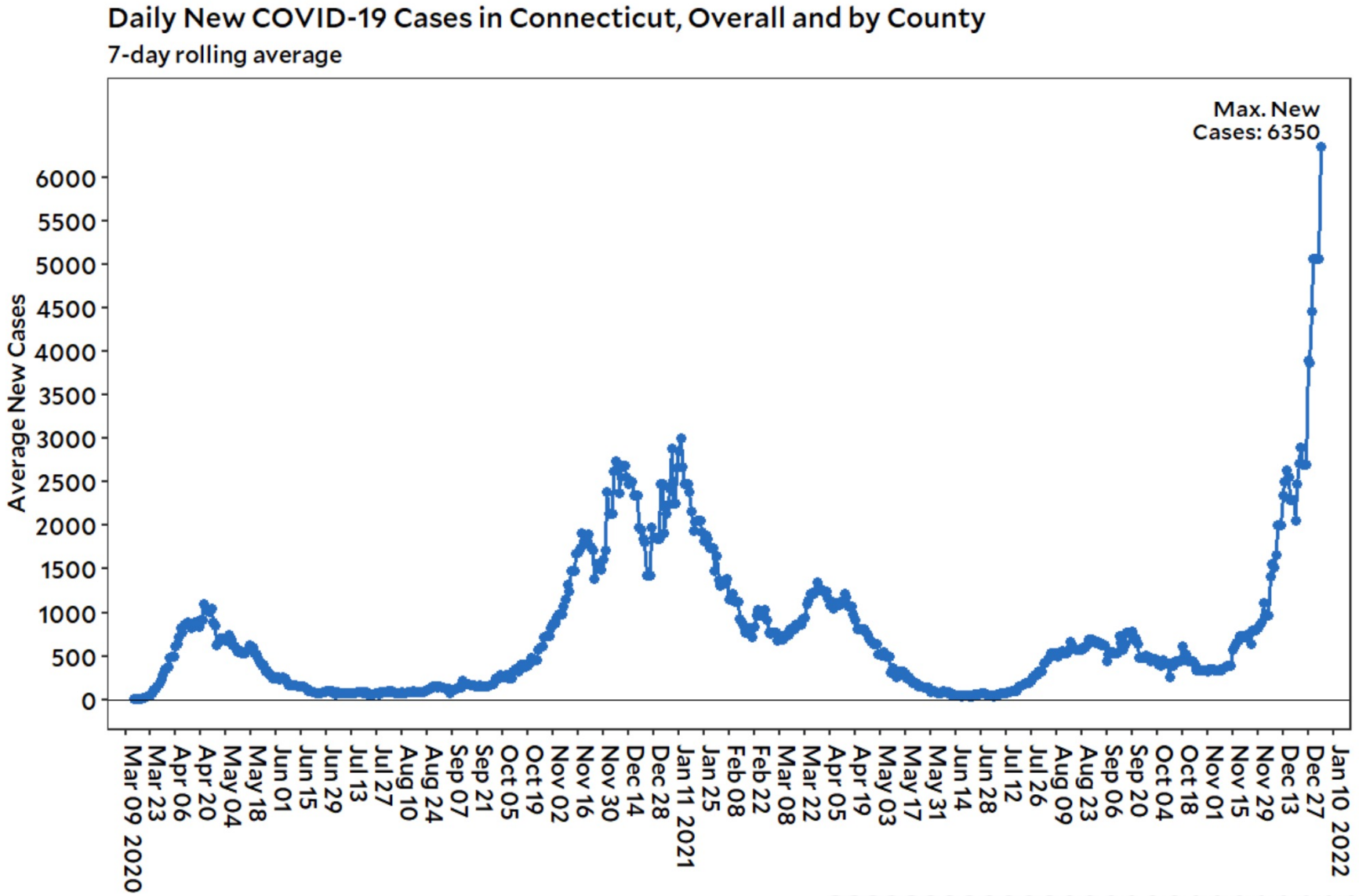
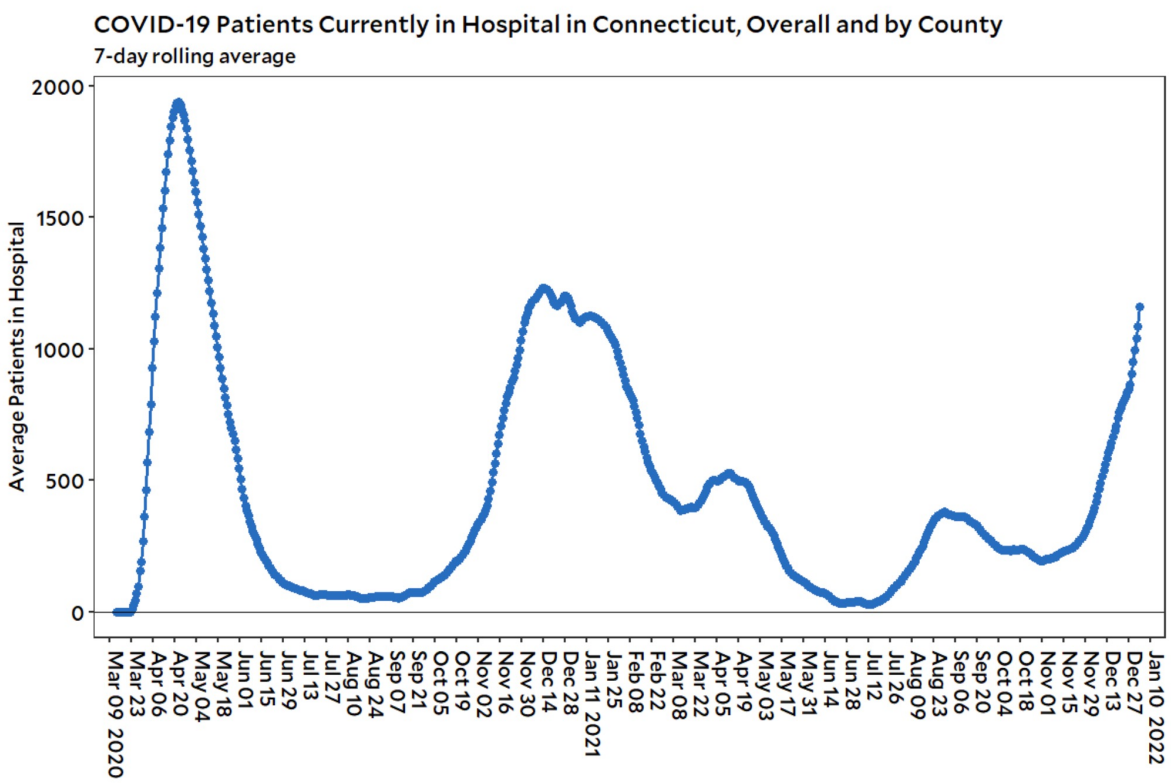
Yale Cancer Center and Smilow Cancer Hospital Town Hall December 2021

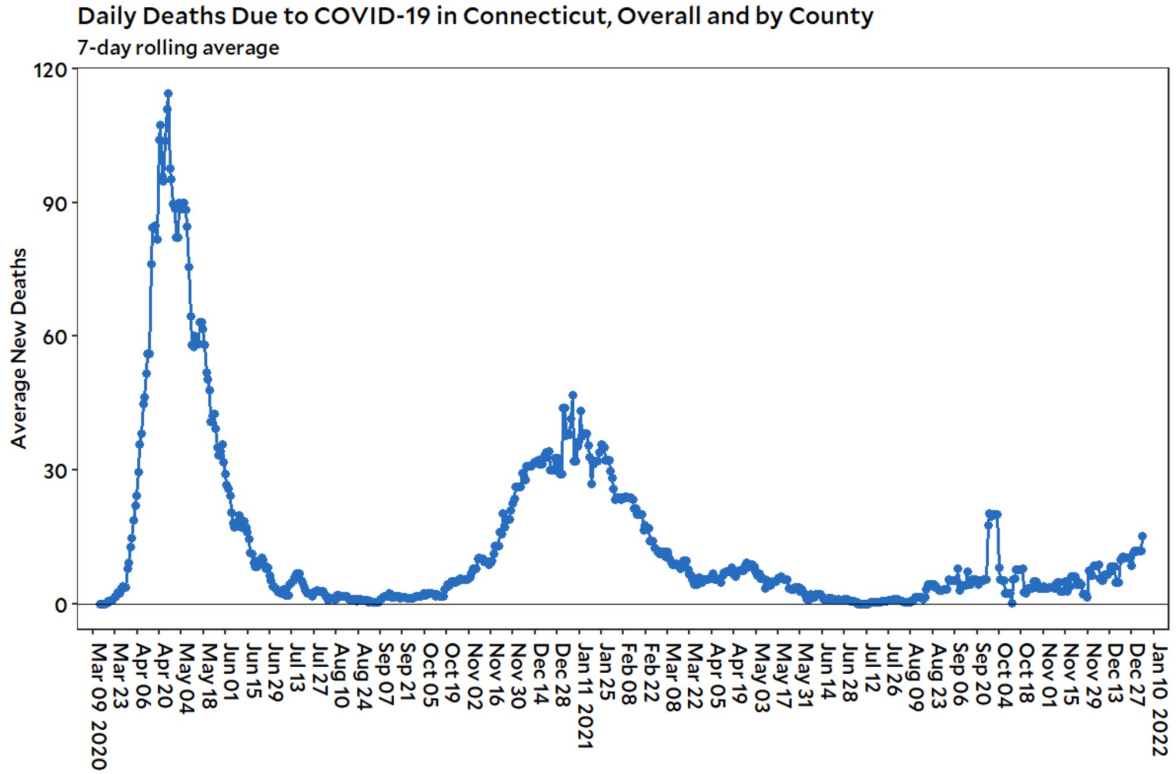
Hosted by: Nita Ahuja, MD, MBA
Interim Director, Yale Cancer Center
Interim Physician-in-Chief, Smilow Cancer Hospital
Chair, Department of Surgery

COVID Rates in Connecticut

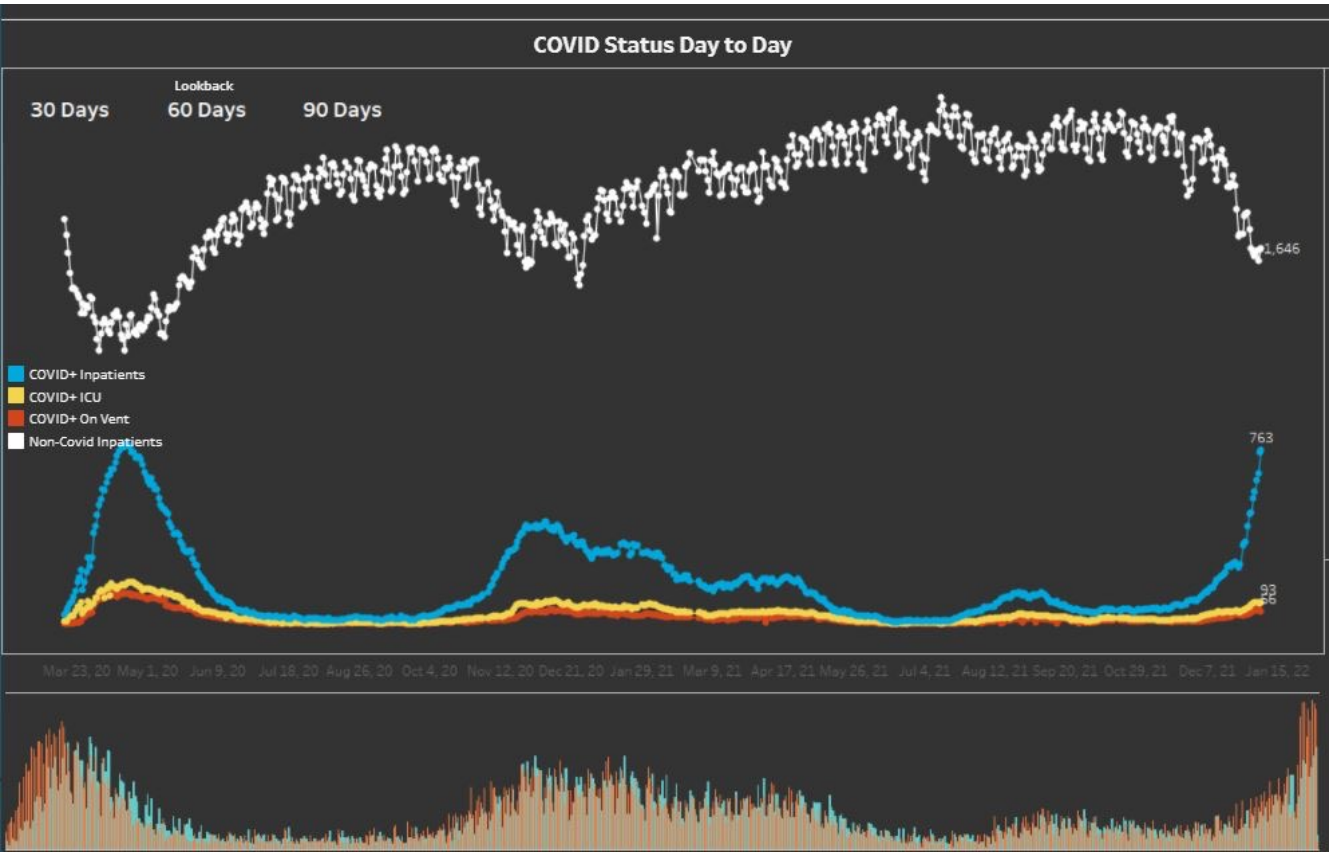


COVID Hospitalization & Death Rates in Connecticut

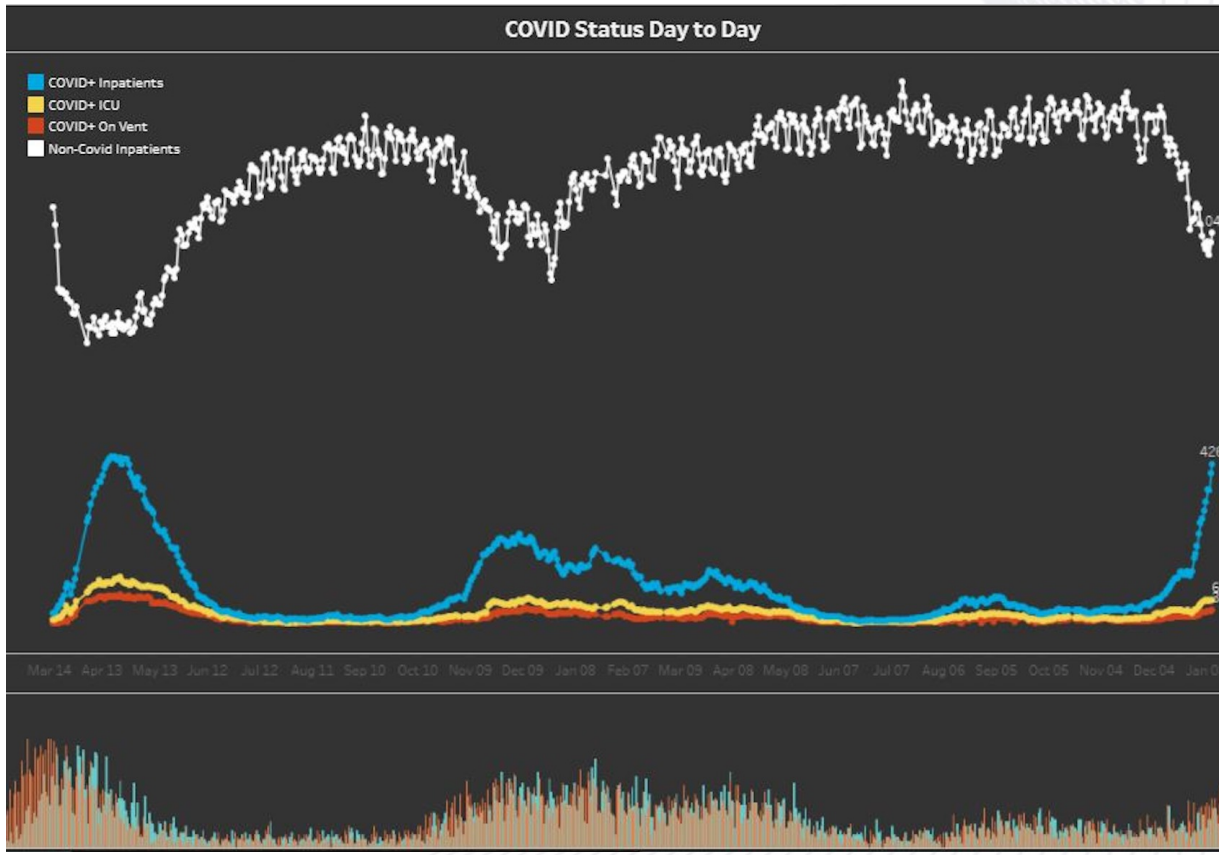




COVID Rates at YNHHS



YNHHS as of January 6 at 10am – 763 Inpatients



YNHH as of January 6 at 10am – 426 Inpatients

Yale University Salary Increases

- Effective January 1, 2022
- All eligible M&P staff will receive a 2% increase to salaries. Eligible staff include:
  - Staff who have been hired before 10/1/2021
  - Staff who received a “3 - Meets/Exceeds Expectations” or higher in last annual performance rating
- All eligible faculty will receive a 2% increase on their Yale base salaries.
  - Must be in a faculty rank (i.e., not emeritus)

YaleNewHavenHealth
Smilow Cancer Hospital

Yale CANCER CENTER
A Comprehensive Cancer Center Designated by the National Cancer Institute

Appointments (December)

Ian Krop, MD, PhD
Associate Cancer Center Director for Clinical Research
Director of the CTO

Paris D. Butler, MD, MPH, FACS
Vice Chair for Diversity, Equity & Inclusion (DEI) & Associate Professor of Surgery

John Lewin, MD, PhD
Chief of Breast Imaging

David Braun, MD, PhD
Assistant Professor of Medicine (Medical Oncology)

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Endowed Professorships

Ranjit S. Bindra, MD, PhD
Harvey and Kate Cushing Professor of Therapeutic Radiology

Stephanie Halene, MD, PhD
Arthur H. and Isabel Bunker Associate Professor of Medicine (Hematology)

Suchitra Krishnan-Sarin, PhD
Albert E. Kent Professor of Psychiatry

David Rimm, MD, PhD
Anthony N. Brady Professor of Pathology

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Select Awards & Honors (December)

Patricia LoRusso, DO
Chair, American Association for Cancer Research (AACR) KRAS Task Force

Sanjay Aneja, MD, PhD
2022 William O. Seery Clinical Investigator Grant

Rong Fan, PhD
Fellow of the National Academy of Inventors

Nancy Ruddle, PhD
2022 Distinguished Fellow of the American Association of Immunologists

Agenda

Clinical and COVID Surge Updates

Kevin Billingsley, MD, MBA, Professor of Medicine (Surgical Oncology), Chief Medical Officer

Kim Slusser, RN, MSN, Vice President for Patient Services

Fellowship Program Update

Alfred Lee, MD, PhD, Director, Associate Professor of Medicine (Hematology), Hematology/Oncology Fellowship Program

Clinical Trials Office Enrollment Prioritization Update

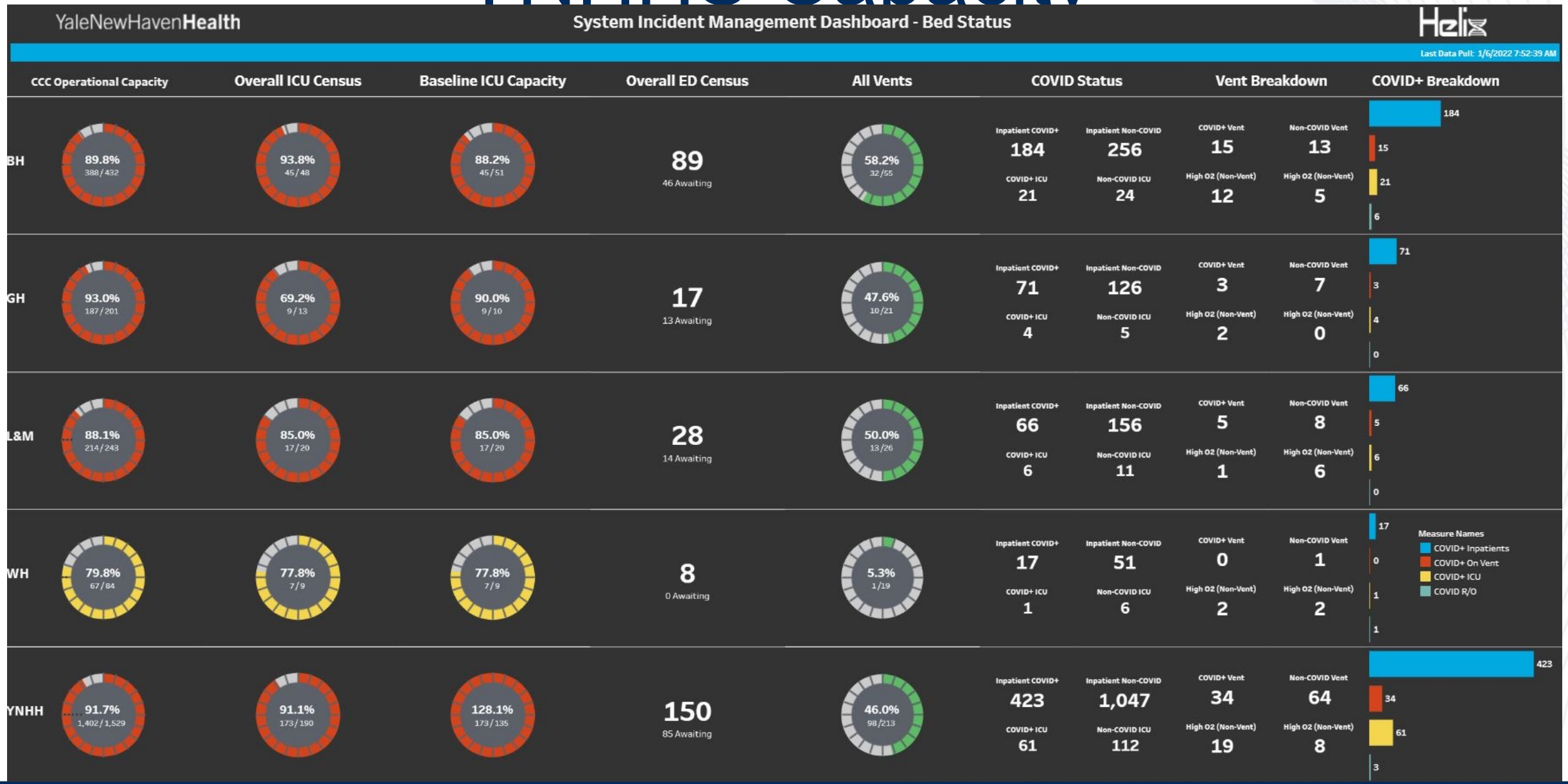
Roy S. Herbst, MD, PhD, Ensign Professor of Medicine (Medical Oncology); Chief of Medical Oncology; Associate Cancer Center Director for Translational Research; Acting Associate Cancer Center Director for Clinical Research

Alyssa Gateman, MPH, CCRP, Interim Administrative Director, Clinical Trials Office

Clinical and COVID Surge Updates

Kevin Billingsley, MD, MBA
Kim Slusser, RN, MSN

YNHHS Capacity



Regional Sites for COVID+ and/or ECF Patients

Regional Site	Geographic Sites Served
St. Francis Hospital Michelle Randall-Doran	St. Francis
	Torrington
	Waterbury
Bridgeport Hospital WT7 James Wittstein	Derby
	Trumbull
	Fairfield
Greenwich Hospital Inpatient 3rd Floor Kristina Capretti	Smilow at Greenwich Cancer Center (Bendheim)
Smilow Rapid Evaluation Clinic 203-200-1919 for referrals* **For questions contact Brianna Lutz*	New Haven
	Orange
	North Haven
	Guilford
Smilow Waterford Mary Ann Nash/Kim Hanna	Waterford
	Westerly

Visitor Restrictions

- No inpatient visitors except at end-of-life or for patients with disabilities
- Ambulatory visitation restrictions are in place, with the exception of:
  - Patients with disabilities
  - Patients with mobility concerns
  - New consults

Exposure Guidelines for Staff

- COVID+ healthcare personnel who are not immunocompromised will need to isolate for 7 days; no testing is required to return to work.
- Asymptomatic healthcare personnel who had a high-risk exposure to someone infected with COVID-19 can continue to work if they have received the booster. Personnel who are not fully vaccinated or are fully vaccinated but do not have their booster dose may continue to work but should be tested for COVID-19 once on day 1 or 2 after the exposure and once again between day 5-7 after the exposure.
- All healthcare personnel testing should be scheduled through: https://ocucovidtesting.ynhhs.org/

PPE Guidelines

- Cloth masks can no longer be worn on University or Hospital property. Everyone must wear a surgical or N95 mask.
- Providers in contact with COVID+ or suspected COVID+ patients should wear N95 respirators and eye protection, in addition to gowns and gloves. The PPE policy remains essentially unchanged and is permissive for the use of respirators.
- All clinical sites, including ambulatory locations, shall stock N95 respirators and ensure they are available to staff. Site managers shall implement a distribution process to ensure staff access to one respirator when requested.
- Managers and administrators are working to ensure that all clinical sites are stocked with N95 respirators and that they are readily available to all staff.
- The YCC Director's Office is coordinating distribution for faculty and patient facing staff in the CTO. For more information, please email marion.miller@yale.edu
- **We respect staff's ability to assess the risk their work environment, and to use respirators responsibly. Respirators and other PPE are to be used judiciously and in alignment with policy.**

Booster Vaccinations for Staff

- COVID-19 vaccine boosters have a substantial impact on reducing COVID-19 infections, severity of illness, hospitalization, and death. Of our COVID-19 admissions, between 70-80% are unvaccinated, and of the 20-30% of admitted patients who are vaccinated, 80% did not receive a vaccine booster.
- ~40 percent of our healthcare workers have received a vaccine booster. **Those who have not been boosted should do so as soon as possible.**
- For YNHHS employees, healthcare worker booster appointments can be accessed within **Infor**. For members of the Medical Staff who are not employed by the System, the vaccination clinics can be accessed at https://vaccinepartner.ynhh.org

State of Staffing

- Waiting for incentive information from Kim
- Are there any details on the number of YNHH or Smilow staff out?

Telehealth

- Yale Medicine is encouraging transition of appointments to Telehealth, when appropriate.
- Goal is 30%
- Please review your schedules for appropriate appointments to transition to Telehealth in the coming days/weeks

Oncology Pharmacy

- Sotrivimab, (the monoclonal antibody therapy that is effective against the omicron variant), paxlovid (the very effective oral COVID-19 antiviral drug), and molnupiravir (another oral antiviral COVID-19 drug) are all available for our patients with COVID-19. Please reach out to pharmacy for assistance.
- Reinstated our system pharmacy incident command structure to plan for potential interruptions in operations and supply chain.
- Created a contingency plan, that includes site consolidation to address operational needs during severe staffing shortages.
- Working with the Department of Public Health and Department of Consumer Protection on allowing centralized compounding to support the health system.

Updated NCCN Guidelines Released

Patients Treatment/Cancer Type	Timing to Start Series[†,‡,¶]
Hematopoietic Cell Transplantation (HCT)/Cellular Therapy	
Allogeneic transplantation Autologous transplantation Cellular therapy (e.g. CAR T-cell)	At least 3 months post-HCT/cellular therapy[a,b]
Hematologic Malignancies	
Receiving intensive cytotoxic chemotherapy (e.g. cytarabine/anthracycline- based induction regimens for acute myeloid leukemia)	Delay until absolute neutrophil count (ANC) recovery or for those not expected to recover, as soon as possible
Marrow failure from disease and/or therapy expected to have limited or no recovery	As soon as possible
Long-term maintenance therapy (e.g. targeted agents for chronic lymphocytic leukemia, myeloma or myeloproliferative neoplasms)	As soon as possible[c]
Solid Tumor Malignancies	
Receiving cytotoxic chemotherapy	As soon as possible[c,d]
Targeted therapy	As soon as possible
Checkpoint inhibitors and other immunotherapy	As soon as possible[e]
Radiation	As soon as possible
Major surgery	Separate date of surgery from vaccination by at least a few days[f]

Pre-Exposure Prophylaxis/Evushield

- Available in limited supply for patients in active treatment for solid tumor and hematologic malignancies; receipt of solid-organ transplant and taking immunosuppressive therapy; receipt of chimeric antigen receptor (CAR)-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy); moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome); advanced or untreated HIV infection
- Should be administered at least two weeks after COVID-19 vaccination
- Recommended the use of tixagevimab plus cilgavimab in these high-risk patients as soon as supply is available

Escalation of Care Protocol

- Applies to life-prolonging interventions, including but not limited to:
  - Cardiopulmonary Resuscitation; Intubation; Extracorporeal Membrane Oxygenation (ECMO); Renal Replacement Therapy; Vasopressor Medications; Blood products; ICU transfer
- Applies to any patient where two attending physicians assess that:
  1. The patient is in a **terminal state**: “the final stage of an incurable or irreversible medical condition which, without the administration of a life support system, will result in death within a relatively short time period”
  2. The patient is **permanently unconscious**: “an irreversible condition in which the individual is at no time aware of himself or herself or the environment and shows no behavioral response to the environment and includes permanent coma and persistent vegetative state” (requires neurological assessment)
  3. The patient would be in a terminal state if the intervention in question were indicated (e.g. CPR in a patient with metastatic lung cancer)

Surgical Case Prioritization

- Ongoing coordinated review of status and capacity by Delivery Network
- Continue all scheduled IP emergency, urgent, and semi-urgent cases
- Elective cases with planned admission under review
- Scheduled ambulatory cases potentially delayed/relocated
- Considerations for limiting surgery: resources, staffing, capacity, acuity of cases.
- Visitation suspended for all IP and ambulatory patients, with few exceptions
- PPE/Masks required
- Test requirements: All patients, test 2-3 days pre-op
- COVID+ surgery patients: Defer ~7 weeks (reference guidelines)

Surgical Category	Procedural Example (examples below, not comprehensive)		Potential Consequence of Delay
Emergent 6 week delay has **very high** risk of impacting organ function or survival; Recognized emergency	• Ruptured aneurysms • Pericardial tamponade or post cardiac surgery bleeding • Post-operative hemorrhage requiring surgical intervention • Acute appendicitis and cholecystitis • Necrotizing soft tissue infections • Perforated viscus	• Compartment syndrome • Intestinal obstruction (small/large bowel) • Cardiogenic shock requiring ECMO/CABG/valve surgery/mechanical complication of MI • Acute type A aortic dissection • Airway emergencies/ Respiratory failure requiring ECMO	• Severe organ dysfunction and death
Urgent 6 week delay has a **severe** risk of impact on organ function or survival	• Coronary artery bypass for coronary ischemia • Acute endocarditis with heart failure, heart block or recurrent emboli • VAD for cardiogenic shock • Symptomatic aneurysmal disease • Symptomatic carotid disease • Infant surgery	• Aneurysm surgery with evidence of significant growth in size • Heart transplant UNOS status 1 or status 2 • Stenting for obstruction • Chronic intestinal obstruction (Adhesive or hernia related) • Tendon or nerve injuries • Craniofacial trauma / Fractures	• Likely severe organ dysfunction and/or death
Semi-Urgent 6 week delay has **moderate** risk of impact on organ function or survival. "Time-Sensitive" Cases	• Patients with malignancy • Cancer staging • Lobectomy for lung cancer • Esophagectomy after chemoradiation • Diagnostic VATS/Lobectomy for slower growing cancers • Chronic cholecystitis, gallstone pancreatitis	• Feeding tube for patients with malnutrition • CABG for stable angina • Valve surgery for mild symptoms (Class 1 or Class 2 symptoms) • Aneurysm surgery meeting size criteria for operation • Asymptomatic carotid disease • Discharge-dependent inpatients requiring surgery	• Likely progression of a potentially treatable or curable condition to a more co-morbid condition, such as: malignant spread of cancer, rupture of aneurysm, stroke
Scheduled – Ambulatory 6 week delay does not impact, or has limited impact on organ function or survival	• Cosmetic Procedures • Hernias • Stoma reversals • Routine nasal, sinus or ear surgeries	• Benign breast masses • Endovascular cases for claudication • Varicose veins • Tonsillectomy, adenoidectomy • Benign thyroid cases	• Some potential for progression of surgically treatable conditions and symptom relief
Scheduled – Same Day Admission 6 week delay does not impact, or has limited impact on organ function or survival	• Bariatric surgeries • Prophylactic mastectomy for high-risk patients	• Benign thyroid cases • Valve surgery for asymptomatic patients • Musculoskeletal and spine cases	• Some potential for progression of surgically treatable conditions and symptom relief

Week of January 3

- 28% system-wide positivity (symptomatic + asymptomatic)
- 7% asymptomatic pre-procedural positivity rate
- 147 staff callouts
- 957 surgical cases
  - 796 pre-scheduled
  - 161 same day admits
- 70 surgical cases deferred
  - 48 same day
  - 22 COVID+