CMO REPORT

FROM THE DESK OF
Amy Tucker, MD, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

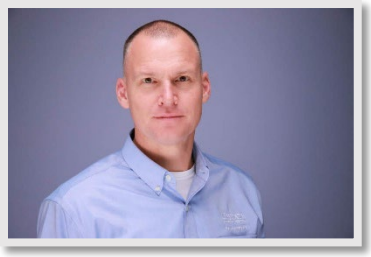
UPSTATE UNIVERSITY HOSPITAL

August 5, 2022

COVID Update

# Positive	# ICU	# Vent
22	3	0

Brian Pratt Appointed as Interim Clinical Operations Officer



We are delighted to share that Brian Pratt, MSN, RN, ACCNS-AG, CCRN has accepted the role of Interim Clinical Operations Officer at Upstate University Hospital effective July 12, 2022.

In this new role, Brian will work directly with the Chief Medical Officer, Chief Nursing Officer, and the Clinical Operations Leadership Team to meaningfully orchestrate hospital flow. In collaboration with all stakeholders, Brian will be responsible for designing practices and processes that direct our patients to the right care location, at the right time to obtain the best care, so that we can succeed at our triple aim of superior quality, efficiency of cost, and optimal value.

Brian's background includes expertise in nursing, systems management, disaster response, and logistics. During the early days of the COVID-19 pandemic, he distinguished himself by managing our supply chain during a time of critical PPE shortage. When Upstate became the vaccination hub for Central New York, Brian coordinated vaccination efforts across 5 counties, 5 distinct health departments and 366 vaccinating organizations in Central New York. Additionally, when the Department of Health tasked Upstate with creating a pathway for patients identified as high risk for allergic reactions to vaccination, Brian partnered with an allergist in Auburn to evaluate the patients and then established a pathway through our ED for safe vaccination administration in this population. Brian also orchestrated the onboarding process for the Health and Human Services DMAT teams and the USAF Disaster Medical Teams deployed to Upstate earlier this year.

As if his service to Upstate were not enough, Brian continues to serve our country as an active member of the US Army Reserves.

Please join us in welcoming Brian to his new role!

Update on IV Contrast Studies

By Jennifer Carey

We have resumed to normal operations for IV contrast ordering for inpatients, emergency department patients and outpatients. We still need to be judicious with our use of contrast since we are not yet receiving consistent shipments. We continue to monitor the contrast shortage and will communicate if we need to resume restrictions based on the supply chain. We appreciate your patience during this national shortage.

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

CMO REPORT

FROM THE DESK OF
Amy Tucker, MD, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

August 5, 2022

Updated Monkey Pox Guidance

By Christopher Dunham

Please see attached for updated guidance on Monkey Pox. This is a living document that will continue to be revised as new guidelines become availability. For the latest information about monkey pox cases in the United States, please visit: https://www.cdc.gov/poxvirus/monkeypox/index.html

NYS DOH Health Advisory

Please read the attached NYS DOH health advisory update regarding Poliomyelitis in Rockland County, NYS.

Upcoming Provider Education / Engagement Opportunities

By Darcy DiBiase

We've had some great feedback on the Primary Care Task Force Education Sessions, along with a request to promote these more directly to our own Upstate primary care providers. These sessions are focused on giving PCP's focused information to better manage conditions before they refer, when to refer and what's needed when the referral is made. These are held on the second Wednesday of the month, 12:15-1 online.

Upcoming presentations include:

12:15 pm, Wednesday, August 10: Robert Swan, MD
Associate Professor of Ophthalmology and Visual Sciences
Ophthalmology in the Primary Care Setting
https://upstate.webex.com/upstate/j.php?MTID=m834ad87f96ae3bc43f9db853b64bda16

12:15 pm, Wednesday, September 14: Auyon Ghosh, MD, MPH
Assistant Professor of Medicine, Division of Pulmonary/Critical Care
Management of Asthma and COPD in the Primary Care Setting
https://upstate.webex.com/upstate/j.php?MTID=m9dd56af30a8c9ddbe57de4390494566e

12:15 pm, Wednesday, October 12: Diane Nanno, RN
Director Transitional Care
Upstate Hospital at Home for the Primary Care Provider
https://upstate.webex.com/upstate/j.php?MTID=m4db685d95d604ad985ea0d6cf633ca4a

All past presentations (managing seizures, gout, tinnitus, new developments in monitoring type 2 diabetes) can be accessed from the Primary Care Task Force web page here: https://www.upstate.edu/primary-care/task-force.php

Please email Darcy DiBiase at dibiased@upstate.edu with questions or suggestions for future engagement opportunities.

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

CMO REPORT

FROM THE DESK OF
Amy Tucker, MD, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

August 5, 2022

Call for Nominations – Nancy Page Nursing Leadership Award

We are currently seeking nominations for the Nancy Page Nursing Leadership Award. This award will be presented at the Nursing Excellence Celebration on October 5, 2022.

The Nancy Page Nursing Leadership Award recognizes a nurse who exhibits inspirational nursing leadership in the tradition of Nancy Page. Whether in a formal role or by virtue of example, a leader lights the flame of those around them, encourages others to achieve their highest potential, enhances the enthusiasm and camaraderie of their teams, and embodies the spirit of nursing by improving the quality of care for our patients and the well-being of our staff.

To submit a nomination, please email a one-page letter of recommendation to Heidi Chapman at ChapmanH@upstate.edu describing how the nominee exemplifies the above criteria. The deadline to submit nominations is Friday, August 19, 2022.

Clinical Documentation Improvement (CDI)

By Dr. Emily Albert and Dr. Abha Harish; Co-Directors, CDI

Multiple CDI opportunities, for quality and mortality documentation impact, have been identified through new review processes for many medical and surgical services. CDI Leadership has created a tip sheet for each opportunity (see attached), with input from the CDI Physician Advisors and vetting through the CDI Medical Director and Quality Officer. As CDI staff begins taking these opportunities by way of queries in EPIC to help you improve your documentation (or avoid queries altogether), you can expect to see communication from CDI Physician Advisors regarding these concepts.

For questions, please email the CDI team at cdi@upstate.edu. Thank you to all providers for your strong work in improving documentation!

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

Revised

- Heart and Vascular Center Procedures During Prevalence of COVID-19 (COV H-01): Added section VIII. – Anesthesia procedures. Table: revised urgent/medically necessary procedures to remove MD must verify status; updated POC testing for elective and medically necessary/urgent procedures. Removed enhanced precautions for SNF patients.

- PPE Requirements During COVID-19 Pandemic (COV P-08): Removed images from the policy that contained pictures of brown paper bags.

- Upstate COVID-19 Plan (COV U-01): New – reformatted Upstate COVID-19 Plan into policy format. Revised UW C-16 under Vaccinations section.

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

CMO REPORT

FROM THE DESK OF
Amy Tucker, MD, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

August 5, 2022

Deleted

- Ambulatory Guidance: COVID Testing Prior to Ambulatory Clinic Invasive Procedures (COV A-06): has been archived from MCN. No longer needed.

- Adult Patients Admitted to Upstate Golisano Children's Hospital During COVID-19 (COV A-08) has been archived and removed from MCN. Policy no longer needed.

Wellness Update

By Dr. Leslie Kohman

Turning to One Another

There is no power greater than a community discovering
what it cares about.

Ask "What's possible?" not "What's wrong?" Keep asking.

Notice what you care about.
Assume that many others share your dreams.
Be brave enough to start a conversation that matters.
Talk to people you know.
Talk to people you don't know.
Talk to people you never talk to.

Be intrigued by the differences you hear.
Expect to be surprised.
Treasure curiosity more than certainty.

Invite in everybody who cares to work on what's possible.
Acknowledge that everyone is an expert about something.
Know that creative solutions come from new connections.

Remember, you don't fear people whose story you know.
Real listening always brings people closer together.

Trust that meaningful conversations can change your world.

Rely on human goodness. Stay together.

-Margaret Wheatley, "Turning to One Another," 2002

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

CMO REPORT

FROM THE DESK OF
Amy Tucker, MD, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

August 5, 2022

Outstanding Physician Comments

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

Adult Hematology Oncology: I can't say enough for **Dr. Sam Benjamin**, he is the greatest. I have had a lot of different doctors, but he is just great. **Dr. Lisa Lai** – kind, thoughtful, goes the extra mile.

Boarders: **Dr. Jason Wallen** – impressive!

CC Emergency Department: **Dr. Eric Hojnowski** was extremely efficient, knowledgeable, and concerned. **Dr. Kelsey Stack** – compassionate.

Dental Services: **Dr. Patrick Smith** provided exemplary care in a professional, yet friendly manner.

Dermatology Clinic: **Dr. Ramsey-Sami Farah** is not only a first-class dermatologist, but also a first-class human being.

Family Medicine: **Dr. Kaushal Nanavati** was exceptional. I was impressed with his comprehensive assessment, attention to contextual information, and his thorough explanation of related medical information. I appreciated **Dr. Kaushal Nanavati's** medical care. **Dr. Rupali Singla** is very thorough and knowledgeable.

Family Medicine at Community Hospital: **Dr. Maryanne Arienmughare** was absolutely phenomenal! I was very pleased with her care, and I feel so confident and comfortable with her! This was my first time meeting her and I was extremely impressed. Thanks, **Dr. Maryanne Arienmughare**! **Dr. Sana Zekri** is willing to have a real conversation, to explain things thoroughly, and to make me feel heard.

GYNONC MI: **Dr. Douglas Bunn** – he is amazing! **Dr. Douglas Bunn** is a wonderful doctor! **Dr. Douglas Bunn** and **Dr. Brittany Simone** are both impressive. Each are extremely knowledgeable, confident, low key in manner and are excellent guides through my cancer journey. From the day I entered into **Dr. Douglas Bunn's** care, he was extremely caring, compassionate, knowledgeable and professional. He understood about my modesty and nervousness about seeing a male doctor and took steps to make me feel at ease by talking me through the procedures while at the same time keeping the atmosphere light and friendly. I have now completed my fifth year of follow up and have great faith that I received the very best care I could have received anywhere! He, and his entire staff, are a great asset to the Upstate Cancer Center and I am grateful to them all!! I was so impressed with **Dr. Douglas Bunn** for his professionalism and his ability to put his patients at ease during a difficult time in their life. I can't thank him enough! Great care from **Dr. Douglas Bunn**. **Dr. Mary Cunningham** is outstanding in the care of her patients. **Dr. Mary Cunningham** listens to the patient's needs or concerns and addresses each one. She is always willing to take the time with patients and does not make them feel rushed.

HEMONC CC: **Dr. Ian Pinto** – caring and extremely knowledgeable about my transfer infusion from Florida to Syracuse. He has a nice manner that made me feel comfortable.

Multidisciplinary Programs Cancer Center: **Dr. Mark Crye** is amazing! Took 45 minutes with my husband and myself to make sure I was doing good after lung cancer surgery and answered every question we had! He was very patient and

caring! He is a blessing to the Upstate Cancer Center! **Dr. Mark Crye** is my amazing surgeon and very considerate and caring! **Dr. Kristin Kelly** is the best. She really cares about her patients and is an excellent doctor. **Dr. Jesse Ryan** calmed me down, fully explained things to me regarding my issue, eased my mind (somewhat) and caring. Would recommend **Dr. Jesse Ryan** to everyone. **Dr. Anna Shapiro** told me that I was able to have a breast reduction with the lumpectomy – very pleased hearing this news.

Pediatric Cancer Center: **Dr. Andrea Dvorak** was great. **Dr. Andrea Dvorak** is the absolute best! Speaking as a mother to 2 children in her care, a nurse myself, and more! She is one in a million!!

Peds Neph, Rheum, Integrative Med: **Dr. Caitlin Sgarlat Deluca** always has the attitude of "I will do what it takes to get your child the care she needs," which we really appreciate.

Pulmonology Clinic: **Dr. Dragos Manta** is impressive due to his calm demeanor, knowledge, and interpersonal skills. **Dr. Dragos Manta** is thorough, professional and a good listener. Knowledgeable about my disease process and I feel very comfortable with his observations and suggestions.

Regional Perinatal Center: We absolutely love, love, **Dr. John Nosovitch**! He made us feel so welcome, comfortable, and heard. Very knowledgeable doctor. Was willing to answer every question I had in detail. Wonderful personality! Look forward to working with him.

Rheumatology Clinic: **Dr. Hom Neupane** is great. He listens and tries to find the best treatment! **Dr. Patrick Riccardi** always takes the necessary amount of time with me. He is very professional and sensitive to my needs.

SUNY Upstate – Virtual: **Dr. Sharon Brangman** is always very attentive to our situation and shows concern for both the patient and the caregiver.

Surgery – UH LL022: **Dr. Michael Luca** explained everything in terms I could understand. **Dr. Joseph Valentino** is a very thorough, careful doctor. He takes the time to do things right. He explains everything in great detail, has a great bedside manner, and a wonderful skill as a surgeon. I'm so very glad that **Dr. Joseph Valentino** and his staff were the ones to do my surgery. **Dr. Crystal Whitney** is knowledgeable, compassionate, and easy to talk to. **Dr. Crystal Whitney** changes my feeding tube every 3 months. She is always personable. She treats me as a person not as a patient. I'm always very nervous when going in to see a doctor, but NOT with **Dr. Crystal Whitney**. She is an awesome doctor. A great asset to Upstate.

Transplant Center: **Dr. John Leggat** – best doctor, always there for me. **Dr. John Leggat** – the best, saved my life.

UHCC – Neurology: **Dr. Deborah Bradshaw** – top notch! Very well prepared for my visit and questions that I had used the portal to ask. **Dr. Deborah Bradshaw** – listens, caring, and compassionate. **Dr. Deborah Bradshaw** is awesome. **Dr. Sherif Elwan** is very good and shows concern and is quite thorough in his examinations. **Dr. Sherif Elwan** is a top doctor. **Dr. Sherif Elwan** is one of the best doctors I have known. **Dr. Dragos Mihaila** – very good! **Dr. Victoria Titoff** takes excellent care of me, listens to my concerns, and does her very best to tailor my treatment plan around all of the other medical conditions I have. **Dr. Eufrosina Young** is always compassionate and understanding and takes the time to

discuss my husband's needs with him and his family. **Dr. Awss Zidan** did a great job explaining how this issue will be treated and look forward to working with him.

University Cardiology: **Dr. Robert Carhart** – first class ability to make you understand all concerns. I always enjoy my appointment with **Dr. Robert Carhart** and his staff. If you have any concerns or any questions, they will take the time to explain everything we ask about, my heart condition, drugs or any new symptoms that I might have. **Dr. Robert Carhart** and his staff are very thorough and professional. It's always a pleasure to come to **Dr. Robert Carhart's** office.

University Center for Vision Care: **Dr. Samuel Alpert** – very professional. I have always considered myself very fortunate to have **Dr. Robert Fechtner** for my eye care. **Dr. Robert Fechtner** – personality, knowledge, and sensitivity to my scared concerns. I truly believe he is one of the best. **Dr. Preethi Ganapathy** always impresses me with her care. Everything went smoothly on my visit with **Dr. Preethi Ganapathy**. I am truly thankful for **Dr. Robert Swan**. Always **Dr. Robert Swan** – he always knows every detail of my eye issue and what needs to be done – even when I give him a hard time lol!

University Geriatricians: **Dr. Andrea Berg** is exceptionally awesome. Highly recommend **Dr. Andrea Berg**. **Dr. Sharon Brangman** was an excellent, friendly person to talk to. I was educated and know all I need about the geriatric services at Upstate. **Dr. Dona Varghese** took the time and showed sincere interest in listening to my experience. She explained possibilities, described treatment options, shared her thought process in why she would choose certain treatment options and provided detailed instructions and follow up plans. My partner and I really appreciate and are grateful for her knowledge and care. **Dr. Dona Varghese** is very thorough, very pleasing to talk with, and very concerned about her patients.

University Internists: **Dr. Tingyin Chee** is very personable. She makes me feel very comfortable. **Dr. Vincent Frechette** – great! **Dr. George Gluz** is a very capable physician, and is willing to communicate with his patients. My transition to **Dr. George Gluz** was flawless. Because of the plethora of medical issues, I was certain that I would have to overly discuss and bring him up to speed on everything that was going on and much to my surprise he had already read through my entire record and was ready to discuss the medical issues I was there for. **Dr. Catherine White** just seems like a capable, professional, human who strives to do good work. **Dr. Catherine White** is awesome!

Upstate Brain & Spine Center: **Dr. Satish Krishnamurthy** has an easy manner about him. Explained my options.

Upstate Pediatrics: **Dr. Jaclyn Sisskind** for coming over to check on her, realizing it was not going well, and helping us while she was upset and in pain.

4North at CC: **Dr. Matthew Glidden** – the best! **Dr. Matthew Glidden** treated me as an individual and not a number. He was very concerned about my progress and overall health. Super doctor.

05A: **Dr. Mashaal Dhir's** fantastical surgical skills and compassionate medical care.

06B: **Dr. Victor Tung** – kind, careful, helpful.

08E: I remember **Dr. Mark Marzouk** keeping me calm in the OR and being very respectful and professional.

08F: **Dr. Dana Aiello** did a wonderful job coordinating after care. It seemed he really was concerned about what the next steps would be.

08G: **Dr. Michael Archer** – very caring and concerned doctor.

10E: **Dr. Jeffrey Albright** provided excellent care.

Thank you for all that you do!

~Amy

UPSTATE
UNIVERSITY HOSPITAL

HIM MD *Guideline* Communication: HIV

Explanation: The term "HIV infection, PMH, HIV" are ambiguous terms and are not sufficient for code assignment as there are two codes that represent "HIV infection". Further clarification is required.

***Z21 - Asymptomatic HIV infection status**:* represents "HIV-positive only" patients, whether they are receiving HAART treatment or not, that are described in the medical record as being "HIV-Infection". If the patient has "HIV infection only", state "HIV positive status only"

***B20 - HIV disease**:* represents an HIV infection with a documented HIV related condition, such as opportunistic infection or recurrent infection, cachexia, etc.

If the patient has:

- Ever been diagnosed with AIDS but it is not being documented in the current encounter
- Ever been diagnosed with HIV disease but it is not being documented in the current encounter
- The patient has ever been diagnosed with an HIV Infection and it is not linked to a related illness in the current encounter, such as:
  - Opportunistic &/or recurrent infections (Candida, Coccidioidomycosis, Cryptococcus, Cryptosporidiosis, Histoplasmosis, Herpes Simplex, Mycobacterium, Pneumocystis, Toxoplasmosis, CMV), Kaposi's Sarcoma, Burkitt's Lymphoma (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5710a2.htm)
- The CD4 count is currently less than 200 and AIDS or HIV Disease is not documented
- The CD4 count is PMH less than 200 and AIDS or HIV Disease is not documented

Once a patient has been diagnosed as having any of the above conditions, they should always be documented as having HIV disease or AIDS from that point forward and for all future hospitalizations

Please always clarify the HIV Status as:

1. HIV positive status only without any PMH or current HIV related illness
2. HIV Disease with PMH or current HIV related illness
3. AIDS

Please contact CDI Physician Advisor, Dr. Abha Harish, with any questions.

6/2022

UPSTATE
UNIVERSITY HOSPITAL

Acute Pulmonary Insufficiency Following Surgery

Acute post-op pulmonary insufficiency is an MCC following surgery and it is not PSI.

However, it is a complication *code* and associated with postoperative complications following surgery such as atelectasis, pleural effusions and prolonged weaning from oxygen. It requires resource intensive treatment beyond what is expected, such as pulmonary toileting, and ongoing supplemental oxygen use beyond standard postoperative expectations, telemetry, step down level of care, increased LOS, etc..

This can be due to risk factors such as preexisting conditions like COPD, Smoking, OSA, OHS, and/or the severity of the surgery. In general, this term falls short of respiratory failure with milder symptoms but beyond expected care for the specific type of surgery.

The ICD 10 code for Acute Post-Op Pulmonary Insufficiency was *created* to capture the cost of treating those patients requiring greater than expected resources such as LOS, higher level of care, ongoing treatment.

This is a resource utilization definition and not a clinical standard.

The diagnosis becomes reportable when the post-operative care exceeds the expected or average post op recovery services and, because it is classified as an ICD-10 complication code, coding guidelines require the documentation clearly links the condition to the surgery, risk factors and what was beyond expected treatment provided.

Common Causes of Acute Post-Op Pulmonary Insufficiency

Atelectasis, interstitial lung edema, incision location causing tidal volume reduction
Reduced lung expansion from post op pain, supine position, abdominal distension, sedatives, and narcotics. Increased ventilation rate due to anxiety causing hyperinflation
Diaphragmatic splinting from pneumoperitoneum, especially following laparoscopic surgery
SIRS from trauma surgery, causing edema in lung parenchyma

Please consider the following for complete documentation

- State condition: acute pulmonary insufficiency following surgery
- Document: What was the unexpected treatment, treatment required beyond standard postoperative expectation for this type of surgery
- Link: Are there preexisting conditions contributing the unexpected care
- Link: Was this also due to components of surgery such as anesthesia, length of surgery, positioning, etc..

Document: Acute pulmonary insufficiency following surgery, unexpected tx: for this type of surgery due to comorbid conditions and /or surgery:(reason must be given; comorbid conditions must be given.)

Please contact CDI Physician Advisor, Dr. Emily Albert, with any questions.

6/2022

UPSTATE
UNIVERSITY HOSPITAL

Debilities: Mortality Risk Adjustment

Explanation: Documentation of 'deconditioning' and/or 'functional decline' are general terms that do not correspond with an ICD-10 code. An individual's overall decline is representative of the acuity or severity of their condition. These circumstances often increase resources required during hospitalization, result in prolonged hospitalization or post-discharge placement, and/or impair recovery, therefore increasing mortality risk. Diagnoses are often omitted from provider documentation. *Specified debilities and linkage to underlying conditions or circumstance is required to capture this frequent mortality variable.*

Debility related ICD-10 conditions and codes:

- **Neoplastic related fatigue** – fatigue must have linking documentation to malignancy
- **Functional quadriplegia** – quadriplegia in the absence of spinal cord injury, usually related to underlying conditions like Alzheimer's disease, Parkinson's, ALS, Cerebral palsy, Huntington's disease, morbid obesity, frailty, debilitating arthritis, etc.
- **Chronic Fatigue**
- **Age related physical debility** – functional and/or cognitive debility related to age
- **Limitation of activities due to disability** – may be related to acute or chronic disability or disabling conditions
- **Bed confinement status** (Bedbound/Bedridden)
- **Reduced mobility** – must be related to an underlying condition or circumstance

Considerations for Specifying Debility

- When patients are described as 'deconditioned' or specified with 'functional decline' or similar terminology
- Patients who present with weakness or fatigue
- Documentation in PT/OT, nursing, or progress notes specifies or alludes to:
  - 'frail' description
  - exercise intolerance
  - pain or discomfort with activity
  - decreased strength, endurance, or balance
  - coordination difficulties impairing functional status
  - difficulty performing ADLs with or without assistance
  - nursing assistance required for ambulation, positioning, feeding, etc. in the absence of sedation or paralytics, or chronic debility like paraplegia/quadriplegia

Documentation Concepts

- Should reflect link to underlying condition, when applicable
- Must have documented support of treatment, monitoring, contribution to extended hospitalization, or increase in nursing care - PT/OT, SNF placement, nursing assistance, ambulation aids (cane, walker, wheelchair), contact guard, hoyer assist, etc.

Please contact CDI Physician Advisor, Dr. Abha Harish, with any questions.

7/2022

UPSTATE
UNIVERSITY HOSPITAL

Coagulation Defect: Mortality Risk Adjustment

Explanation: Coagulopathy is any derangement of hemostasis resulting in either *excessive bleeding or clotting*. This diagnosis is often omitted from provider documentation. Etiology and linking the documentation is required to capture this frequent mortality variable.

Hypercoagulable state: D68.69 represents hypercoagulable states that are acquired disorders of thrombosis due to complex and multifactorial mechanism. *If systemic anticoagulation is used to treat acute clots or prevent new clot formation, a hypercoagulable state should be documented.*

Examples of conditions causing acquired secondary coagulopathy: Active cancer, Trauma Myeloproliferative disorders, HIT, Nephrotic syndrome, SS crisis, Burns, Trauma, Sepsis, COVID Antiphospholipid antibodies, Mechanical mechanism of the atrium due to afib/flutter. Risk factors: Thrombophilia, obesity, dehydration, hormonal shifts such as pregnancy or menopause, lack of activity, recent surgery COVID 19, infection. Mechanical in nature such as Afib, smoking, hormonal therapy.

Hemorrhagic disorders: D68.32 due to extrinsic circulating anticoagulant, antithrombotic, and anti-platelets: If bleeding such as hemoptysis, hematuria, hematemesis, hematochezia, etc., that is *associated* with a drug, as part of anticoagulation therapy and has an established cause and effect association: "complicated by or contributing to, associated with, due to the bleeding is due to the patient medication"

Trauma & Surgical Quality Tip: When documenting these coagulation diagnoses as POA, they can be used as a global exclusion to some postoperative preventable complications (PPC), HAC and other quality metrics.

Documentation examples:

- Coagulopathy due to liver failure, continue to monitor
- Hypercoagulable state due to COVID -19, start heparin
- Bleeding ulcer due to elevated INR from appropriate warfarin use contributing to the bleed.
- Hypercoagulable state due to trauma, continue Lovenox for prevention
- Hypercoagulable state resulting from A-Fib, continue Warfarin
- Hypercoagulable associated with cancer, has active DVT, no other provoking factors, continue Eliquis
- Hypercoagulable state with cardioembolic stroke related to A-Fib
- Epistaxis due to accidental overdose of coumadin (explain the reason for the INR)

Please contact CDI Physician Advisor, Dr. Emily Albert, with questions.

UPSTATE
UNIVERSITY HOSPITAL

Paroxysmal atrial fibrillation, anticoagulant therapy and acquired hypercoagulable state

ICD-10-CM/PCS Coding Clinic, **Second Quarter ICD-10 2021** Page: 8 Effective with discharges: June 7, 2021

Related Information

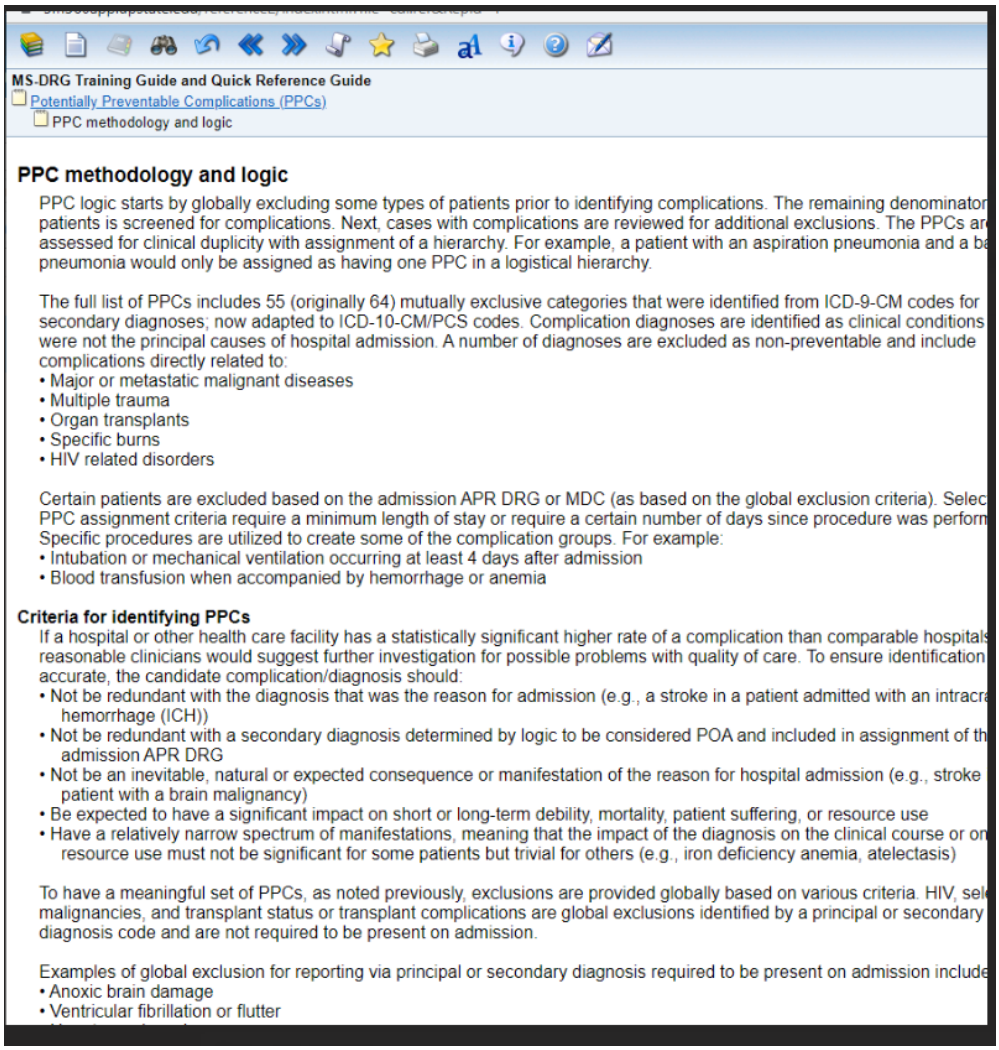
Question:

A 79-year-old patient is diagnosed with secondary hypercoagulable state and has a history of paroxysmal atrial fibrillation (AF) on anticoagulant maintenance. Does the provider need to link the secondary hypercoagulable state with the atrial fibrillation? What is the appropriate ICD-10-CM code assignment for secondary hypercoagulable state in this scenario?

Answer:

Assign code D68.69, Other thrombophilia, for secondary hypercoagulable state. Secondary hypercoagulable state is specifically indexed to this code and includes secondary hypercoagulable state NOS.

Secondary hypercoagulable states are acquired disorders of thrombosis due to complex and multifactorial mechanisms. Patients with AF on chronic anticoagulant therapy may have an increased incidence of acquired hypercoagulable state. However, unless specifically documented by the provider, coding professionals should not assume the presence of a secondary (acquired) hypercoagulable state, in patients with atrial fibrillation. In this case, although the provider did not link the hypercoagulable state to the atrial fibrillation, secondary hypercoagulable state was documented by the provider.



MS-DRG Training Guide and Quick Reference Guide
Potentially Preventable Complications (PPCs)
PPC methodology and logic

PPC methodology and logic

PPC logic starts by globally excluding some types of patients prior to identifying complications. The remaining denominator patients is screened for complications. Next, cases with complications are reviewed for additional exclusions. The PPCs ar assessed for clinical duplicity with assignment of a hierarchy. For example, a patient with an aspiration pneumonia and a b pneumonia would only be assigned as having one PPC in a logistical hierarchy.

The full list of PPCs includes 55 (originally 64) mutually exclusive categories that were identified from ICD-9-CM codes for secondary diagnoses; now adapted to ICD-10-CM/PCS codes. Complication diagnoses are identified as clinical conditions were not the principal causes of hospital admission. A number of diagnoses are excluded as non-preventable and include complications directly related to:

- Major or metastatic malignant diseases
- Multiple trauma
- Organ transplants
- Specific burns
- HIV related disorders

Certain patients are excluded based on the admission APR DRG or MDC (as based on the global exclusion criteria). Selec PPC assignment criteria require a minimum length of stay or require a certain number of days since procedure was perform Specific procedures are utilized to create some of the complication groups. For example:

- Intubation or mechanical ventilation occurring at least 4 days after admission
- Blood transfusion when accompanied by hemorrhage or anemia

Criteria for identifying PPCs

If a hospital or other health care facility has a statistically significant higher rate of a complication than comparable hospitals reasonable clinicians would suggest further investigation for possible problems with quality of care. To ensure identification accurate, the candidate complication/diagnosis should:

- Not be redundant with the diagnosis that was the reason for admission (e.g., a stroke in a patient admitted with an intracr hemorrhage (ICH))
- Not be redundant with a secondary diagnosis determined by logic to be considered POA and included in assignment of th admission APR DRG
- Not be an inevitable, natural or expected consequence or manifestation of the reason for hospital admission (e.g., stroke patient with a brain malignancy)
- Be expected to have a significant impact on short or long-term debility, mortality, patient suffering, or resource use
- Have a relatively narrow spectrum of manifestations, meaning that the impact of the diagnosis on the clinical course or on resource use must not be significant for some patients but trivial for others (e.g., iron deficiency anemia, atelectasis)

To have a meaningful set of PPCs, as noted previously, exclusions are provided globally based on various criteria. HIV, sel malignancies, and transplant status or transplant complications are global exclusions identified by a principal or secondary diagnosis code and are not required to be present on admission.

Examples of global exclusion for reporting via principal or secondary diagnosis required to be present on admission include

- Anoxic brain damage
- Ventricular fibrillation or flutter

Please contact CDI Physician Advisor, Dr. Emily Albert, with questions.

UPSTATE
UNIVERSITY HOSPITAL

Pulmonary Hypertension: Mortality Risk Adjustment

Explanation: Pulmonary hypertension can be coded when there is reasonable evidence of elevated blood pressure in the pulmonary circulation ***and*** associated etiology. The causal link, 'due to', will allow for clarification on inherent circumstances and when to report.

Common Imagining Findings:

- **Echocardiogram:** Estimated PASP > 35 - 40 mmHg and/or TRV (peak tricuspid regurgitant jet velocity) equal to/greater than 2.8 m/sec, which are then combined with other risk signs, ie: increased IVC-diameter or flattening of the interventricular septum, **with risk factors**
- **Right Heart Cath:** mPAP > 20 **with risk factors**
- **CT Findings:** interventricular septal bowing, ie deviation of the septum into the left ventricular cavity due to increased right intra-ventricular pressure, or "contrast reflux into the inferior vena cava **with risk factors**

Cor pulmonale can be diagnosed when the right side of the heart is affected by a pressure overload that induces changes in RV function and morphology. To diagnose cor pulmonale there should be evidence of pulmonary HTN-induced altered structure and/or function of the right ventricle, such as hypertrophy or dilation. Although cor pulmonale may be considered inherent to some types of pulmonary hypertension, its presence should be documented, as both can be reported when applicable, in accordance with coding guidelines.

Cor pulmonale should **not** be diagnosed when RV dysfunction is due to left-sided heart disease or congenital heart disease. Cor pulmonale is usually a chronic condition but it can occur acutely secondary to a pulmonary embolism.

To support accurate code assignment for patients with pulmonary hypertension, providers should specify:

- The pulmonary hypertension group classification (1-5) or the etiology of the pulmonary hypertension
- Chronic cor pulmonale, if present
- Right ventricular failure, if present (include acuity)
- Example: ***Group 3 pulmonary hypertension secondary to COPD with chronic cor pulmonale and chronic right ventricular failure***

For patients with an ***acute pulmonary embolism***, documentation should specify **acute** cor pulmonale, if present. Coding guidelines currently only allow **acute** cor pulmonale code assignment for patients with a pulmonary embolus. This cannot be inferred based on documentation of intermediate or high risk pulmonary embolism or by use of the terms 'submassive' or 'massive'. Specific documentation of acute cor pulmonale is required for accurate code assignment.

Please contact CDI Physician Advisor, Dr. Markus Gutsche with any questions.

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

DATE: August 4, 2022

TO: Healthcare Providers, Hospitals, Clinical Laboratories, and Local Health Departments (LHDs)

FROM: New York State Department of Health (NYSDOH), Division of Epidemiology

HEALTH ADVISORY: Update Regarding Poliomyelitis in Rockland County, New York State

For clinical staff in Epidemiology/Infection Control, Emergency Department, Infectious Disease, Neurology, Radiology, Nursing, Internal Medicine, Pediatrics, Family Medicine, Intensive Care, Pharmacy, Laboratory Services, and all patient care areas.

Updates Since Last Advisory

- NYSDOH is conducting enhanced surveillance activities to detect additional polio cases. These surveillance activities may be modified as additional information becomes available and as we enter the height of enterovirus season.
- Approximately 75% of poliovirus infections are asymptomatic, and approximately 25% have mild signs and symptoms compatible with other acute viral illnesses, e.g., sore throat, fever, tiredness, nausea, headache, stomach pain. Poliovirus can also cause meningitis.
- When evaluating individuals who live, work, or attend school in southeastern New York, health care providers should have a heightened vigilance for polio.
- Patients who are unimmunized or incompletely immunized against polio are at higher risk.
- Polio should be part of the differential diagnosis in patients who present with an acute illness compatible with either paralytic or non-paralytic polio, particularly if they are unimmunized.

- **Surveillance for non-paralytic polio – non-specific viral symptoms**
  - NYSDOH recommends that the following individuals undergo testing for enterovirus (poliovirus is a type of enterovirus):
    - Unimmunized for polio, or unknown immunization status (patient report acceptable if records are not available), and
    - Resident of Rockland or Orange County, or works or attends school in Rockland or Orange County, and
    - Symptoms consistent with non-paralytic polio:
      - Sore throat and/or fever, AND
      - At least two of the following symptoms (sore throat and/or fever can count as one or both): sore throat, fever, tiredness, headache, nausea, stomach pain.
    - If tested, negative results for COVID-19, influenza, streptococcal infection, and other respiratory pathogens (with the exception of enterovirus or "rhino-enterovirus", for which positive results might indicate poliovirus).
  - Individuals who meet the criteria above should have a diagnostic **stool specimen collected for enterovirus PCR** and **sent to the clinical laboratory** that you routinely use.

        - If a stool specimen cannot be obtained, then an oropharyngeal (OP) swab is also acceptable, although stool is preferred.
        - The relevant ICD-10 code should be included on the lab requisition (e.g., B34.9, J02.9).
        - **The Rockland or Orange County connection and the polio immunization status should be included on the lab requisition.**
        - An enterovirus-specific PCR test should be ordered; that is, point-of-care or other tests that return a "rhino-enterovirus" result are not acceptable.
    - NYSDOH will contact clinical laboratories and request that they send specimens positive for enterovirus to the New York State public health laboratory, Wadsworth Center , for poliovirus testing.

- **Surveillance for non-paralytic polio – meningitis**
    - NYSDOH recommends that the following individuals with meningitis undergo diagnostic testing for poliovirus:
        - Resident of Rockland or Orange County, or works or attends school in Rockland or Orange County, and
        - If tested, positive results for enterovirus in cerebrospinal fluid (CSF). If not tested for enterovirus, then no other apparent cause for the meningitis.
    - Individuals who meet the criteria above should have a diagnostic **stool specimen collected for enterovirus PCR** and **sent to the clinical laboratory** that you routinely use.
        - If a stool specimen cannot be obtained, then an OP swab is also acceptable, although stool is preferred.
        - **The Rockland or Orange County connection should be included on the lab requisition.**
        - An enterovirus-specific PCR test should be ordered; that is, point-of-care or other tests that return a "rhino-enterovirus" result are not acceptable.
    - NYSDOH will contact clinical laboratories and request that they send specimens positive for enterovirus to the New York State public health laboratory, Wadsworth Center, for poliovirus testing.

- **Surveillance for paralytic polio or strongly-suspected non-paralytic polio**
    - **Immediately notify the local health department** where the patient resides and/or contact the New York State Department of Health. See additional information below in section entitled "Guidelines for Healthcare Providers".
    - The specimen collection recommendations in this section apply for cases of possible paralytic polio, or when there is a high suspicion of non-paralytic polio (e.g., compatible illness in a contact of a polio case).
    - Specimens should be collected as follows (in order of priority) and **sent directly to Wadsworth Center**:
        - **Two stool specimens** collected 24 hours apart
        - **Oropharyngeal swab**
        - **Nasopharyngeal swab**
        - **Cerebral spinal fluid (CSF;** 2-3 cc, if available, in sterile collection tube**)**
        - **Serum** (acute and convalescent), collected **before** treatment with intravenous immunoglobulin (IVIG; 2-3 cc in red or tiger-top tube)
        - A shipping manifest from an electronically-submitted Remote Order OR an Infectious Disease Requisition form should accompany all specimens sent to Wadsworth, noting symptoms and immunization history.
        - Specimens should be stored refrigerated and shipped on frozen gel packs.

- **Specimen collection, storage, and shipping**
    - For stool specimens, a quarter-sized amount of stool should be collected in a sterile, wide-mouth container with no additives.
    - For OP swabs, flocked swabs are preferred. Sterile Dacron or rayon swabs with plastic or metal handles may also be used. Do NOT use cotton or calcium alginate swabs or swabs with wooden sticks. Place the swab in liquid viral transport media (VTM) or universal transport media (UTM). The same swabs and media used for COVID or influenza PCR testing can be used. Do not use saline or send dry swabs.
    - Specimens should be stored refrigerated and shipped on frozen gel packs.

Summary of Case

- A case of poliomyelitis has been identified in Rockland County, New York.
- An adult presented to an emergency department with respiratory symptoms, fever, neck stiffness, and back pain. The symptoms progressed to include paralysis.
- Samples were tested for several pathogens as part of the evaluation for acute flaccid myelitis (AFM). **A stool sample tested positive for poliovirus.**
- Subsequent sequencing showed that the strain was NOT wild-type virus but rather was revertant poliovirus Sabin type 2.
- Poliovirus Sabin type 2 is used in some formulations of oral polio vaccine (OPV). OPV is longer licensed, available, or administered in the United States and has not been used in the United States since 2000. Rather, inactivated polio vaccine (IPV) is used in the US.
- The individual was not vaccinated against polio.
- There is an ongoing investigation to determine community risk.

Clinical Presentation of Poliomyelitis

- Most people with poliovirus infection have no symptoms or only a non-specific febrile illness. Fewer than 1 in 100 people will develop acute flaccid weakness of the limbs.
- Progression of weakness is rapid and often associated with fever and muscle pain.
- Weakness is typically asymmetric and more severe proximally than distally.
- Deep tendon reflexes are absent or diminished.
- Bulbar paralysis can result in respiratory distress and often requires mechanical ventilation.
- There may be a history of fever, sore throat, nausea, and malaise up to one week before weakness onset.
- Polio is a disabling and life-threatening disease which can affect a person's brain and spinal cord, leading to paralysis, meningitis, paresthesia, and long-term disability.
- There can be long-term sequelae, post-polio syndrome, even decades after the original infection.
- Polio has been eliminated from the United States, but it still occurs in other parts of the world, especially where there are low vaccination rates. Wild-type polio has been eliminated everywhere but Afghanistan and Pakistan. Recently, cases of polio caused by revertant Sabin-derived strains have been identified in several countries in Europe, Asia, and Africa, and poliovirus has been detected in wastewater in the UK. The last case of polio identified in the US was in 2013 in an immunocompromised infant who received OPV abroad.
- The incubation period is 3 to 6 days for non-paralytic poliomyelitis and 7 to 21 days for onset of paralysis in paralytic poliomyelitis.
- Transmission is fecal-oral, respiratory, or oral-oral.

- Poliovirus is highly infectious and is most transmissible up to 14 days before and after onset of symptoms, although ongoing fecal shedding can occur for weeks.
- The best way to protect your patients is to maintain high immunity against polio in the population through vaccination, along with rapid identification and isolation of suspected polio cases.

Guidelines for Healthcare Providers

- Poliomyelitis should be considered in the differential for patients with acute flaccid weakness, particularly if they are not vaccinated for polio.
- In the event paralytic or non-paralytic polio is suspected in a patient:
  - Ideally, only healthcare workers **with evidence of complete polio immunization** should provide care to the patient. For adults, this would be at least three documented doses of poliovirus-containing vaccine. If healthcare worker polio immunization status is not tracked, then any healthcare workers who know or suspect that they have not received polio immunizations (e.g., as part of routine childhood immunizations) should be excluded from care of the patient. Efforts should be made to document polio immunization of healthcare workers whenever possible, especially when polio is known or high on the differential diagnosis.
  - Standard and Contact Precautions should be used while evaluating a potential or confirmed case, and facility infection control should be notified immediately.
  - The patient should be evaluated for flaccid weakness by a neurologist.
  - **Immediately notify the local health department** where the patient resides and/or contact the New York State Department of Health.
  - Test for polio as recommended above, section entitled “Surveillance for paralytic polio or strongly-suspected non-paralytic polio”.
  - Other routine pathogen-specific testing should continue at hospital laboratories as determined by the patient's clinical picture.

Polio Immunization Recommendations

- Children, adolescents, and adults who are unvaccinated or do not know if they were vaccinated are at risk for polio if exposed and should be offered an outbreak dose of IPV if they reside in an area with possible community transmission of poliovirus or if they have other potential exposures.
- Previously vaccinated individuals who are at risk for exposure because of their community of residence or who have had close contact with a patient infected with poliovirus should also receive a booster dose of IPV.
- Polio vaccine may be given to children and adults as a stand-alone vaccine (not combined) in an outbreak setting.
- IPV or the first dose of combination products containing IPV can be given as early as 6 weeks of age and should be considered for administration when infants who are at least 6 weeks old and reside in an area with possible community transmission of poliovirus present for care.
- Polio vaccine can be given during pregnancy and is recommended if the individual is at risk of exposure. Pregnant persons should discuss the risks and benefit of IPV with their healthcare provider.
- Polio vaccine may be given at the same time as other vaccines.
- IPV, the only polio vaccine available in the US, is highly effective, with 90% or more of vaccine recipients developing protective antibody levels to all three poliovirus types after 2 doses, and 99% developing protective antibody levels following 3 doses.
- Unvaccinated adults at risk for poliovirus infection should get three doses of IPV: two doses separated by 1 to 2 months, and a third dose 6 to 12 months after the second dose. Often

during an outbreak, the first dose may be administered by a public health agency but follow up doses can be obtained where the patient receives regular health care.
- The schedule for polio vaccination for unvaccinated or under-vaccinated children through age 17 years is 2 doses of IPV separated by 4–8 weeks, and a third dose 6–12 months after the second dose. For details and age groups, refer to the ACIP IPV catch-up vaccine table.
- If you are interested in obtaining IPV for your patients, please contact the Bureau of Immunization via email at immunize@health.ny.gov or by phone at (518) 473-4437.

Acute Flaccid Myelitis

- AFM is a rare but serious paralytic condition that adversely affects the nervous system, specifically the gray matter of the spinal cord, which in turn causes muscles and reflexes in the body to weaken.
- AFM can be difficult to diagnose because it shares many symptoms with other neurological diseases, including transverse myelitis, Guillain-Barre syndrome, and polio.
- Poliomyelitis should be considered as part of the differential diagnosis.
- Samples sent to Wadsworth are tested for multiple potential causes of AFM.
- Most cases are seasonal and occur between August and November. Full details can be found at NYS recent AFM Health Advisory: https://apps.health.ny.gov/pub/ctrldocs/alrtview/postings/NYSDOH_AFM_Health_Advisory_06242022_FINAL_1656100564923_0.pdf
- Report suspected cases promptly to the NYSDOH at 518-473-4439 during business hours or 866-881-2809 evenings, weekends, and holidays or via email at AFM@health.ny.gov or BCDC@health.ny.gov

Resources

- CDC Suspect Polio Factsheet: https://www.cdc.gov/polio/pdf/Polio-Fact-Sheet-Suspect-Polio-508.pdf
- ACIP Recommendations for Polio Vaccination: https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/polio.html
- CDC Polio Vaccination: What Everyone Should Know: https://www.cdc.gov/vaccines/vpd/polio/public/index.html
- CDC Polio Vaccine Information Statements: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/ipv.html
- CDC Polio Education Materials: https://www.cdc.gov/vaccines/vpd/polio/public/index.html#educational-materials
- Vaccine Derived Polio FAQ: https://www.cdc.gov/vaccines/vpd/polio/hcp/vaccine-derived-poliovirus-faq.html
- Clinicians with questions can contact the NYSDOH at 1-866-881-2809 evenings, weekends, and holidays. In New York City clinicians may contact the healthcare provider access line at 1-866-692-3641.

SUNY Upstate Monkey Pox PUI Initial Guidance Document: August 1 2022

Possible Case Presentation: (https://www.cdc.gov/poxvirus/monkeypox/symptoms.html)

1. The incubation period (time from infection to symptoms) for monkeypox is usually 7–14 days but can range from 5–21 days.
2. Within 1 to 3 days (sometimes longer) after the appearance of fever, the patient develops a rash
3. . Rash classically begins on the face and hands. However, cases in which patients have oral and/or genital lesions ONLY have been seen in the current outbreak.
    a. Lesions progress through the following stages before falling off:
        i. Macules
        ii. Papules
        iii. Vesicles
        iv. Pustules
        v. Scabs
4. The illness typically lasts for 2–4 weeks
5. Recently reported case series report the following:
    - In this case series, 95% of the persons presented with a rash (with 64% having <10 lesions), 73% had anogenital lesions, and 41% had mucosal lesions (with 54 having a single genital lesion). Standard systemic features preceding the rash included fever (62%), lethargy (41%), myalgia (31%), and headache (27%); lymphadenopathy was also common (reported in 56%). Concomitant sexually transmitted infections were reported in 109 of 377 persons (29%) who were tested.

    For more details: https://www.nejm.org/doi/full/10.1056/NEJMoa2207323

Treatment:

1. Recommended for patients with severe illness (including severe pain from skin lesions) or risk for severe illness (children, severely immunocompromised), healthcare workers
    a. Adult or pediatric ID should be consulted for all patients with confirmed or suspected MPV who will be hospitalized
    b. Current guidance includes calling infectious disease on call for outpatients who may require treatment as treatment algorithms for outpatients are being established
2. For more information - https://www.cdc.gov/poxvirus/monkeypox/clinicians/treatment.html

SUNY UPSTATE EMERGENCY DEPARTMENTS

INTIAL COMMUNCIAITONS:

1. Triage RN or Frontline staff will notify the ED Charge RN **IMMEDIATELY**
2. **ED Charge RN will notify:**
    a. ED Attending,
    b. Pharmacy
    c. Administrative Supervisor
    d. Infection Prevention Service (number listed on AMION)
3. **ED Attending will**
    a. Notify and discuss PUI with Hospital Epidemiologist and/or Infection Prevention
4. **Administrative Supervisor will notify**
    a. Public and Media Relations
    b. Environmental services shift Supervisor
    c. Environmental Health and Safety staff on call
    d. Administrator on Call

EXTERNAL COMMUNCAITONS:

1. All initial communications to external agencies (LHD, CDC, etc.) will be completed by the Hospital Epidemiologist and/or Infection Prevention.

a. Healthcare providers must immediately report suspect cases of monkeypox to their local health department (LHD).
b. Reporting should be to the county where the patient resides.
c. Outside of New York City, contact information is available at: https://www.health.ny.gov/contact/contact_information.
d. If you cannot reach the LHD where the patient resides, please contact the NYSDOH Bureau of Communicable Disease Control at 518-473-4439 during business hours or 866-881-2809 on evenings, weekends, and holidays.

INITIAL ED ACTION ITEMS:

1. If PUI triggers the infectious disease questions or is transported via EMS with suspicion of Monkeypox: *(see policy CM T-32 for more info)*
2. **BOTH AIRBORNE AND CONTACT PRECAUTIONS MUST BE TAKEN (including EYEWARE)**
3. Patient Placement: **Negative Pressure is Required**
    a. Have the patient don a surgical mask immediately
    b. If Downtown ED: Place the patient in 34 if available.
        i. If occupied, place the patient in any open room and make 34 available immediately
    c. If Community ED: Room 7 or if multiple PUI utilizes GEM Care.
    d. If Pediatric Patient: Room 8
4. **REMOVE ALL UNNECESSARY ITEMS FROM THE PATIENT ROOM BEFORE PLACEMENT.** EVS will place two-step on trash cans with lids and appropriately labeled them with biohazard labels.
5. **ALL PATIENT WASTE MUST BE KEPT IN THE PATIENT ROOM.**
6. List of ALL employees who have come in contact with PUI. (Utilize form #95395 developed for Covid)
7. Update as needed and ensure Employee Health & infection Prevention receives a copy.
8. Immediately identify and dedicate staff for PUI (One RN/ One Physician) depending on the patient's condition
9. **If PUI is admitted:**
    a. Notify the transport team of the need for PPE if requested. Follow COV A-01 and COV B-03 Appendix C.
    b. Coordinate patient transport with Environmental Services and Environmental Health and Safety
    c. Dedicate at least 5 RN to specific care of PUI for the duration of the stay.
    d. Consider Hospital at Home if possible.
10. **If PUI will be discharged:**
    a. ED Attending, Hospital Epidemiologist, and NYSDOH/Onondaga County Public Health will discuss a telemedicine team to follow up with patients isolated at home.

Outpatient/Clinic Areas

1. Patient Placement: Negative Pressure is required, but if not possible, place the patient in a secluded area or patient room. Request and utilize an Air filtration machine.
2. **REMOVE ALL UNNECESSARY ITEMS FROM THE PATIENT ROOM BEFORE PLACEMENT.** EVS will place two-step on trash cans with lids and appropriately labeled them with biohazard labels.
3. Have the patient don a surgical mask immediately
4. If the patient presents with a caregiver, please separate the caregiver from others in the waiting room and staff until epidemiology is consulted.
5. Any staff member that interacts with PUI must don PPE (both contact and airborne precautions plus eyewear)
6. Create a list of employees who have come in contact with PUI. Update as needed and ensure Employee Health & infection Prevention receives a copy. (see exposure risk below)
7. Notify Unit Charge Nurse, Physician on duty, and Clinic/outpatient manager.
8. Outpatient/ambulatory leadership will notify the AOC *(see policy DIS M-81 for more info)*
9. Physician on-site will confirm patient meets PUI status with Hospital Epidemiologist as soon as possible. In addition, notify the Infection Prevention Service (number listed on AMION) to facilitate this process.

10. Transportation to Hospital, if needed, will be coordinated with EMS, ED Attending & the Onondaga 911 Center per regular communications.

Specimen Collection for Suspected Monkeypox

Prior to specimen collection:

- Notify the Infection Prevention Service (AMION).
- Obtain a specimen collection kit
  - Downtown: Microbiology, 5th floor Cancer Center, 4-4459
  - Community: Laboratory, basement, 315-492-5531.
- Perform hand hygiene and don appropriate PPE.
- Label provided swab device(s) with the patient's name and date of birth, date of collection, specimen source, and name of person collecting the specimen.

Specimen Collection

- Vigorously swab or brush the base of the lesion with one of the swabs. Repeat sampling with a second swab from the same lesion.
- Insert both swabs into the device sleeve. Two swabs should be collected to ensure adequate material is sampled.
- Repeat the collection process using two new swabs on a second lesion (if present) for a total of four swabs per patient.
- Place the tube(s) with swabs into the provided biohazard bag. Discard PPE and collection materials as biohazardous waste.
- *Hand-deliver specimens to the laboratory **IMMEDIATELY** after collection*; do NOT use the pneumatic tube system.
  - **NOTE:** If any other samples are collected from a suspect monkeypox case, label each container with a Special Pathogens sticker.

Room Cleanup/Terminal Cleaning:

1. **Don appropriate PPE**
2. EVS & EHS will coordinate waste removal from ED and patient rooms to a designated holding area.
   a. UH, the holding area will be room 2828A, the hot room.
   b. Community Room 4246
3. EVS will stage and store waste pending Infection Prevention updates for handling. In addition, EVS will work with the current contractor to ensure waste is removed per regulatory requirements and specifications.
4. Hospital Areas:
   a. The patient Room will be cleaned to UH guidelines and follow CDC recommendations.
   b. Department must call the EVS Supervisor UH Via Vocera 4-1400, CC 4-200.
   c. They will need to Identify the type of isolation.
   d. Also, if there is a need for the negative pressure rooms in the EDs to expedite. Rooms PEDS room 8, or Adult room 34. At CC, this is the GEM CARE space.
5. Output/Clinic Areas:
   a. Contact Landlords to request appropriate cleaning is focused on that space after hours.
   b. If outpatient areas are unable to facilitate cleaning with the landlord, please escalate to Environmental Services Leadership
   c. The PUI room cleaning process and dwell time should be discussed with EVS Manager, Infection Prevention, or epidemiologist before the specific room is used for another patient.

   d. Managers with questions can call: EVS OFFICE 315-464-6576, ask to speak to an EVS Manager.
6. Consider all patient waste Category A until proven otherwise.
7. Packaging of Untreated Monkeypox Medical Waste (per NYSDOH Advisory 5/31/22)
   a. There are two clades of monkeypox virus: The West African clade and the Central African clade.
   b. the USDOT, in conjunction with other Federal partners, has issued new guidance indicating that during the ongoing 2022 multi-national outbreak of West African clade monkeypox, if clinician teams determine that a patient does not have known epidemiological risk for the Congo Basin clade of monkeypox (e.g. history of travel to the Democratic Republic of the Congo, the Republic of Congo, the Central African Republic, Cameroon, Gabon, or South Sudan in the prior 21 days) it is appropriate to manage waste from suspected monkeypox patients as RMW.
   c. If the Congo Basin clade of monkeypox is excluded, medical waste does not have to be held pending clade confirmation and medical waste needs to be packaged, transported, and treated as RMW.
   d. If the West African clade of monkeypox is identified, then the untreated RMW being shipped for off-site treatment must be packaged and shipped as Category B.
   e. In general, Category A waste requires triple packaging that may include one or two leakproof primary bags contained in a secondary leakproof rigid package and then over-packed in a rigid outer package such as a corrugated cardboard box or a disposable poly drum. Absorbent packing material is necessary for liquids.
   f. Category B waste packaging is above Category A except that an additional leakproof bag may be used instead of a rigid inner package.
      i. Note: packaging and transport of Category A or B waste may otherwise be determined by USDOT and may also require a special permit from USDOT that includes additional packaging and marking requirements
8. Category A or B waste and RMW must be treated prior to disposal in NYS. Commercial treatment and disposal facilities must have a 6 NYCRR Part 360 permit and be authorized explicitly by the NYSDEC to accept Category A or B waste for treatment or disposal.
9. For questions regarding approvals for treating medical waste on-site in a hospital or clinical laboratory, contact the NYSDOH Regulated Medical Waste Program at rmwp@health.ny.gov.
10. For questions regarding the commercial treatment or disposal of Category A or B waste and RMW, contact the NYSDEC at swmfprogram@dec.ny.gov. For questions regarding the transport of these wastes, contact the NYSDEC at transport@dec.ny.gov.
11. Note: transporting Category A or B waste and RMW requires a 6NYCRR Part 364 medical waste transporter permit. Waste transported both in and out of state must be transported directly to a facility properly permitted to manage the waste.

Monitoring Exposed Healthcare Professionals (per CDC website 6/22/2022)

1. CONSULT INFECTION PREVENTION and EMPLOYEE STUDENT HEALTH WHENEVER MAKING A RISK DETERMINATION.
2. Any healthcare worker who has cared for a monkeypox patient should be alert to the development of symptoms that could suggest monkeypox infection, especially within the 21 days after the last date of care.
3. Healthcare workers who have unprotected exposures (i.e., not wearing PPE) to patients with monkeypox do not need to be excluded from work duty, but should undergo active surveillance for symptoms, which includes measurement of temperature at least twice daily for 21 days following the exposure.

SUNY Upstate Monkey Pox PUI Initial Guidance Document: August 1 2022

4. Before reporting for work each day, the healthcare worker should be interviewed regarding evidence of fever or rash.
5. Healthcare workers who have cared for or otherwise been in direct or indirect contact with monkeypox patients while adhering to recommended infection control precautions may undergo self-monitoring or active monitoring as determined by the local health department.
6. Transmission of monkeypox requires prolonged close contact with a symptomatic individual.
7. Brief interactions and those conducted using appropriate PPE following Standard Precautions & Airborne Precautions are not high risk and generally do not warrant post-exposure prophylaxis

Degree of Exposure	Recommended Actions	Exposure Characteristics
HIGH	Monitoring & postexposure prophylaxis is recommended	Unprotected contact between a person's skin or mucous membranes and the skin, lesions, or bodily fluids from a patient (e.g., any sexual contact, inadvertent splashes of patient saliva to the eyes or oral cavity of a person, ungloved contact with the patient), or contaminated materials (e.g., linens, clothing) -OR- Being inside the patient's room or within 6 feet of a patient during any procedures that may create aerosols from oral secretions, skin lesions, or resuspension of dried exudates (e.g., shaking of soiled linens), without wearing an N95 or equivalent respirator (or higher) and eye protection -OR- Exposure that, at the discretion of public health authorities, was recategorized to this risk level (i.e., exposure that ordinarily would be considered a lower risk exposure, raised to this risk level because of unique circumstances)
INTERMEDIATE	MONITORING and postexposure prophylaxis – Informed clinical decision making recommended on an individual basis to determine whether the benefits of PEP outweigh the risks	Being within 6 feet for 3 hours or more of an unmasked patient without wearing, at a minimum, a surgical mask -OR- Activities resulting in contact between sleeves and other parts of an individual's clothing and the patient's skin lesions or bodily fluids, or their soiled linens or dressings (e.g., turning, bathing, or assisting with transfer) while wearing gloves but not wearing a gown -OR- Exposure that, at the discretion of public health authorities, was recategorized to this risk level because of unique circumstances (e.g., if the potential for aerosol exposure is uncertain, public health authorities may choose to decrease risk level from high to intermediate)
LOW or Uncertain	MONITORING	Entered the patient room without wearing eye protection on one or more occasions, regardless of the duration of exposure -OR- During all entries in the patient care area or room (except for during any procedures listed above in the high-risk Category), wore gown, gloves, eye protection, and at minimum, a surgical mask -OR- Being within 6 feet of an unmasked patient for less than 3 hours without wearing at minimum, a surgical mask -OR- Exposure that, at the discretion of public health authorities, was recategorized to this risk level based on unique circumstances (e.g., uncertainty about whether Monkeypox virus was present on a surface and whether a person touched that surface)