

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

February 15, 2021

COVID Update

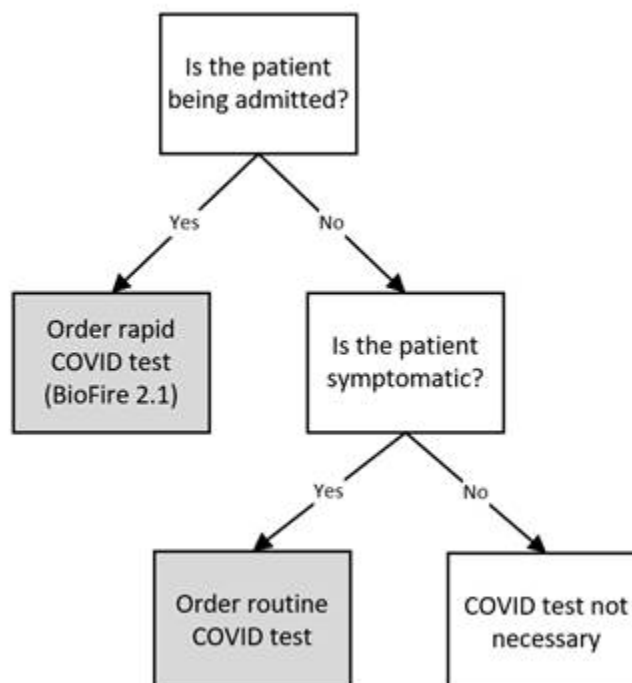
# COVID Inpatients	# ICU
58	18

Rapid Tests in ER by Dr. Jeremy Joslin

Currently, Upstate's supply of rapid COVID tests can accommodate use in the EDs for patients being admitted. If supply changes, we will modify use of rapid testing accordingly.

Use of rapid COVID tests in the EDs should follow the process/algorithm below:

- All patients being admitted (including psych), regardless of symptoms, will receive a RAPID COVID test
- Patients who are not being admitted, and are symptomatic, will receive a routine COVID PCR test.



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CDC Vaccine Guidance

A CDC update on interim clinical considerations for the use of mRNA COVID-19 vaccines currently authorized in the United States can be found at the following link: <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>

Badge In / Badge Out by Mark Zeman

For those workstations that use Imprivata for authentication, once logged into the workstation via a badge swipe, any application that is single sign-in enabled like Epic and Outlook will be accessible without additional authentication. This means that when these applications are launched, the user enters the app without re-authenticating. It also means that if a user logs off the app and not the workstation, the app essentially remains “open” – if relaunched, any user will be allowed into the app without challenge (authentication request). Therefore, it is essential that when you are done with the workstation you badge out.

Note Auto Release to MyChart – Go Live March 1, 2021

WHO is impacted?

- All providers including Physicians, Advanced Practice Providers, Residents and Medical Students

WHAT will be released to MyChart?

- Progress Notes
- H&Ps
- Discharge Summaries
- Consult Notes
- Procedure Notes

WHEN is go-live?

- Monday, March 1, 2021

WHERE will this occur?

- All Upstate locations that utilize EPIC for documentation. This includes:
 - Inpatient Units
 - The Emergency Departments
 - Hospital-Based Outpatient Clinics
 - All Ambulatory sites including Hospital, Provider-Based and Private

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WHY are we doing this?

- The 21st Century Cures Act legislation finalized in March 2020 requires that institutions and providers who offer patients a portal to access their health information, must also provide access to a subset of the electronic medical record which includes the above listed not types, along with other information. Failure to comply by April 2021 can result in significant fines / penalties for both the institution and individual provider.

HOW can you prepare and learn more?

- Watch your email for:
 - Updates via the CMO Blast
 - Dates / times for live Q&A sessions
 - Links to a recording from the live Q&A sessions
 - A Tips and Tricks sheet from IMT on how you can prevent a patient note from going to MyChart in the event there is a legal reason for not releasing the note.

New Guidelines about Timing of Mammograms and COVID-19 Vaccine

by Dr. Dinesh John and Dr. Leslie Kohman

New mammography guidelines from the Society of Breast Imaging and adopted by Intermountain Health and other hospitals nationwide recommend that women over the age of 40 get their annual mammogram prior to COVID-19 vaccination, or delay the imaging study by six weeks after their second dose.

Ipsilateral axillary lymphadenopathy can occur in up to 11% of vaccine recipients after the first dose and 16% after the second dose of COVID-19 vaccine. Considering that axillary adenopathy in women with an otherwise normal screening mammogram is a rare occurrence (reported in 0.02%-0.04% of screening mammograms), having this done soon after vaccination may confound the accurate reading of the mammogram and lead to extra imaging (radiation, cost, inconvenience and effort by both woman and practitioners).

Bottom Line: please counsel your patients about the appropriateness of mammography screening in the setting of COVID-19 vaccination. You may consider getting them scheduled for their mammogram prior to COVID-19 vaccination, or six to eight weeks after their second dose.

Please refer to the attached flyer for more information.

Utilization Management: Optimizing IR Procedure Requests by Dr. Housam Hegazy

It has come to our attention that a number of IR procedures considered to be elective are being ordered on an urgent or emergent basis in the inpatient setting.

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Some of the untoward consequences of doing so are as follows:

- Changing the nature of a procedure from elective to urgent/emergent may negatively affect the quality of the procedure
- Increasing the workload on the inpatient IR physicians, causing delays in the performance of other urgent/emergent procedures
- Delaying the patient's discharge and negatively affecting the throughput/hospital operation

The current process is as follows:

1. If the IR provider believes that an outpatient procedure is ordered as inpatient, they would request UM approval for such procedure.
2. The ordering physician would contact the UM provider on-call (listed on AMION) to discuss the case.
3. The decision is then made based on the discussion between the ordering physician and UM provider on-call. The IR provider will then be contacted by the UM provider for final approval.

Protecting the Supply Chain by Stephanie Shattuck

Recent removal of 3M N95 masks from distribution and media reports of counterfeit product have raised questions regarding the integrity of Upstate's supply chain. This communication is to clarify and assure staff the supply chain is sound and at no time was staff safety compromised. Upstate has seen no increase in any hospital acquired COVID infections of staff on either COVID or non-COVID units; this data is continuously tracked.

Upstate has many tools at its disposal to protect the supply chain and follows the 4 P's of best practices: Place, Price, Product, and Packaging.

PLACE: We buy from trusted sources. All vendors are registered with the New York State Financial System (SFS) and go through a thorough vetting process. In addition, each vendor is checked to insure it has a valid Federal Tax ID called an EIN. And lastly, Upstate has very long and well-established business relationships with our vendors – these companies have been in business for years and are not “pop-up” companies who suddenly decided to sell PPE.

PRICE: We follow the axiom “If the price sounds too good to be true, it probably is.” Our Purchasing Department is attuned to market pricing and steers away from suppliers who offer extremely low pricing. Furthermore, the majority of our vendors have pre-established contract pricing agreements with NY State. As an added measure, Hospital Purchasing will no longer make PPE purchases with a VISA card unless the vendor is a NY State Contract Vendor.

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PRODUCT: Before making purchases of new product, Hospital Purchasing requests a sample, which undergoes a quality review by many to include Infection Prevention (IP), Environmental Health and Safety (EHS), and Clinicians.

We monitor and respond to product recall alerts via ECRI, an independent, non-profit organization dedicated to improving the safety and quality of care across the healthcare setting. However, not all counterfeit product is reported through ECRI channels. To address this, Materials Management is implementing a new process whereby we will actively view Government websites dedicated to reporting on counterfeit PPE such as Centers for Disease Control (CDC), Customs Border Protection (CBP) and US Patent and Trademark Office (USPTO).

PACKAGING: As an additional measure to protect the supply chain, Materials Management will “flag” incoming deliveries of product determined to be high-risk for possible counterfeit. As product arrives at the warehouse, it will be subjected to a visual inspection. We will review product packaging for misspellings and blurred printing and graphics. We will also compare it against known, valid product we have on hand for possible discrepancies.

These practices are designed to continue to keep Upstate’s supply chain safe. With this proactive step, Upstate continues to look for known counterfeit product and take steps to keep staff safe.

If you have additional questions, please contact AskTeamIC@Upstate.edu.

Resuscitation EPPE

In an effort to align with current AGP policy, staff involved in **ALL** cardiac arrests/intubations, regardless of patient **COVID** status must wear EPPE.

What Does this Mean for You?



- Units will provide:
- Gowns
 - Gloves



- You will provide:
- N95/Eyewear
 - **ALL** Providers from **ALL** services should carry N95/eyewear with them at **ALL** times



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

New / revised / deleted policies of special interest for clinicians include:

Revised Policies

- [Infection Control for Aerosol Generating Procedures During COVID-19 \(COV A-02\)](#): added private room for all patients requiring CPAP/BiPAP unless for OSA, added that CPAP/BiPAP patients are not able to be transported.
- [Adult Patients Admitted to Upstate Golisano Children's Hospital During COVID-19 \(COV A-08\)](#): adult patients to be admitted under Adult Medicine services.
- [COVID-19: Bed Management and Throughput \(COV B-03\)](#): updated the use of rapid COVID tests for patients being admitted from EDs, added ED COVID test algorithm.
- [Pediatric Resuscitation \(Code White\) Guidelines \(Excludes ED\) During COVID-19 \(COV R-03\)](#): updated to align with COV A-02 and COV R-02
- [Personal Protection Equipment \(PPE\) Table for COVID-19 Exposure Scenario \(COV P-01\)](#): clarification for eye protection for COVID positive patient.
- [COVID-19 Testing at Upstate University Hospital Locations \(COV T-08\)](#): updated the use of rapid COVID tests for patients being admitted from EDs, added ED COVID test algorithm, added saliva COVID test ordering for inpatients, updated COVID testing for PMR in section F.

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

COVID-19 associated conditions are represented by a number of new ICD-10 codes. The accurate assignment of these codes depends on clear documentation of the underlying cause and associated treatments. For the most accurate representation of your patient's condition, and their response to treatment, please always document when something is due to COVID-19.

Outstanding Physician Comments

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

Adult Hematology Oncology: Dr. Alina Basnet - honest and straight forward. Dr. Sam Benjamin – goes beyond duties to be there for me. Dr. Teresa Gentile and Dr. Diana Gilligan – good! Dr. Stephen Graziano



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— exceptional! **Dr. Michael Mix** — helpful and considerate. **Dr. Rahul Seth** — excellent!

Boards: **Dr. Brian Kistler** and **Dr. Eric Keenly** — allayed my fears and took such great care of me!

Radiation Oncology: **Dr. Rahul Seth** — compassionate and thorough.

Radiology: **Dr. Katherine Willer** — wonderful, kind and made procedure easier. **Dr. Katherine Willer** — exceptional skill and expertise, grateful! **Dr. Katherine Willer** went out of way to put me at ease, answer my questions and keep me informed every step of the procedure. **Dr. Katherine Willer** comforted me from the beginning to the end and explained everything each step of the way. **Dr. Katherine Willer** — nice, informative and professional. **Dr. Katherine Willer** did a wonderful job explaining what was going to happen. **Dr. Katherine Willer** — excellent!

3 West at Community Hospital: **Dr. Hammad Rahman** was knowledgeable, skilled and positive. He inspired confidence and I believe I responded to his vitality.

6th Floor at Community Hospital: **Dr. Aart Geurtsen** was friendly, helpful, and knowledgeable.

08G: **Dr. Gennady Bratslavsky** was wonderful, caring, outstanding, the best doctor ever! He's a keeper!

10E: **Dr. Alina Basnet** put me at ease, spoke clearly, and helped me understand what happened to me. **Dr. Alina Basnet** — amazing! **Dr. Adaora Udekwu** — caring attitude and concern for my personal care.

10H: **Dr. Andreea Nitu-Marquise** visited almost every day and answered my questions regarding medications, diagnosis, and health issues.

11E: **Dr. Christopher Lucas** was very informative with our daughter's condition and highly concerned about her. **Dr. Eric MacMaster** spoke at a level respectable for age and took plenty of time to listen to multiple sides of the story.

12E: **Dr. Samantha Jones** — informative and confident.

12F: **Dr. Anthony Mortelliti** — wonderful and amazing!

Thank you for all you do! Please stay safe *in here* and *out there*, and do what you can to help protect those around you.

Amy

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SBI Recommendations for the Management of Axillary Adenopathy in Patients with Recent COVID-19 Vaccination

Society of Breast Imaging Patient Care and Delivery Committee

Lars Grimm, Stamatia Destounis, Basak Dogan, Brandi Nicholson, Brian Dontchos, Emily Sonnenblick, Hannah Milch, JoAnn Pushkin, John Benson, Katia Dodelzon, Neha Modi, Roger Yang, Vandana Dialani, Vidushani Perera

Axillary adenopathy in women with an otherwise normal screening mammogram is a rare occurrence, reported in 0.02%-0.04% of screening mammograms.(1-4) Reported malignancy rates are highly variable (20%-56%) and the few published studies include women with unilateral and/or bilateral adenopathy and malignancy was often due to a non-breast primary (i.e., lymphoma).(1-5) Axillary adenopathy has been rarely reported following the administration of BCG, influenza, and human papilloma vaccinations.(6-8) However, higher rates of axillary adenopathy have been reported with administration of both COVID-19 vaccines currently authorized for emergency use by the US Food and Drug Administration: Moderna and Pfizer-BioNTech. As national vaccination efforts are underway, women with a recent COVID-19 vaccine may present for diagnostic workup for newly palpable axillary adenopathy or have new axillary adenopathy identified on routine screening mammography or ultrasound.

For patients receiving the Moderna COVID-19 vaccine, axillary swelling or tenderness (i.e., lymphadenopathy) was a solicited adverse event reported in 11.6% of patients (vs 5.0% for placebo) following dose 1 and 16.0% of patients (vs 4.3% for placebo) following dose 2.(9) Furthermore, lymphadenopathy was also reported as an unsolicited adverse event in 1.1% of persons in the vaccine group (vs 0.6% in the placebo group). Lymphadenopathy occurred in the arm and neck 2-4 days following vaccination with a median duration of 1-2 days.

For patients receiving the Pfizer-BioNTech COVID-19 vaccine, lymphadenopathy was only reported as an unsolicited adverse event with 58 more cases in the vaccine group than the placebo group (64 vs 6 respectively).(10) Lymphadenopathy occurred in the arm and neck within 2-4 days of vaccination and lasted for a mean of 10 days. As lymphadenopathy was only reported as an unsolicited adverse event, the true incidence rate is likely higher. Reported rates and duration of adenopathy in both trials were based on clinical assessment (i.e., physical examination), and therefore rates and duration of subclinical adenopathy appreciable on mammography are likely greater. Anecdotally, mammographically detectable axillary adenopathy following COVID-19 vaccinations has been unilateral.

Current recommendations from the 5th Edition of the BI-RADS Atlas state that, “In the absence of a known infectious or inflammatory cause, isolated unilateral axillary adenopathy [on screening mammography] should receive a category 0.”(11) Subsequently, “If a benign cause is elucidated, a benign (BI-RADS category 2) assessment would be appropriate. In the absence of a known infectious or inflammatory source, a suspicious (BI-RADS category 4) assessment would be appropriate.” Breast radiologists will increasingly encounter axillary adenopathy as more patients become vaccinated, but the near to long term appearance of mammographic adenopathy following vaccination is currently unknown.

SBI considerations for the management of axillary adenopathy in patients with recent COVID-19 vaccination:

- Consider obtaining the following information on patient intake forms: COVID-19 vaccination status, timing and side (left vs. right arm) of vaccination. To minimize patient anxiety, consider including this introductory statement: Vaccines of all types can result in temporary swelling of the lymph nodes, which may be a sign that the body is making antibodies in response as intended.
- Unilateral axillary adenopathy on screening exams warrants a BI-RADS category 0 assessment to allow for further assessment of the ipsilateral breast and documentation of medical history, including COVID-19 vaccination.
- Following appropriate diagnostic work up for unilateral axillary adenopathy in women who received a COVID-19 vaccination in the ipsilateral upper extremity within the preceding 4 weeks, consider a short term follow up exam in 4-12 weeks (BI-RADS category 3) following the second vaccine dose.
- If axillary adenopathy persists after short term follow up, then consider lymph node sampling to exclude breast and non-breast malignancy.

SBI considerations for patients and providers scheduling screening exams:

- If possible, and when it does not unduly delay care, consider scheduling screening exams prior to the first dose of a COVID-19 vaccination or 4-6 weeks following the second dose of a COVID-19 vaccination.

As more information about the incidence and appearance of axillary lymphadenopathy following COVID-19 vaccination becomes available, it may be appropriate to change the duration of follow up or final assessment recommendations. Furthermore, recommendations for additional COVID-19 vaccinations will be incorporated when they are approved for distribution.

1. Murray ME, Given-Wilson RM. The clinical importance of axillary lymphadenopathy detected on screening mammography. Clin Radiol. 1997;52(6):458-61.

2. Patel T, Given-Wilson RM, Thomas V. The clinical importance of axillary lymphadenopathy detected on screening mammography: revisited. *Clin Radiol*. 2005;60(1):64-71.
3. Lim ET, O'Doherty A, Hill AD, Quinn CM. Pathological axillary lymph nodes detected at mammographic screening. *Clin Radiol*. 2004;59(1):86-91.
4. Chetlen A, Nicholson B, Patrie JT, Harvey JA. Is screening detected bilateral axillary adenopathy on mammography clinically significant? *Breast J*. 2012;18(6):582-7.
5. Bergkvist L, Frodis E, Hedborg-Mellander C, Hansen J. Management of accidentally found pathological lymph nodes on routine screening mammography. *Eur J Surg Oncol*. 1996;22(3):250-3.
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7. Studdiford J, Lamb K, Horvath K, Altshuler M, Stonehouse A. Development of unilateral cervical and supraclavicular lymphadenopathy after human papilloma virus vaccination. *Pharmacotherapy*. 2008;28(9):1194-7.
8. Shirone N, Shinkai T, Yamane T, et al. Axillary lymph node accumulation on FDG-PET/CT after influenza vaccination. *Ann Nucl Med*. 2012;26(3):248-52.
9. Local Reactions, Systemic Reactions, Adverse Events, and Serious Adverse Events: Moderna COVID-19 Vaccine. Centers for Disease Control and Prevention; [January 16, 2021]; Available from: <https://www.cdc.gov/vaccines/covid-19/info-by-product/moderna/reactogenicity.html>.
10. Local Reactions, Systemic Reactions, Adverse Events, and Serious Adverse Events: Pfizer-BioNTech COVID-19 Vaccine. Centers for Disease Control and Prevention; [January 16, 2021]; Available from: <https://www.cdc.gov/vaccines/covid-19/info-by-product/pfizer/reactogenicity.html>.
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