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 11, 2021

Announcement: TeleTracking Project

by Dr. Robert Corona, Dr. Amy Tucker, and Nancy Page, MSN, RN, NEA-BC

We are pleased to announce that Upstate University Hospital will be implementing the patient flow and bed placement technology application known as TeleTracking. In order for this implementation to be successful and for our mutual goals to improve patient care to be achieved, everyone in our organization regardless of role, title or department will need to learn this technology, understand the proven strategies, and utilize our designed standard work processes.

TeleTracking software and process improvement is designed to improve hospital patient flow door to door through the use of organization-wide processes, use of proven technology and access to data for continued improvement of flow and capacity. We will improve our hospital's patient throughput by removing patient flow bottlenecks and reducing delays and hold times in patient intake areas such as the Emergency Department (ED) and Post-Anesthesia Care Unit (PACU). This process will be managed through the health system's center for patient flow management the Throughput Operations Center, who will have visibility to all beds throughout the health system in order to directly place patients to the appropriate facility and level of care. Bottom line, the efforts we are embarking upon to improve flow and capacity will improve patient care, our efficiency and effectiveness and ultimately the communities we serve.

Within the health system, TeleTracking technology coordinates all activities which impact patient flow by:

- Developing processes and technology to support effective discharge and access processes to improve patient flow that results in open beds for incoming patients when needed
- Streamlining patient flow throughout the duration of care and reducing the number of phone calls required to place a patient
- Focusing everyone in the organization on patient flow using visual management through desktop applications and large monitors that show real-time patient and bed status
- Enabling patient care units to indicate bed assignment preferences

However, technology alone will not improve patient flow and capacity in our organization. The combination of process improvement and technology will. Many of you will be asked to assist in patient flow process improvement efforts that will result in the use of standard work to improve and sustain improvement of patient flow and throughput in all areas of our hospital. These efforts are equally important to our success.

Sessions will be held to design and build our technology, learn, and incorporate TeleTracking's proven strategies into our organization, train those directly involved in using the technology and redesigned processes and review our progress to date. You will likely see TeleTracking team members in the future rounding throughout the hospital and in working sessions and meetings. We have also stood up a Patient Flow Governance Council to review patient flow opportunities and help us sustain our improvement in patient flow and capacity.

Thank you in advance for your help in improving patient access and patient care by improving our patient flow and capacity through the use of TeleTracking technology and best practices.

Please reach out to Kyle Choquette (choquetk@upstate.edu) with any questions.

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

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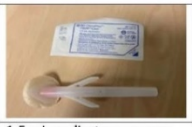
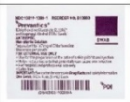
New York State Department of Health (NYS DOH) Advisory - Recommendations to Resume Use of the Janssen/Johnson & Johnson COVID-19 Vaccine

Please see attached guidance from the NYS DOH with regards to understanding the risks and recommendations for resuming use of the Johnson & Johnson COVID-19 Vaccine.

Chloraprep and Duraprep Supply Shortages **by Paul Suits**

Chloraprep and Duraprep are extremely limited in supply due to backorders and recalls.

Please see guidance below on product usage.

Procedure	Product option 1	Product option 2	Product option 3	Product option 4
Peripheral IV Insertion	Alcohol Pad			
Venipuncture (not Blood Culture)	Alcohol Pad			
Arterial Puncture	Chloraprep	Chloraprep Swab	PDI CHG Wipe	Betadine Swab Stick
Arterial Line Insertion	Chloraprep	Chloraprep Swab	PDI CHG Wipe	Betadine Swab Stick
Blood Cultures	Chloraprep	Chloraprep Swab	PDI CHG Wipe	Betadine Swab Stick
Central Line Insertion	Chloraprep	Chloraprep Swab		Betadine Swab Stick
Central Line Dressing Change	Chloraprep	Chloraprep Swab	PDI CHG Wipe	Betadine Swab Stick
Surgical Procedure at the Bedside (Always dependent on location and size of area)	Chloraprep	Chloraprep Swab	PDI CHG Wipe	Betadine Swab Stick
Picture of Product				
Technique	1.5 mL applicator coverage area: 2.5 in x 2.5 in 3 mL applicator coverage area: 4 in x 5 in Directions: use gentle repeated back-and-forth strokes for 30 seconds. Dry Time: 30 seconds	Coverage area: 2.5 in x 2.5 in Directions: Use gentle repeated back-and-forth strokes for 30 seconds. Dry Time: 30 seconds	Directions: Do not unfold the swab. Prep time: 15 seconds Dry Time: 30 seconds	Directions: Clean the treatment area. Remove applicator by end of swabstick & apply to the site. Following procedure, remove the solution from the skin using a sterile alcohol prep pad or swab (sterile saline or sterile water for neonates). Do not allow Betadine to remain on the skin. If using for central line: Start at the catheter exit site and work outward in a circular pattern for several inches. Repeat 2 more times with a new swab each time. Do not return to cleaned area with the same antiseptic Dry Time: Allow to dry completely (about 5 minutes)

We will continue to source our usual supplies as they are available, and return to normal as the supply chain stabilizes. Our suppliers share this disruption may last for several months. Thank you for your understanding and patience.

Charter on Physician Well-Being **by Dr. Leslie Kohman**

As a first step on our journey to become a place where we might all experience joy in practicing medicine, Drs. Mantosh Dewan, Robert Corona, and Lawrence Chin have signed the attached Charter on Physician Well-Being. If you have any

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suggestions as to how to manifest the commitments embodied in the charter, please communicate them directly to our Chief Wellness Officer, Dr. Leslie Kohman, KohmanL@upstate.edu.

LUCAS 3 Chest Compression System Go-Live May 4, 2021

by the Resuscitation Program

The LUCAS 3 Chest Compression System went live on May 4, 2021. This mechanical CPR device delivers guideline-consistent, high-quality, chest compressions. It will be made available and considered for use on all adult patients and non-patients at Upstate University Hospital and Community Hospital who suffer cardiopulmonary arrest (see policy CM L-11 for limited exclusion criteria).

Please see the attached flyer and PowerPoint education material to review and share with your teams. The Resuscitation Team is happy to conduct additional in-services, in-person, upon request. If interested, please reach out to Ellen Anderson (andersoe@upstate.edu), Matt Grover (groverm@upstate.edu), Nicole Staring (staringn@upstate.edu) or any of the Adult SWAT Nurses.

Incomplete / Pended Notes in EPIC **by Andrea Bleyle**

In an effort manage a significant number of incomplete or pended notes outstanding in EPIC, the Health Information Management (HIM) department has requested that IMT run a utility to remove incomplete and pended inpatient notes older than 6 months.

The utility will be completed on May 22, 2021. This message is being sent to make you aware that this utility will be run and provide an opportunity for providers to address their incomplete or pended notes before the utility is completed.

Providers are strongly encouraged to identify, review and address any of their own incomplete or pended notes prior to this date. Any incomplete or pended notes not address by individual providers prior to 5/21/2021 will be addressed as part of the utility that is run. The utility will remove incomplete notes attached to inpatient encounters with discharge dates prior to November 23, 2020.

Please review the **Manage Incomplete and Pended Notes Tip Sheet** to assist you in identifying your incomplete or pended notes. As a reminder incomplete and pended notes must be managed regularly by providers in a timely manner. Please refer to **Policy MSB R-03 Rules and Regulations – Medical Records** for standards for note completion.

Updated Tuberculosis (TB) Policy from Employee-Student Health

Employee-Student Health has changed their TB policy and have created the attached one-page informational memo for Managers and Department Directors to share with staff. Please contact Employee-Student Health with any questions at 315-464-4607.

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Revised COVID-19 Policies of Special Interest for Clinicians

- Novel Coronavirus 2019 Care of the Patient in the Family Birth Center (COV F-01): updated support person ability to leave once a day, updated 90 day positive deemed new exposure.

- Personal Protection Equipment (PPE) Table for COVID-19 Exposure (COV P-01): updated interim return to work guidance.

- Pulmonary Function Testing During the Prevalence of COVID-19 (COV P-10): entered minimum filter requirement and decreased air cleaning time between patients to 15 min, added Infection Prevention as a contributing department, referenced IC F-14 policy.

Upstate Foundation Conducts Annual "The Power of Us" Employee Giving Program **by Bethann Kistner**

All Upstate employees received an email with information about making a contribution to the Upstate Foundation's annual "The Power of Us" employee giving program.

You can support Upstate by donating to one or more of the Foundation's 1000 funds that benefit patient care, education and research. Please consider contributing to a fund that is meaningful to you, it would be greatly appreciated.

Donations can be made through payroll deduction up until June 18th, or by cash, check or credit card until June 30th. You can also participate online through Epledge by logging into Self-Serve and clicking on the "Power of Us" logo or by going to: https://www.upstatefoundation.org/EmployeeGiving.

For more information, contact the Upstate Foundation at 315-464-4416.

Clinical Documentation Improvement (CDI)

by 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 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 sheets for more information and contact the CDI Hotline with questions at 315-464-5455.

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Outstanding Physician Comments

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

Adult Hematology Oncology: **Dr. Mashaal Dhir** and **Dr. Tallat Mahmood** – I have full confidence and trust in their treatment of my cancer.

Community Campus – Virtual: **Dr. Kristina Go** – great! **Dr. Lauren Rabach** was very friendly and answered all of my questions. I feel very confident with her care plan and will continue to see her as my provider. **Dr. J Trussell** gave clear and concise answers.

ENT at Community Hospital: I found **Dr. Mitchell Gore** to be very professional. **Dr. Brian Nicholas** is wonderful. He never rushes you and assures you if you want something it is a phone call away. I owe my hearing to him. **Dr. Brian Nicholas** – proficient and involved. **Dr. Brian Nicholas** reviewed surgery procedures and answered any questions we had. **Dr. Brian Nicholas** has always been very good at explaining exactly what is going on, both in academic terms, and in common language. He is very clear about what my options are, and I feel like I am empowered to make the decisions. I appreciate the kind and courteous patient care I receive from **Dr. Brian Nicholas**. We can't say enough good things about **Dr. Brian Nicholas**! **Dr. Brian Nicholas** is the best! He is friendly, informed, and communicative. He is very careful to explain exactly what the situation is and to explain any details I might not understand. **Dr. Brian Nicholas** – went above and beyond for me. **Dr. Brian Nicholas** – genuinely caring. **Dr. Brian Nicholas** – super, takes his time, listens to all your concerns, never feel rushed. **Dr. Brian Nicholas** is amazing with our daughter, quick to explain things in a way we understand, and I would highly recommend him! **Dr. Brian Nicholas** – takes his time explaining illness and treatment.

Family Medicine at Community Hospital: **Dr. R. Eugene Bailey** always makes me feel better about myself, and my problems. I appreciate him for that. **Dr. R. Eugene Bailey** – love! **Dr. R. Eugene Bailey** – I hold him in high esteem! **Dr. R. Eugene Bailey** – 100% overall care in my mental, spiritual and physical health. **Dr. R. Eugene Bailey** is the best at concentrating on my medical issues and my opinion regarding medical tests/procedures. **Dr. R. Eugene Bailey** is the best! **Dr. R. Eugene Bailey** spent time reviewing my chart and answering any questions I had. He was very thorough and didn't rush through the appointment. He's been our family physician for about 26 years and is a great doctor!! **Dr. R. Eugene Bailey** is very relational and attentive to needs. **Dr. R. Eugene Bailey** – the best! **Dr. R. Eugene Bailey** is a great physician. **Dr. R. Eugene Bailey** is the best! He listens, understands, and cares about his patient. I love **Dr. R. Eugene Bailey**. **Dr. R. Eugene Bailey** has always been a great provider for myself and my family. We feel blessed to have him as our PCP. I was feeling very anxious about current circumstances, and **Dr. R. Eugene Bailey** helped me see things more clearly and objectively. **Dr. Joseph Cincotta** was very thorough and took his time going through all areas of need. It was a very good first visit. **Dr. Joseph Cincotta** listens and responds with helpful information for all physical issues and medications. A real treasure! **Dr. Joseph Cincotta** impressed me with his sensitivity and listening skills. He seems very compassionate and genuinely interested in my health. **Dr. Heather Finn** – very concerned and explored many ideas related to health issues. **Dr. Heather Finn** is my primary doctor and she is awesome, great, understanding and takes care of what she can for you. Without a doubt, she is exceptional and I love having her take care of me. I know that her and her team have my best interest at heart. **Dr. Heather Finn** has on many occasions saved my life. I owe her a lot of gratitude. I could not ask for a better doctor than **Dr. Igor Kraev**. **Dr. Igor Kraev** was one of the best practitioners I have ever experienced. He was thorough and easy to talk to about my problems**. Dr. Igor Kraev** took my problem seriously. **Dr. Igor Kraev** is always attentive, informed, and communicates well. **Dr. Sana Zekri** – awesome! **Dr. Sana Zekri** takes his time listening to me. I find him intelligent and open to what I have to say. He has energy, wants to do his job to the best of his ability, and shows compassion. He is a team doctor and I am a part of his team. **Dr. Sana Zekri** was very kind and comforting as we discussed my difficult diagnosis. He assured me he would help me navigate through the process and assist me whenever he could. I would highly recommend him to my family and friends. This was my first time meeting **Dr. Sana Zekri** and he made sure I knew what he specialized in and that I was comfortable seeing him. He took the time to address my

concerns. **Dr. Sana Zekri** – awesome! **Dr. Sana Zekri** was excellent, and cared about how I felt. **Dr. Sana Zekri** is an asset to your staff.

Pediatrics After Hours at Community Hospital: **Dr. Cynthia Bright** was great with my child, very attentive to detail, and made sure to explain everything well.

SUNY Upstate – Virtual: **Dr. Michael Archer** is the best doctor I have ever had. He is very compassionate and professional. I cannot say enough about him. I am very fortunate I was referred to him and beyond grateful to have him as my doctor. **Dr. Nidhi Bansal** is awesome. I feel very comfortable working with **Dr. Sharon Brangman** because she reviews previous concerns, asks questions, listens to my responses and gives me information that helps me be aware of things to look out for and to do regarding my health. **Dr. Stephen Knohl** is always willing to listen and explain anything I am unsure about. Definitely would recommend **Dr. Leslie Kohman** to friends. **Dr. Kaushal Nanavati's** gentle reminders and caring conversation felt like I had a friend on the other end of the telephone line. I was so happy to get in with **Dr. Kaushal Nanavati** and discuss my issues as he seemed intent on finding me an answer. **Dr. Clyde Satterly** – always helpful and informative. **Dr. Rupali Singla** was very easy to speak with. My video visit with **Dr. J Trussell** was excellent. **Dr. Thomas Vandermeer** was informative, friendly, and put me at ease. **Dr. Awss Zidan** was wonderful. He was very kind, patient, answered my questions and I did not feel rushed. I felt like he was listening to me. **Dr. Awss Zidan** was very informative.

Surgery – UH: When I saw **Dr. Michael Luca** I felt that my concerns were completely addressed. **Dr. Crystal Whitney** is a very good doctor.

Surgical Subspecialties at Community Hospital: **Dr. Lauren Rabach** is awesome and so easy to understand.

UHCC – Neurology: **Dr. Karen Albright** was exceptional. She listened to concerns/questions and had very informative responses. She took her time and was very thorough. We could tell she took the time to review the case before we arrived. She's an EXCEPTIONAL doctor. I have a severe hearing loss and **Dr. Sara Ali** really worked with me to make sure that the communication between us was not hampered. I truly appreciated this. **Dr. Anuradha Duleep** is by far one of the best doctors that I have ever met. She is a very kind and compassionate doctor, who listens to the patient. She is very thorough and extremely knowledgeable. I am so impressed with **Dr. Anuradha Duleep's** intelligence, thorough care, and attention to detail. **Dr. Anuradha Duleep** wowed me! I have never had a physician who listened with such intensity and was able to retell my story with such detail and accuracy. **Dr. Anuradha Duleep** is an exceptional physician. I feel blessed to have had such incredible care – thank you! **Dr. Jenny Meyer** was very considerate and caring. She didn't make me feel rushed and gave me her time and attention. Loved **Dr. Jenny Meyer**! **Dr. Dragos Mihaila** – grateful! **Dr. Dragos Mihaila** did an incredibly thorough examination. I've seen other neurologists for my pain and he stands out as being the most concerned and sensitive to my issues. He did not give up and I was very grateful. **Dr. Dragos Mihaila** is concerned about my health and I am confident in his treatment of my disease. He is detailed in our discussion and open to further questions. I have a great level of confidence in him.

Vascular Surgery at Community Hospital: **Dr. Palma Shaw** – I think the world of her! She is kind and caring and takes all the time you need. I would recommend **Dr. Palma Shaw** in a heart beat. She saved my foot. **Dr. Scott Surowiec** is an outstanding surgeon and caregiver. He is a skilled provider and has consistently demonstrated wonderful patient interaction skills. **Dr. Scott Surowiec** is compassionate and understanding. **Dr. Scott Surowiec** – skillful, communicates, and caring.

2East at Community Hospital: **Dr. Kenneth Rhee** is the best!

05B: **Dr. Laura Simionescu** – the most professional doctor ever!! **Dr. Laura Simionescu** evaluated my chart and test results,

thoroughly explained issues to students/residents, did a thorough exam tying clinical to physical, and followed up with me after I was released from hospital. Excellent patient care.

6th Floor at Community Hospital: **Dr. Robert Sherman** – great!

06A: **Dr. Brian Changlai**, **Dr. Timothy Ford** and **Dr. Daniel Villarreal** – top notch, good manner, gave me assurance, great people.

07C: **Dr. Moustafa Hassan** explained very thoroughly what the procedure would involve, my pain control and recovery, listened to all my concerns and responded very satisfactorily.

09G: **Dr. Christine Courtney** in the ER was wonderful in explaining my condition and the plan for tests and my care.

10E: **Dr. Suman Swarnkar** in the ICU did a good job looking after me, listened, made sure I was given paper to write and made sure that I was able to get a health proxy that I was comfortable with.

11G: **Dr. Melissa Schafer** – went above and beyond, wonderful and caring.

Thank you for all you do!

Amy

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

DATE: May 3, 2021

TO: Health Care Providers, Health Care Facilities, Pharmacies, and Local Health Departments

FROM: New York State Department of Health (NYSDOH)

Health Advisory: Recommendations to Resume Use of the Janssen/Johnson & Johnson COVID-19 Vaccine

Please distribute immediately to all personnel conducting medical screening, medical evaluation, vaccine administration, local health departments, pharmacists, specialists, and all primary care providers.

Summary

- On April 13, 2021 the CDC and the FDA recommended pausing administration of the Janssen (Johnson & Johnson) COVID-19 vaccine due to reports of cases of thrombosis with thrombocytopenia syndrome (TTS) among Janssen (Johnson & Johnson) vaccine recipients.
- A review of all available data determined that the known and potential benefits of the Janssen (Johnson & Johnson) COVID-19 vaccine outweigh the known and potential risks.
- On April 23, 2021 the Advisory Committee on Immunization Practices (ACIP) reaffirmed its interim recommendation for the use of the Janssen (Johnson & Johnson) COVID-19 vaccine in all persons aged ≥18 years under the U.S. Food and Drug Administration (FDA) Emergency Use Authorization (EUA).
- Following discussions with New York State's Clinical Advisory Task Force, NYS Health Commissioner Dr. Howard Zucker recommended on April 24, 2021 that New York State accept the federal recommendations and resume Johnson & Johnson vaccinations effective immediately.
- TTS is a very rare syndrome that involves acute venous or arterial thrombosis with new onset thrombocytopenia in patients with no recent known exposure to heparin. Although rare, TTS has been noted after receipt of the Janssen (Johnson & Johnson) vaccine primarily in women 18-49 years of age.
- The FDA has added warnings regarding these rare clotting events to the EUA, the fact sheet for health care providers, the fact sheet for vaccine recipients, and the prescribing information.
- Women younger than 50 years can receive any COVID-19 vaccine if they do not have a contraindication. However, they should be counseled on the rare occurrence of TTS after receipt of the Janssen (Johnson & Johnson) vaccine.
- The NYSDOH, CDC, and FDA will continue to monitor the safety of all COVID-19 vaccines.

Thrombosis with thrombocytopenia syndrome (TTS)

TTS is a very rare syndrome involving acute venous or arterial thrombosis and new onset thrombocytopenia with no recent known exposure to heparin. It appears to be similar to a rare immune-mediated syndrome known as heparin-induced thrombocytopenia (HIT). Rare occurrences of TTS have occurred after receipt of the Janssen (Johnson & Johnson) COVID-19 vaccine. Blood clots have occurred in the blood vessels in the brain, abdomen and legs along with thrombocytopenia.

- Most incidents occurred 1-2 weeks after receipt of the Janssen (Johnson & Johnson) vaccine in women 18-49 years of age. TTS reporting rates to VAERS were:
  - 7.0 cases per million doses administered to women aged 18-49 years, and
  - 0.9 cases per million doses administered to women aged ≥ 50 years.
- The FDA has added warnings regarding rare occurrences of TTS after Janssen (Johnson & Johnson) vaccination to the EUA, fact sheets, and prescribing information.
- Women under 50 years of age can receive the Janssen (Johnson & Johnson) vaccine, but they should be made aware of the rare risk of TTS.

Additional information for the diagnosis and treatment of TTS are available in the April 13th Health Alert Network (HAN) announcement from the CDC (available here: https://emergency.cdc.gov/han/2021/han00442.asp) and in guidance from the American Society of Hematology (available here: https://www.hematology.org/covid-19/vaccine-induced-immune-thrombotic-thrombocytopenia).

Considerations for the use of the Janssen (Johnson & Johnson) COVID-19 vaccine in certain populations

Until more is known about the etiology of TTS, experts advise that persons with a history of an episode of an immune-mediated syndrome characterized by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT), should be offered another FDA-authorized COVID-19 vaccine (i.e., mRNA vaccine) if they are within 6 months after resolution of their illness.

Venous thromboembolism (VTE) as deep vein thrombosis, pulmonary embolism or both are common. The underlying biological mechanism of VTE differs from HIT and TTS. Based on the current knowledge of TTS, experts believe that persons with risk factors for VTE (or arterial thrombi) without thrombocytopenia are unlikely to be at increased risk for TTS.

Women under 50 years of age can receive any FDA authorized COVID-19 vaccine. However, they should be made aware of the rare occurrences of TTS in persons who have received the Janssen (Johnson & Johnson) vaccine.

Pregnant women can receive any FDA authorized COVID-19 vaccine for which they do not have a contraindication. They should be counseled on the limited data available on COVID-19 vaccine administration during pregnancy, but early data from three U.S. vaccine safety surveillance systems did not identify any safety concerns for pregnant people who were vaccinated or for their babies. People who are pregnant or postpartum do not appear to have higher rates of TTS after the Janssen (Johnson & Johnson) vaccine than people who are not pregnant. Pregnant women may receive any FDA-authorized COVID-19 vaccine. They may

choose to receive mRNA vaccines if they do not wish to receive the Janssen (Johnson & Johnson) vaccine.

People who take aspirin or anticoagulants as part of routine medical treatment do not need to stop these medications prior to vaccination with the Janssen (Johnson & Johnson) COVID-19 vaccine. The American Society of Hematology recommends avoiding aspirin for treatment or prophylaxis for TTS as aspirin is not effective at preventing HIT antibodies from activating platelets and could increase bleeding risk in TTS.

Persons who receive the Janssen (Johnson & Johnson) vaccine should be made aware of these rare occurrences of TTS and to seek medical attention right away if they have any of the following symptoms:

- Shortness of breath
- Chest pain
- Leg swelling
- Persistent abdominal pain
- Severe or persistent headaches or blurred vision
- Easy bruising or tiny blood spots under the skin beyond the site of the injection

All adverse events after receipt of any vaccine, including COVID-19 vaccines, should be reported to VAERS even if it is not known that the vaccine caused the adverse event. Information on reporting to VAERS is available at: https://vaers.hhs.gov/reportevent.html.

The CDC has also developed a patient education fact sheet with information regarding the Janssen (Johnson & Johnson) COVID-19 vaccine. The fact sheet is available here: https://www.cdc.gov/coronavirus/2019-ncov/downloads/talking-patients-jj-vaccine-html.pdf.

Resources:

For questions, call the NYSDOH COVID-19 hotline 1-888-364-3065 or email the NYS Department of Health at immunize@health.ny.gov or the NYC DOHMH at nycimmunize@health.nyc.gov.

- CDC: Morbidity and Mortality Weekly Report (MMWR): Updated Recommendations from the Advisory Committee on Immunization Practices for Use of the Janssen (Johnson & Johnson) COVID-19 Vaccine After Reports of Thrombosis with Thrombocytopenia Syndrome Among Vaccine Recipients – United State, April 2021: https://www.cdc.gov/mmwr/volumes/70/wr/mm7017e4.htm?s_cid=mm7017e4_w
- CDC Interim Clinical Considerations for Use of mRNA COVID-19 Vaccines Currently Authorized in the United States: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html
- Reporting an adverse event to VAERS: https://vaers.hhs.gov/reportevent.html
- NYS COVID-19 Vaccine web page: https://covid19vaccine.health.ny.gov/
- FDA Janssen COVID-19 Vaccine Frequently Asked Questions: https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/janssen-covid-19-vaccine-frequently-asked-questions
- Janssen COVID-19 Vaccine Fact Sheet for Health Care Providers: https://www.fda.gov/media/146304/download

- Janssen COVID-19 Vaccine Fact Sheet for Vaccine Recipients: https://www.fda.gov/media/146305/download
- American College of Obstetricians and Gynecologists (ACOG): Vaccinating Pregnant and Lactating Patients Against COVID-19: https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/12/vaccinating-pregnant-and-lactating-patients-against-covid-19

VIEWPOINT

Charter on Physician Well-being

Larissa R. Thomas, MD, MPH
Division of Hospital Medicine, Zuckerberg San Francisco General Hospital, and Department of Medicine, University of California, San Francisco School of Medicine, San Francisco.

Jonathan A. Ripp, MD, MPH
Departments of Medicine, Geriatrics and Palliative Medicine, and Medical Education, Icahn School of Medicine at Mount Sinai, New York, New York.

Colin P. West, MD, PhD
Division of General Internal Medicine, Department of Medicine, Mayo Clinic, Rochester, Minnesota; and Division of Biomedical Statistics and Informatics, Department of Health Sciences Research, Mayo Clinic, Rochester, Minnesota.

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Dedication to serving the interest of the patient is at the heart of medicine's contract with society. When physicians are well, they are best able to meaningfully connect with and care for patients. However, challenges to physician well-being are widespread, with problems such as dissatisfaction, symptoms of burnout, relatively high rates of depression, and increased suicide risk affecting physicians from premedical training through their professional careers. These problems are associated with suboptimal patient care, lower patient satisfaction, decreased access to care, and increased health care costs.

Addressing physician well-being benefits patients, physicians, and the health care system. Governing bodies, policy makers, medical organizations, and individual physicians share a responsibility to proactively support meaningful engagement, vitality, and fulfillment in medicine. Furthering these ideals within the culture of medicine and across its diverse members may help to strengthen health care teams and improve health care system performance.

On behalf of the Collaborative for Healing and Renewal in Medicine (see acknowledgment), we set forth guiding principles and key commitments as a framework for key groups to address physician well-being from medical training through an entire career (Box).

Governing bodies and policy makers could use this charter to help advance a high-functioning health care system by ensuring that policies and regulations align with best practices that promote physician well-being. Organizations could use this charter to help identify strategic priorities and interventions that can maximize meaning, engagement, and job satisfaction. Individual physicians could use this charter to work with local and national partners to guide their practices in service of both patient needs and individual fulfillment.

Guiding Principles

Effective Patient Care Promotes and Requires Physician Well-being

Maintaining meaning and efficacy in the practice of medicine is likely protective against physician-reported burnout, a syndrome of emotional exhaustion, cynicism, and decreased effectiveness at work. For example, in a study of 465 physicians, spending even 1 day per week on the aspect of work identified as most meaningful was associated with lower physician burnout rates (53.8% vs 29.9%).[1] Targeted practice improvement interventions have yielded similar reductions in burnout. Caring for patients has intrinsic value that is not fully captured by performance and financial metrics. Authentic, humanistic interactions with patients and colleagues enhance physician well-being, and physicians who are well may, in turn, provide better patient care and practice high-quality medicine.

Physician Well-being Is Related With the Well-being of All Members of the Health Care Team

Physicians practice within a matrix of important relationships with patients, members of an interprofessional team, administrative leaders, and in some settings, learners and educators. The entire team is affected by the health of each of its members. Approaches to address physician well-being are most effective when contextualized within efforts to enhance the well-being of all health care team members.

Physician Well-being Is a Quality Marker

Enhancing physician well-being likely benefits health systems seeking to provide high-value care.[2] For example, physician burnout has been estimated to contribute one-third of the cost of physician job turnover to the health care system.[2] The "Triple Aim" for health system improvement, optimizing the care experience and population health while reducing the cost of care, should be supplemented with physician well-being, the fourth component of a "Quadruple Aim" and an essential metric that should be tracked and included in organizational performance reports. Healthy organizations use systems improvement tools to identify factors associated with reduced well-being, including assessments of physician well-being in the planning stages of systems improvement initiatives.

Physician Well-being Is a Shared Responsibility

Physician well-being requires collaboration between individual physicians and their organizations. Partnerships among health care team members and medical organizations, local and national physician groups, and institutions and regulatory bodies/policymakers are essential. Healthy organizations could use these partnerships to proactively identify and respond to challenges and continually cultivate well-being.

Summary

Physicians who are well can best serve their patients. Meaningful work, strong relationships with patients, positive team structures, and social connection at work are important factors for physician well-being. Although evidence to support some of the recommendations in this charter is still emerging, medical organizations, regulatory groups, and individual physicians share a responsibility to support these needs. The Charter on Physician Well-being is intended to inspire collaborative efforts among individuals, organizations, health systems, and the profession of medicine to honor the collective commitment of physicians to patients and to each other.

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Box. Charter on Physician Well-being

Societal Commitments

Foster a Trustworthy and Supportive Culture in Medicine. Alignment between the stated values of medicine and actual practice is essential for enhancing engagement in work and trust in the profession. Individual physicians and physician leaders have a responsibility to examine the extent to which the culture of medicine, broadly and locally, facilitates meaning, fulfillment in practice, and professionalism. To encourage a supportive culture, leaders could identify and minimize perceived discrepancies between organizational and individual values, promote community and connection at work, and recognize the innate value of individuals beyond their professional achievements. Individual physicians, especially those in leadership or educational roles, could practice and role model self-compassion and vulnerability as essential components of physician practice.

Advocate for Policies That Enhance Well-being. Policies and rules at the national level have an effect on physician well-being locally. For example, regulations may influence physician workload and willingness of physicians to access mental health care. Productivity-based reimbursement drives documentation requirements and physician job structure, contributing to increased workload and administrative burden. Policies could better align regulatory and documentation requirements with clinical activity and reduce excessive administrative work through task-sharing among team members. Although licensing organizations must ensure that physicians are fit to practice, physician leaders and organizations could advocate for processes that encourage physicians to seek routine mental health care without fear of licensing penalty.

Organizational Commitments

Build Supportive Systems. Optimal systems support for well-being includes providing adequate practice resources to manage the pace and volume of work and designing spaces that streamline work and communication, such as by colocating teams. Practice leaders and organizations could use quality improvement strategies to improve technology and the physical environment and reduce administrative burden. For example, automated prescription lines, having medical assistants enter patient data into electronic health records, and more efficient patient flow through the clinic have each demonstrated benefits to physician burnout and satisfaction. Decreased time spent on administrative work and documentation may enhance meaning and the patient experience by increasing the time physicians can dedicate to direct patient care. Organizational processes that ensure adequate rest and a manageable workload include coverage systems for physicians when they are ill, adequate staffing, provisions for family leave, flexibility for time off to address nonwork interests and obligations, and integration of administrative time within the clinical schedule.

Develop Engaged Leadership. Leaders within organizations, including medical schools, residency programs, hospitals, and health care systems, have a role in promoting physician well-being in their communities of physicians. Leaders could establish physician well-being as an organizational priority by including well-being initiatives in strategic planning efforts, using organizational awareness strategies to better identify and respond to emerging well-being challenges, and integrating well-being measures into assessments of organizational performance. By fostering opportunities for social connection and shared decision making, leaders could build engagement and develop a healthier, more productive workforce.

Optimize Highly Functioning Interprofessional Teams. Highly functioning interprofessional teams optimize patient care by enabling physicians and other members of the team to do the work for which they are uniquely trained. Team-based training and community-building activities enrich collaborative interprofessional practice. Additionally, organizations could mitigate burnout symptoms for all members of the health care team by designing staffing models and using process improvement initiatives to match workload to expectations, manage work intensity, and allow variety in practice.

Interpersonal and Individual Commitments

Anticipate and Respond to Inherent Emotional Challenges of Physician Work. Certain challenges to well-being are inherent to physician work and expected over the course of a career, including adverse events, patient deaths, and exposure to human pain and distress. Incorporating coping strategies for such experiences into training and continuing education may help mitigate their effect, promote emotional awareness, and normalize seeking support. Organizations could aid physicians by integrating regular protected opportunities for debriefing within the workday and by building professional support systems to address the influence of adverse events on physicians and other members of the health care team.

Prioritize Mental Health Care. Both individuals and organizations have a role in prioritizing mental health care. Leaders could counter stigma by openly promoting systems that encourage physicians to seek assistance. Increased availability of confidential mental health services during off hours and provision of coverage to attend appointments could decrease barriers to seeking care. More broadly, psychological support should be considered as a means to optimize physician performance proactively rather than solely as a response to crises.

Practice and Promote Self-care. Individual physicians who learn and incorporate self-care skills can enrich their own well-being. As part of their ongoing professional development, physicians may benefit from opportunities to enhance emotional awareness, mindfulness, and self-reflection. Organizations and training programs could provide education, resources, and protected time for physicians to devote to these practices. Additionally, organizations could encourage healthy choices by incorporating healthy food and exercise facilities at or near the workplace and incentivizing participation in lifestyle initiatives.

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2. Shanafelt T, Goh J, Sinsky C. The business case for investing in physician well-being. *JAMA Intern Med*. 2017;177(12):1826-1832.

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L.U.C.A.S.

MECHANICAL CPR DEVICE

Official Go Live Date: 5/4/2021

THE LUCAS MECHANICAL CPR DEVICE DELIVERS GUIDELINE-CONSISTENT, HIGH-QUALITY CHEST COMPRESSIONS. IT WILL BE MADE AVAILABLE AND CONSIDERED FOR USE ON ALL ADULT PATIENTS AND NON-PATIENTS AT BOTH CAMPUSES WHO SUFFER CARDIPULMONARY ARREST(see CM L-11 for limited exclusion criteria)

ADDITIONAL EDUCATION CAN BE OBTAINED VIA BLACKBOARD, SCHEDULED TRAINING WITH RESUSCITATION PROGRAM PERSONNEL, OR BY UTILIZING THE FOLLOWING LINK: https://www.lucas-cpr.com/web_training/lucas3/device_orientation/#home

MATTHEW GROVER: RESUSCITATION PROGRAM QUALITY COORDINATOR
ELLEN ANDERSON: RESUSCITATION PROGRAM MANAGER
NICOLE STARING: RESUSCIATION PROGRAM DATA COORDINATOR
DR CARLOS LOPEZ: RESUSCITATION MEDICAL DIRECTOR

LUCAS 3 Chest Compression System

L. MINNOE
MSN, RN

PDL

MAY 2020

What it is

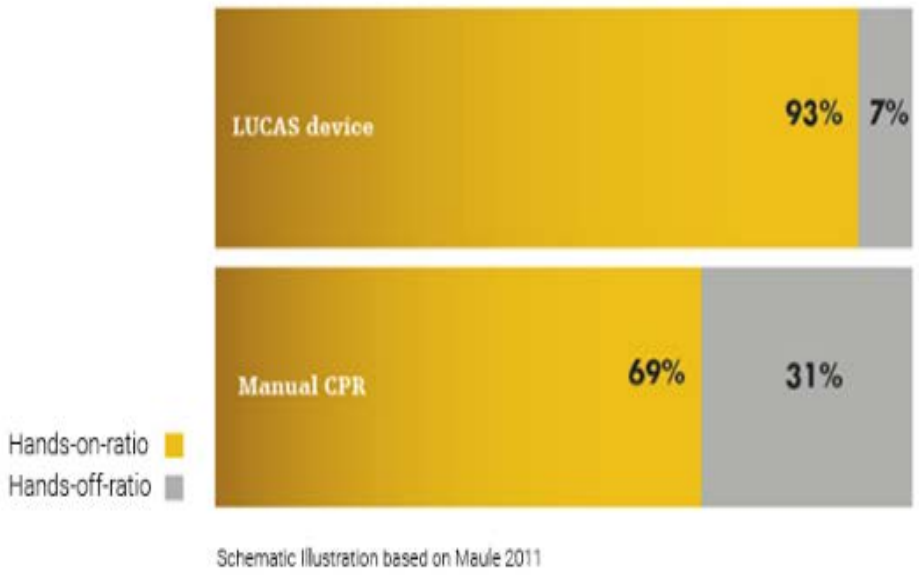
The LUCAS chest compression system enables extended, high quality CPR

Fatigue, individual variations or psychological factors are removed from CPR and there is no longer a need to switch compressors every 2 minutes.

The LUCAS has been shown to provide consistent quality of chest compressions and create good neurological outcomes by per fusing the brain

There is a median 7 second interruption when transitioning from manual CPR to the LUCAS.

Effectiveness



Schematic Illustration based on Maule 2011

More documented “hands on” time as compared to manual CPR

CONTRAINDICATIONS

Do not use the LUCAS in these cases:

- It is not possible to position the LUCAS device safely or correctly on the patient's chest.
- Too small patient: if the LUCAS device alerts with 3 fast signals when lowering the suction cup and you cannot enter the PAUSE or ACTIVE mode.
- Too large patient: if you cannot lock the upper part of the LUCAS device to the back plate without compressing the patient's chest.
- It is not indicated for pediatric patients.
- **Patients who qualify for the Cardiac Surgery Arrest Protocol on 8F and 8G**
- **Use for patients with upper body traumas will be at the discretion of the attending physician.**

Size matters but a patient's weight does not

If the LUCAS alerts with 3 fast signals when lowering the suction cup and you cannot enter the PAUSE mode or ACTIVE mode the patient is too small.

Immediately resume manual compressions

If the patient is too large, the Upper Part of the LUCAS device cannot lock to the back plate without compressing the patient's chest.

Immediately resume manual compressions.

Main Components of the LUCAS

- Back Plate
  - Positioned under the patient as support for the external chest compressions
- Upper Part
  - Contains the LUCAS battery and the compression mechanism with the disposable suction cup
- Stabilization Strap
  - Helps secure the position of the device in relation to the patient
- Carrying Case

Complications of LUCAS device use

Rib fractures

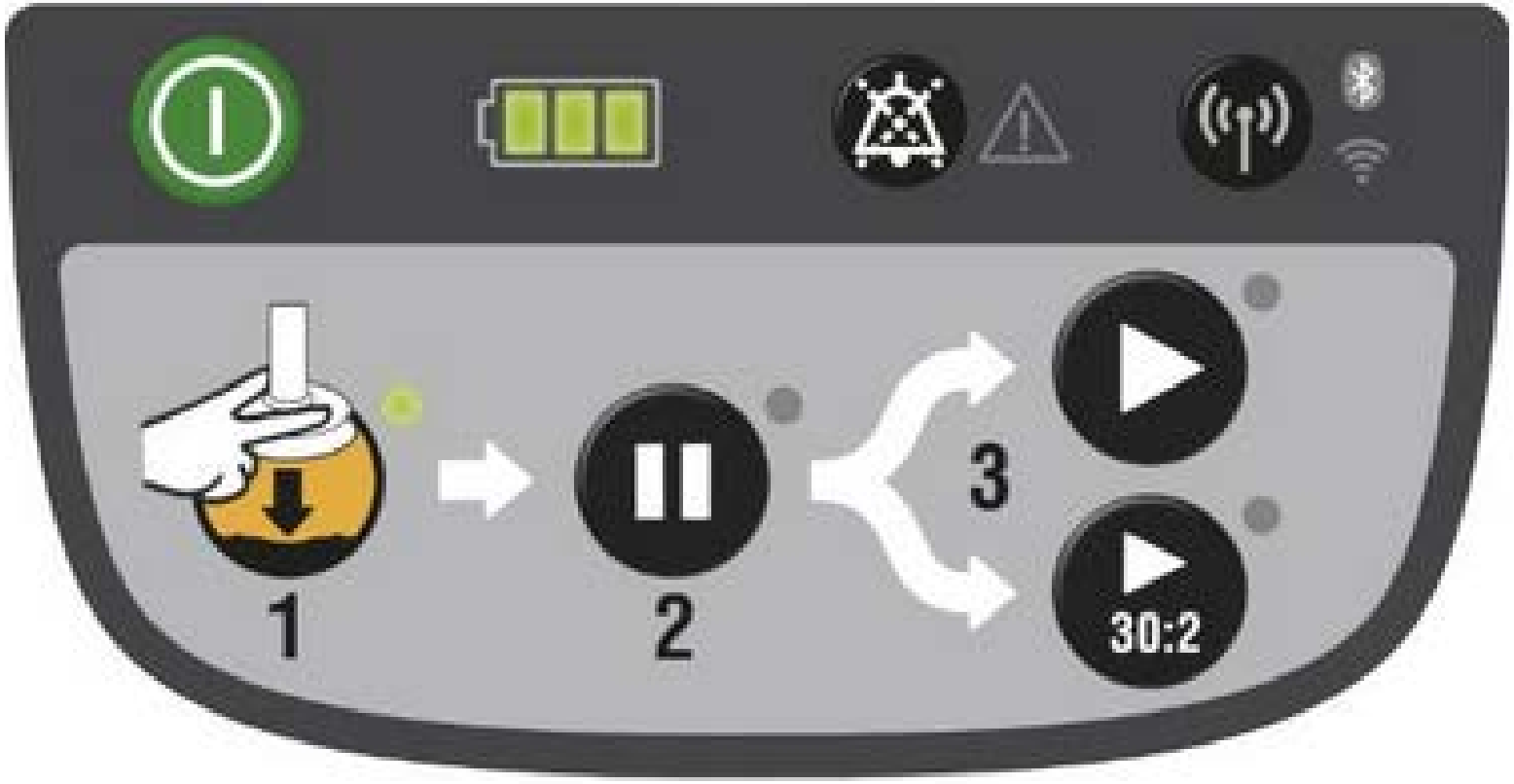
Skin abrasions

Bruising

Chest soreness

Clinical studies have shown the LUCAS compressions are safe for patients with the same type side effects as for manual CPR

Control Panel



Mute button/Alarm indicator

Pushing the mute button will mute the alarm for 60 seconds.

If you push this button when the device is powered off, the Battery indicator will show the charge status of the battery.

On the alarm indicator, a red LED and alarm signal a malfunction.

Adjust

Once the unit is turned on, it automatically enters the adjust mode.

When the unit is in this mode, you may adjust the position of the suction cup.

Pause

Press this button to lock the Piston in the start position.

Also use this when you want to stop the device and temporarily pause compressions but still want to keep the Start position of the suction cup.

Active mode

Active mode

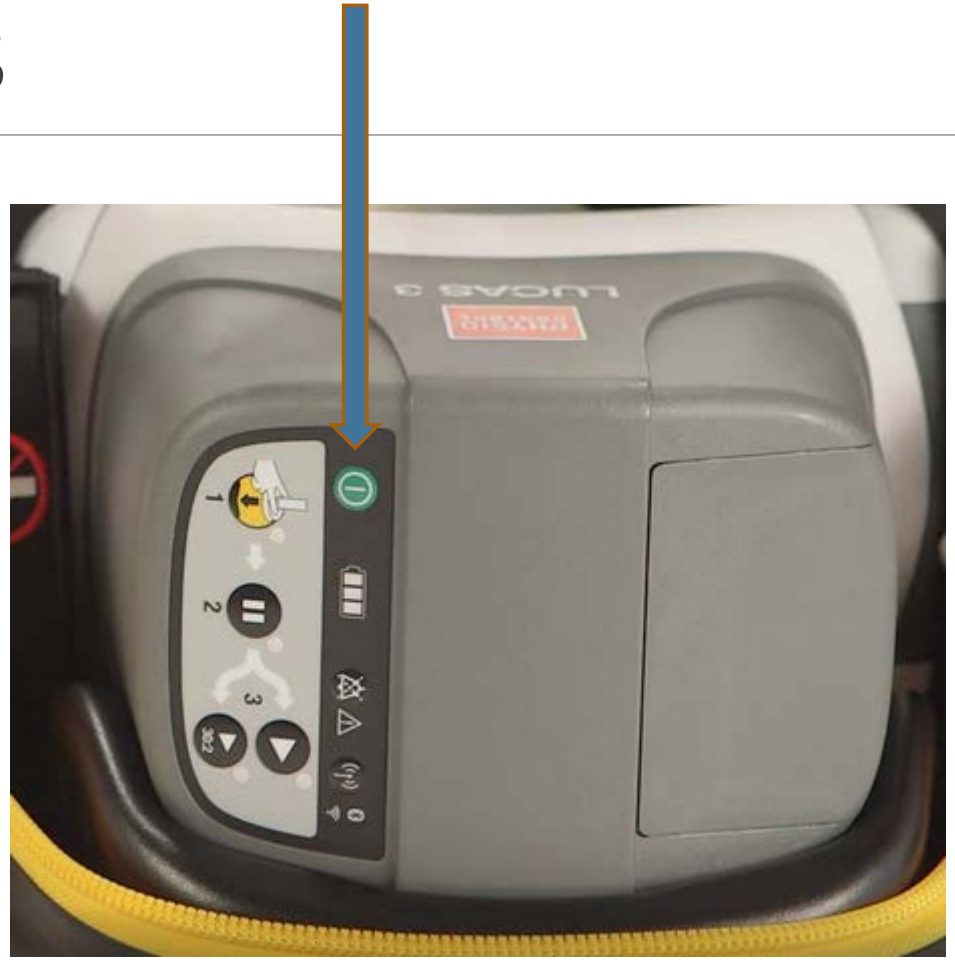
Starting compressions

Push the ON/OFF button for one second to turn on the device (or turn it off) and begin the self test.

Once the self-test is complete, the green LED beside the ADJUST key illuminates.

This takes approximately 3 seconds.

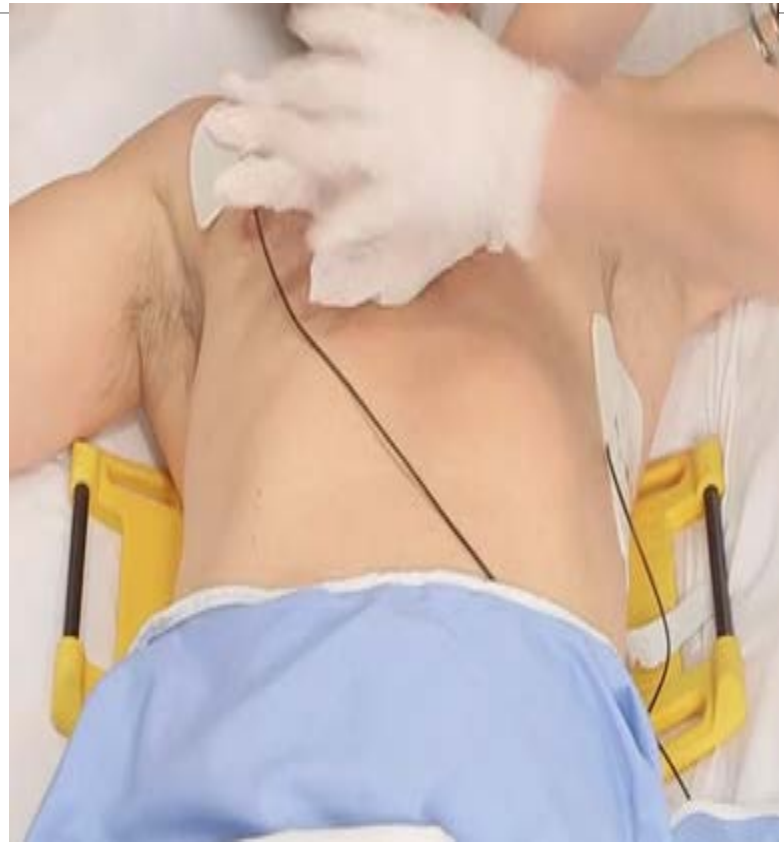
You will hear audible beeping.



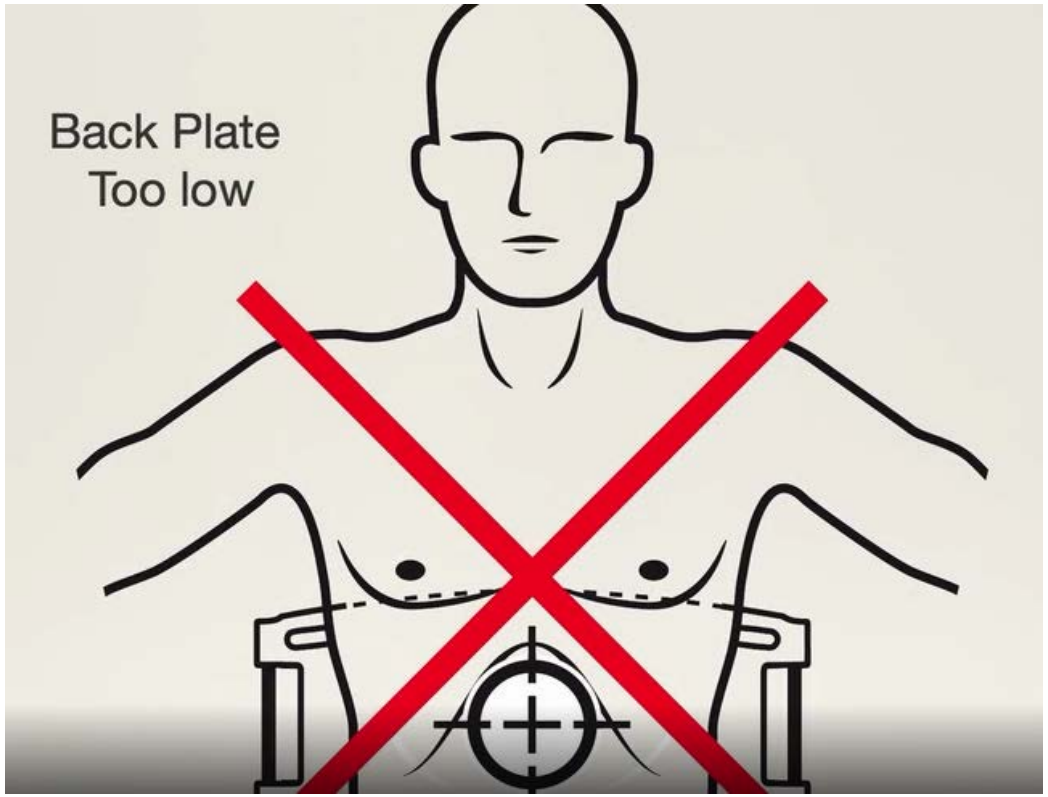
Place the back plate

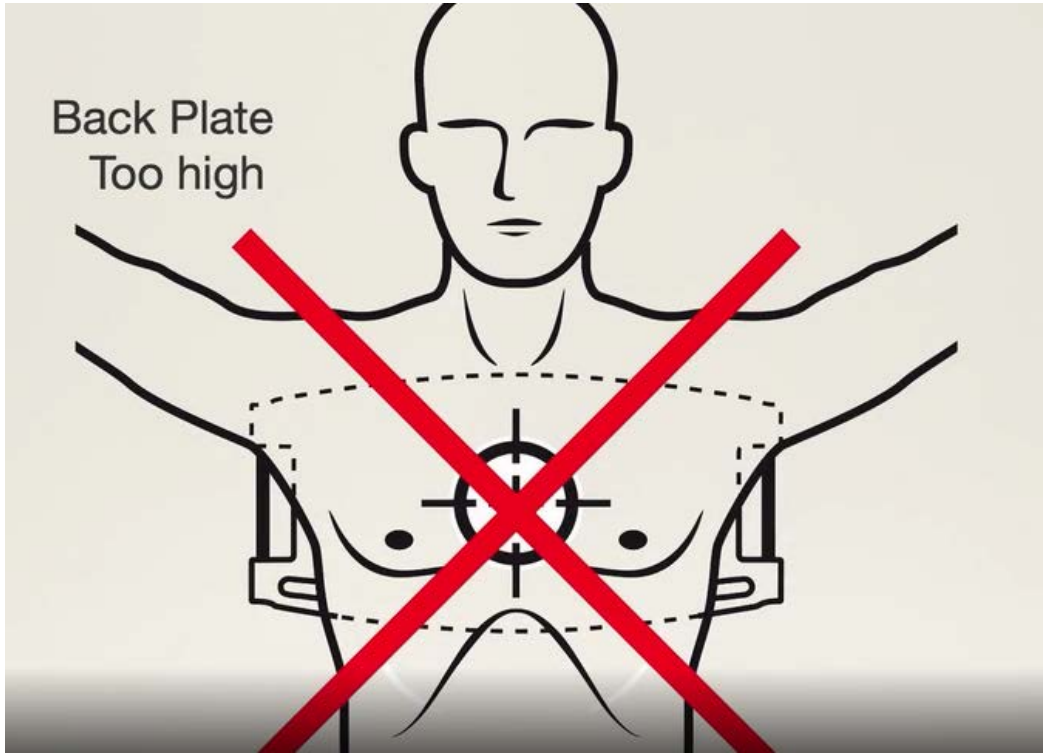
The plate can be placed by either log rolling the patient or lifting up the torso and sliding in underneath the head.

It should sit just below the armpits.



Incorrect placement





Test the locks

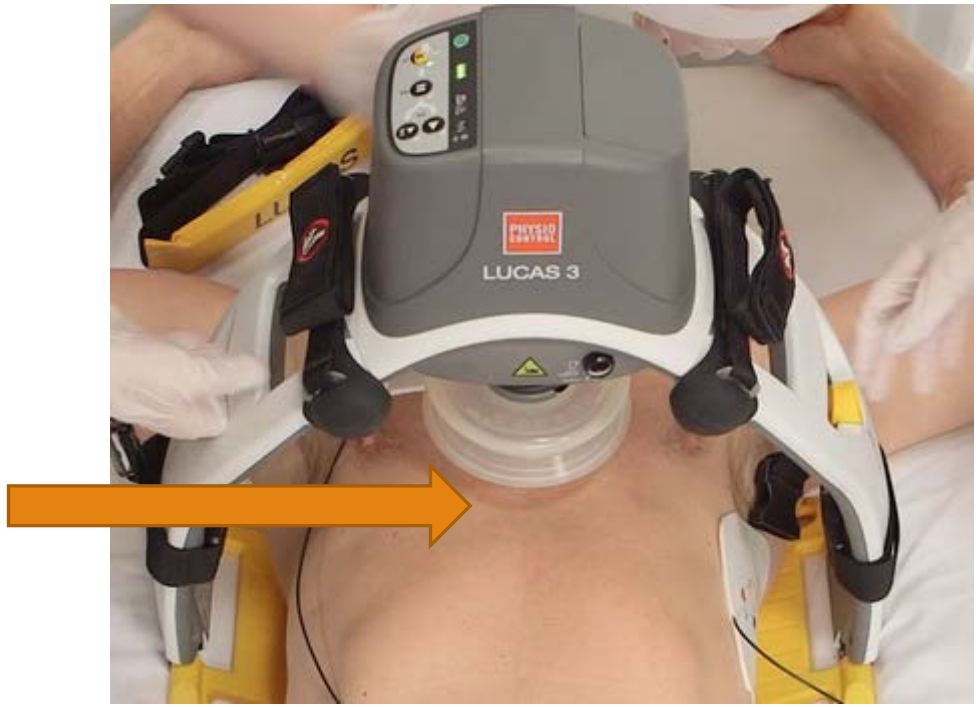
Pull the release rings once to make sure the claw locks are open.

Let go of the release rings.

Attach to the backboard

Use your finger to make sure the lower edge of the Suction Cup is immediately above the end of the sternum.

If needed, move the device by pulling the support legs to adjust the position.



Set position of the suction cup

Lock the Start Position by hitting #2

When adjusting the suction cup, use 2 fingers of one hand and push down until the pressure pad touches the chest without compressing the chest.

Active mode

Start compressions by choosing one of the 2 active modes.

Active mode (cont)

There are 2 active modes.

In the **30:2 mode**, the device will perform 30 compressions and then temporarily stop for 3 seconds to allow for 2 breaths.

In the **Continuous mode** the device will perform continuous compressions at 102 (+/- 2) per minute. This cycle is for the patient with an advanced airway.

Ventilation

The LUCAS device will alert staff when it is time to pause compressions for ventilation

An intermittent LED along with an audible signal will alert staff on the 28th,29th and 30th compression before each ventilation pause.

Compressions will automatically resume.

Ventilation

If using the LUCAS in continuous compression mode, the green LED will blink 10 times per minute to alert for ventilations during ongoing compressions.

Caution

Do not block the vent holes

If blocked, it may cause the device to overheat.

Battery

The battery is located in the hood of the device, across from the control panel.

If fully charged the battery can run for 45 minutes.

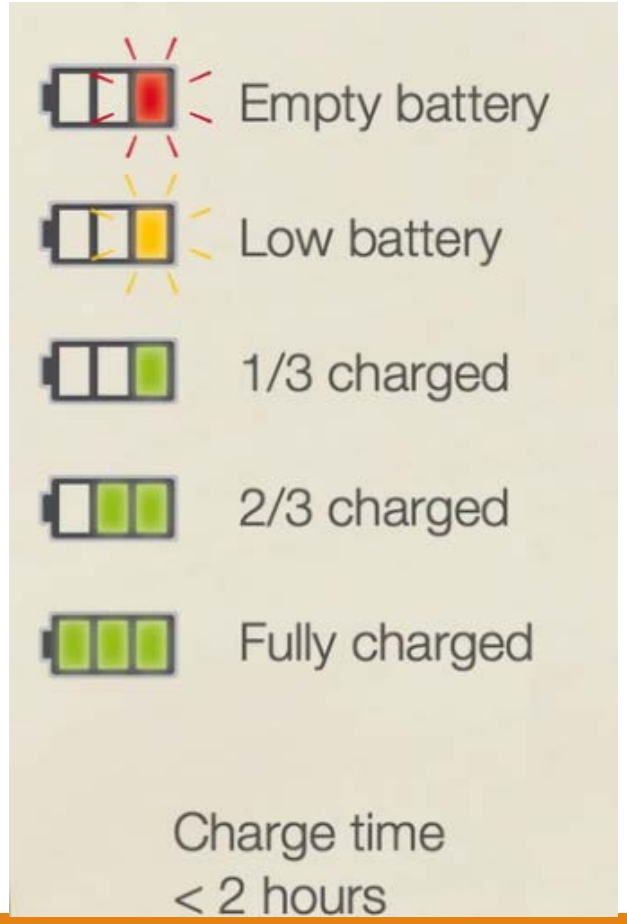
If the battery is fully depleted, it will charge in less than 2 hours if the power supply cord is used and in less than 4 hours in the standalone battery charger.

Once the indicator reaches an intermittent yellow, the battery has less than 30% capacity or approximately 10 minutes of battery life.

Battery use


Empty
Partial charge
Fully charged
Charge time < 4 hours
LUCAS

Battery life

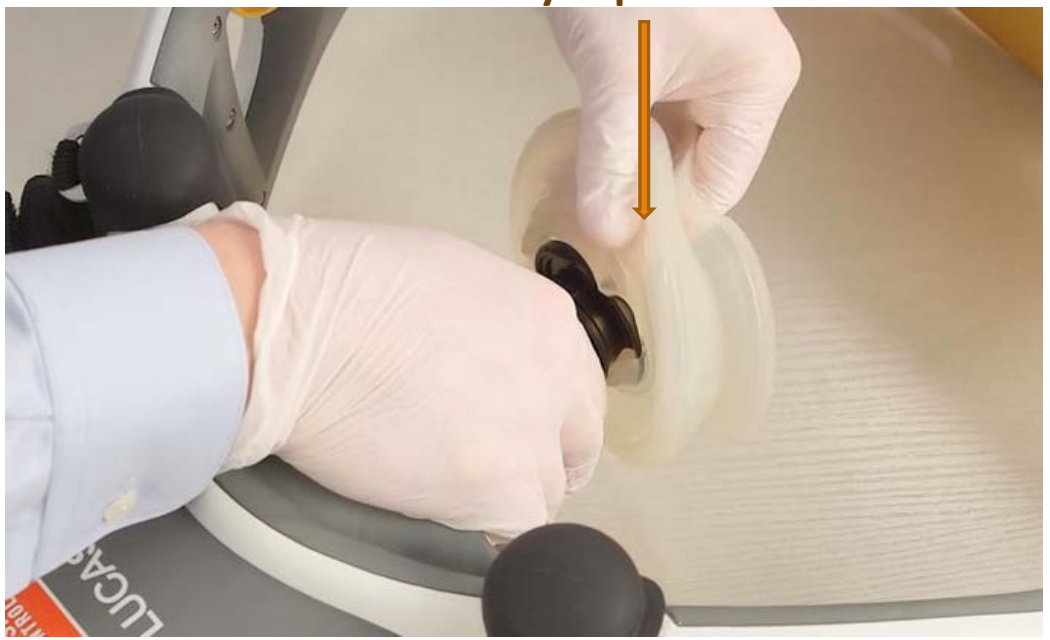


Care and cleaning after use

Remove suction cup

Replace with new suction cup. Contact distribution to obtain.

Clean all surfaces and straps with



Returning the device to the carrying case

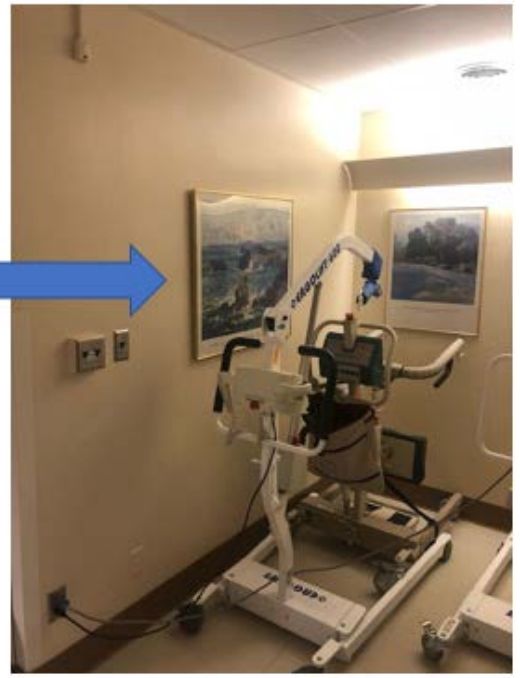
Where are the devices located?

- Applies to Downtown Campus
- Will be mounted on the wall with the exception of the E.D.
- There are a total of 8 Devices
  - **1** on 6th Floor on the wall by the PT stairs
  - **1** in the Heart & Vascular Center (6W)
  - **1** on the 6th Floor in the alcove with Silver Elevators (between 6A &B)
  - **1** on 2nd Floor pillar across from admitting (near bridge)
  - **1** in Emergency Room between bay 4R & 5R, next to code cart (this will be the only one mounted on a WOW stand)
  - **3** in East Tower 8,9,10 will all be in the same area, positioned outside of main family waiting rooms (8414, 9414, 10414) on the side with window not door, these will need **Outlets Installed**
  - SEE FOLLOWING PICTURES

Locations

6th Floor: Down the hall from 6I/6H in the alcove with Physical Therapy Stairs

6th Floor waiting room by the Silver Elevators: Alcove that sits between 6A and 6B (this will service 6A/B, 7A/B, 5A/B)



Locations

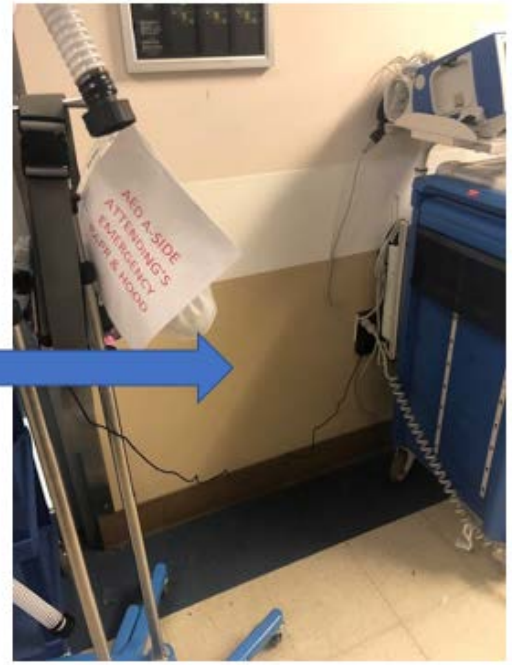
6W (Heart & Vascular): Outside Endovascular Sweet (6604) by the sink: Will hang below the outlet

8th, 9th, 10th Floors (East Tower): This will be the same for all 3 floors: Outside of the main family waiting rooms, if your facing the waiting room it will be to the right, all 3 will need Outlets installed…

Locations

2nd Floor Main Lobby: Pillar across from admitting desk

Adult ED: Next to Crash Cart between bays 4R & 5R (across from nurses station): This is the only device that will be mounted on a WOW base, but this will be primary location.



Locations at Community

- There will be 2 LUCAS devices at the Community campus
- One will be located in the ED
- The second will be in the ICU

Questions?

Please contact Matt Grover or Ellen Anderson for any questions regarding the LUCAS device.

Employee/Student Health Updated TB Policy (T-02)

Employee/Student Health
Email: ESHealth@upstate.edu
Phone: Downtown 315-464-4260 Community 315-492-5624
Portal access: https://eshportal.upstate.edu/

Background:

Since 1991, US Tuberculosis (TB) rates in the US have steadily declined.

The CDC in 2019 and the NYS DOH on 12/16/2020 have therefore updated the screening and testing guidelines for health care workers.

A health care worker (HCW) is defined as someone who has direct or indirect interaction with patients or infectious materials.

Updated Policy Changes:

Initial pre-employment TB testing for HCW. This will be with either a tuberculin skin test (TST) or IGRA (TB blood test). **Those with no patient contact do not need an initial TB test.**

NO ROUTINE PERIODIC (ANNUAL) TB Testing after the initial baseline test.

Aspects of the TB policy that are unchanged:

If baseline testing is positive, treatment options will be facilitated for those incoming employees found to have latent TB infection (LTBI).

Testing (TST, IGRA or chest x-ray) will be performed in the event of an exposure to TB, or in response to any risk factors.

Annual screening for any signs, symptoms, or risk of transmission of TB.

Annual TB education for all HCW.

Documentation of treatment for LTBI if applicable.

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

Clinical Documentation Improvement – How to answer a query

Applies to all providers

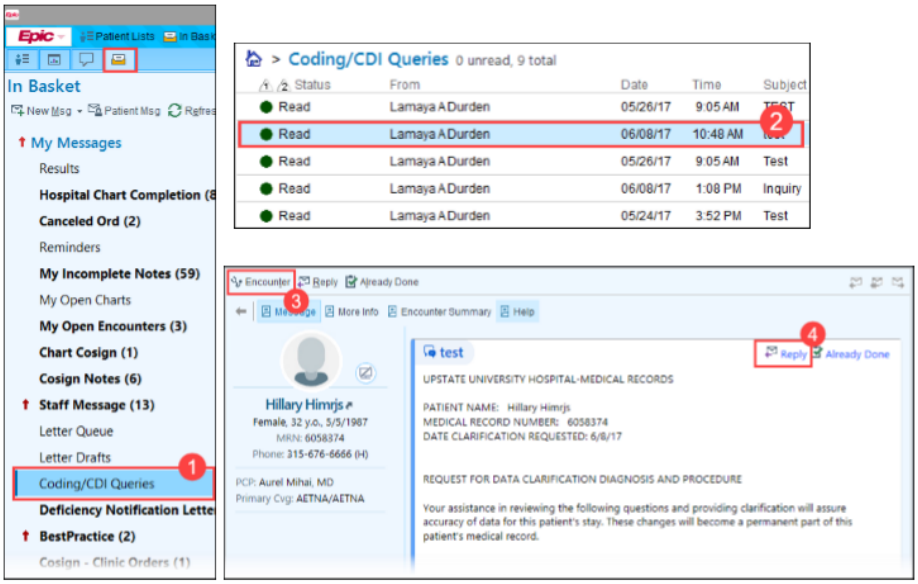
All CDI query responses should be **placed on the query** and the documentation should be **carried into the progress notes** to ensure consistency and good communication. Please note, the auto generated reply is not considered a query response as it does not provide clarification nor give direction as to where in the record the response can be found.

Responding within the In Basket – Queried providers only

***If you view the query here, please respond to it as well, it is no longer easily viewed by other providers on the team once you've viewed it in your In Basket.**

1. From your In Basket select the Coding/CDI Queries folder.
2. Select the query and double-click to open it.
3. Select Encounter to open the patient's chart directly to the CDI Sidebar.
4. Or, click Reply which will open a Coding Query Message allowing you to respond directly to the query.

*With this method you can also click "Respond with Note" and your response will be in a Progress Note that is linked to the CDI Query as well, with a hyperlink. This is the preferred method and meets both objectives for CDI query responses.



As of February, 2020 CDI queries are now part of the permanent medical record and appear in the provider's In Basket within the "Coding/CDI Queries" folder in EPIC.
The attending provider queried will have the option to "reply" directly in the query or select "encounter" to open the patient's chart.

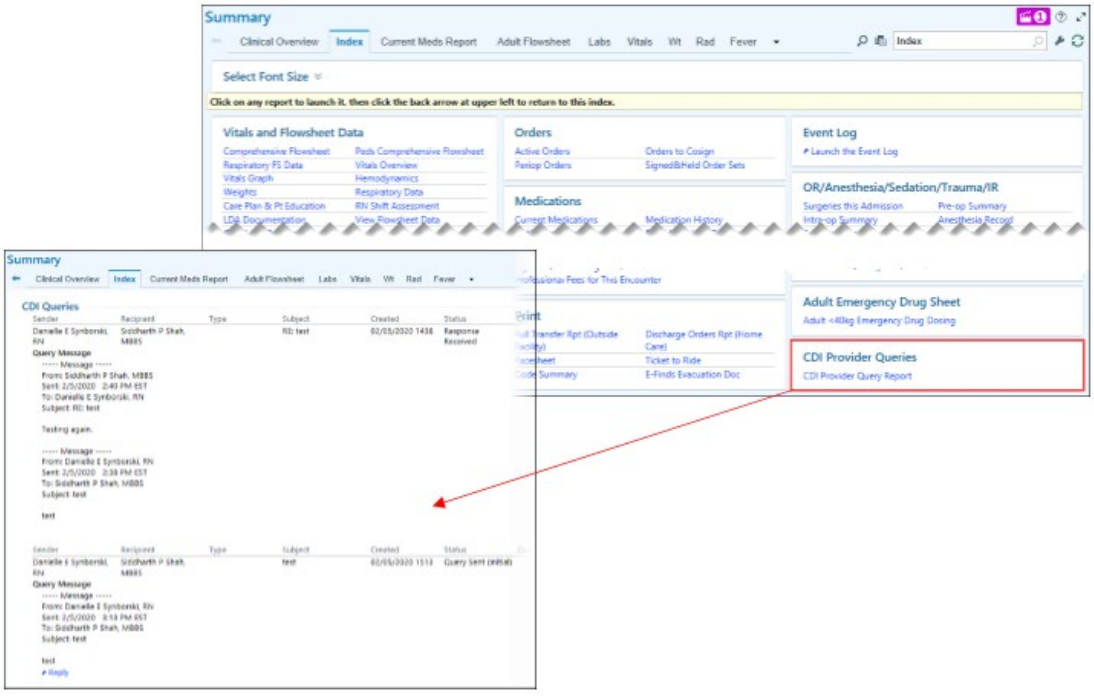
Other providers caring for the patient can also view/reply to the query from the patient's chart – the CDI To-do sidebar displays when there is an outstanding query (it can also be viewed from the "Index" report (See section titled Index Report).

cdi@upstate.edu
for help with anything documentation related

Responding from the CDI Sidebar – All providers caring and documenting on the patient

- Within the "CDI Queries" section (at the bottom) there is a hyperlink for "reply" that the provider can respond from (a pop-up window will open a message to respond) without taking the provider out of the patient workspace.
- The CDI Sidebar will only appear for providers if there is a query that has NOT been responded to or acknowledged in the queried provider's In Basket.
- Once one provider responds to the outstanding query or the queried provider has read the query in their In Basket, the other providers will no longer see it in their sidebar when they open the patient chart.
- If you have been contacted to reply to a CDI query but you can't see it in the CDI Sidebar, look in the "Index Report".

Index Report



- "CDI Provider Queries" will only show if CDI queries exist on the patient.
- Click the hyperlink to review queries that have been answered.
- If you have been contacted to reply to a CDI query but you can't see it in the CDI Sidebar, look here.

cdi@upstate.edu
for help with anything documentation related