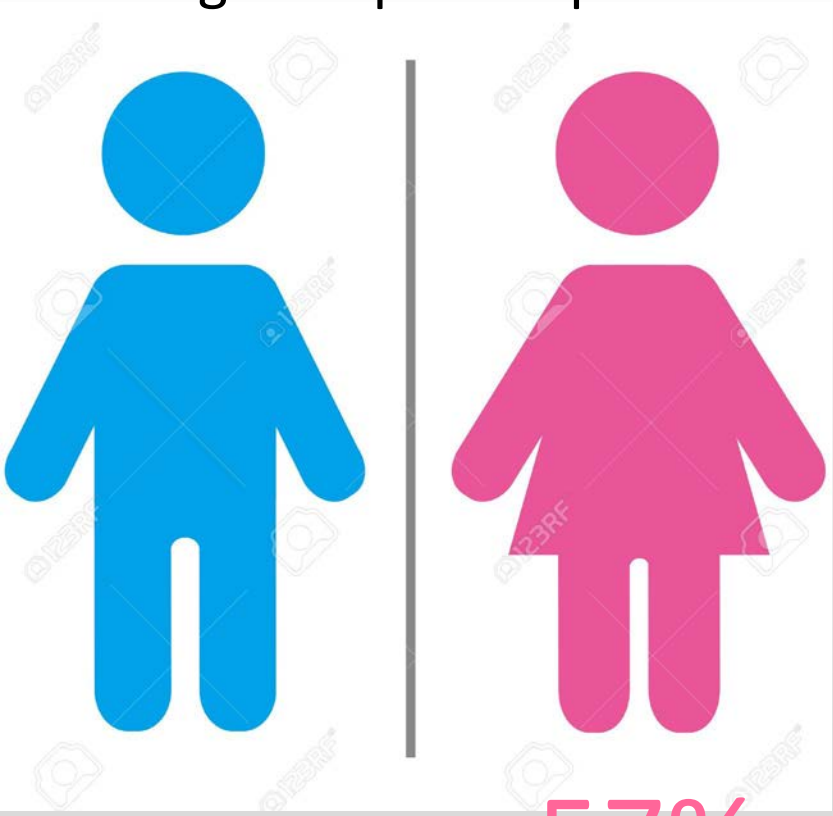
PUREWICK Female External Catheter

BB Fast Facts 12/1/2017

TRACKER CODE: PUREWICK

#2 Risk Factor = FEMALE GENDER

Average Hospital in-patients



57%

3X
higher
CAUTI Risk

61%
More likely
to be
catheterized

PUREWICK® Female External Catheter

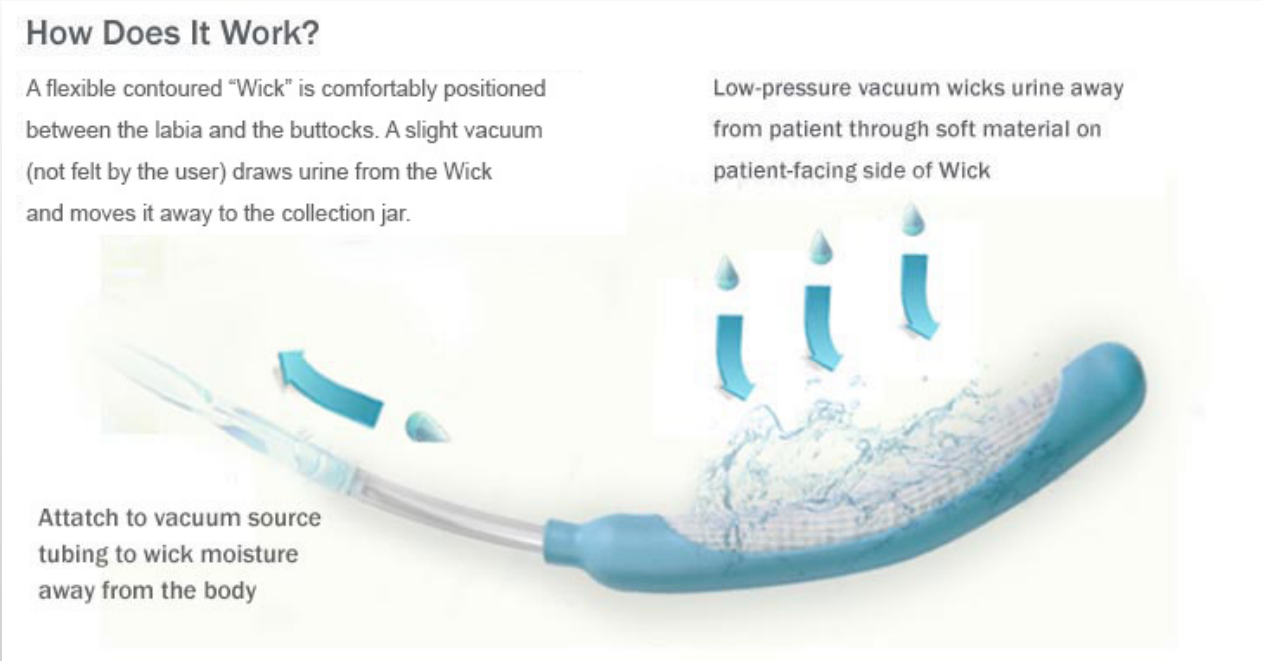
Helps reduce urinary catheter days, lowering CAUTI risk

Non-invasive urine output measurement

Protects skin by wicking away urine

Procedural Set Up

- Prior to starting the procedure, obtain all of your necessary supplies:
  - Clean Gloves – clean technique
  - Peri-care supplies
  - Suction canister and standard suction tubing
  - PUREWICK Female External Catheter
- Explain procedure to patient
- Wash hands and don clean gloves

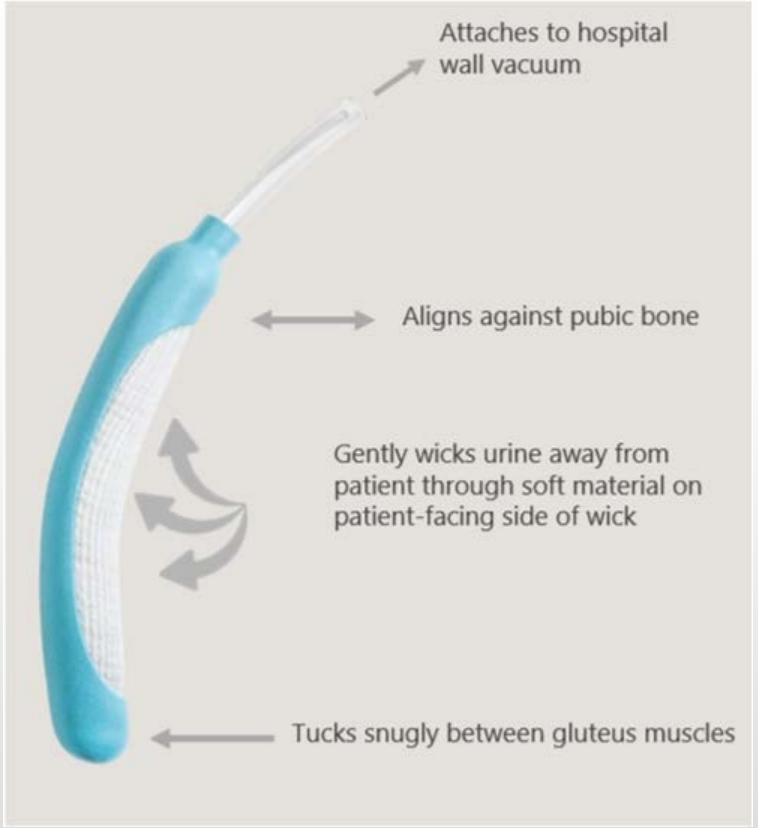


Procedural Set Up

- Connect canister to wall suction and set to a minimum of 40mmHg continuous suction. Always use the minimum amount of suction necessary.
- Using standard suctioning tubing, connect the PUREWICK Female External Catheter to the collection canister.
- Change suction tubing per hospital protocol.

Peri-Care and Placement

- Perform perineal care and assess skin integrity. Separate legs, gluteus muscles and labia. Palpate pubic bone as anatomical marker.
- With soft gauze side facing patient, align distal end of the PUREWICK female catheter at gluteal cleft. Gently tuck soft gauze side between separated gluteus and labia. Ensure that the top of the gauze is aligned with the pubic bone. Slowly place legs back together once the PUREWICK female catheter is positioned.
- Assess patient's skin at least every 2 hours



Repositioning & Ambulation

- Ensure that the PUREWICK catheter remains in correct alignment after turning the patient
- Remove PUREWICK catheter prior to ambulation
- Properly placing the catheter snugly between the labia and gluteus holds the PUREWICK catheter in place for MOST patients. Mesh underwear may be useful for securing for some patients

Removal

- To remove the PUREWICK female catheter, fully separate the legs, gluteus and labia. To avoid potential skin injury upon removal, gently pull the PUREWICK female catheter directly OUTWARD.
- Ensure suction is maintained while removing the PUREWICK female catheter.
- After use, this product may be biohazard. Dispose in accordance to Upstate policy.

Maintenance

- Replace the PUREWICK female catheter at least every 8 to 12 hours or if soiled with feces or blood
- Always assess skin for compromise and perform perineal care prior to placement of a new PUREWICK female catheter

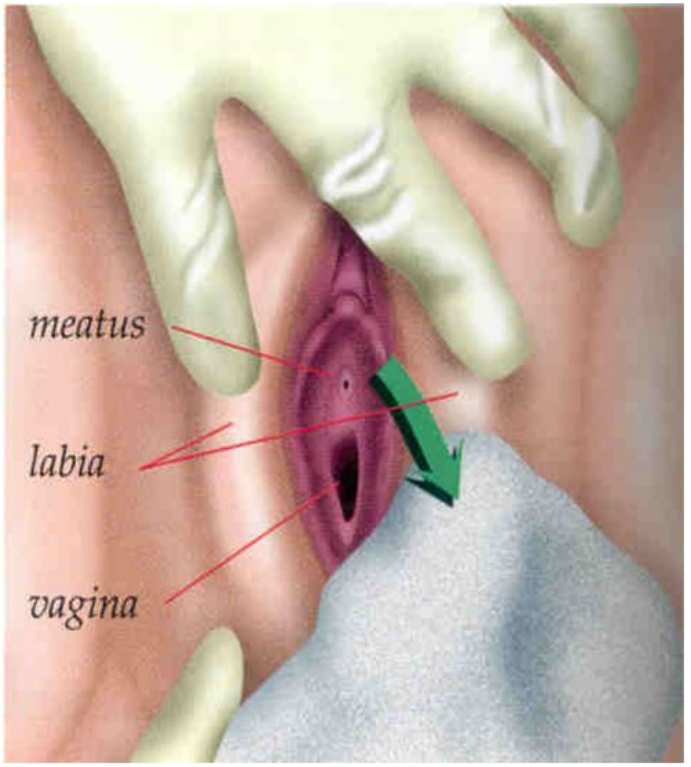
FEMALE PERI-CARE

✓ALWAYS CLEANSE FROM THE URINARY MEATUS TOWARD THE ANUS. (CLEAN TO DIRTY)

✓MAY HAVE A PREPACKAGED KIT OR USE WET WASHCLOTHS.

✓USE A DIFFERENT PART OF THE WASHCLOTH FOR EACH STROKE

✓TO CLEAN THE ANAL AREA , CLEANSE FROM THE VAGINA TOWARD THE ANUS (CLEAN TO DIRTY)



Precautions

- Not recommended for patients who are:
  - Agitated, combative or un-cooperative and might remove PUREWICK catheter
  - Having frequent bowel incontinence
  - Experiencing skin irritation or breakdown at the site
  - Experiencing heavy menstruation and cannot use tampon
- Not recommended for patients with a known latex allergy
- Do NOT use barrier cream on perineum when using PUREWICK, could impede suction.
- Proceed with caution in patients who have undergone recent surgery of the external urogenital tract.