CLINICAL GUIDELINES 2017

YUKON-KUSKOKWIM HEALTH CORPORATION

Using this Acrobat Document

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Revised October, 2017

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CLINICAL GUIDELINES 2017

rev. 10-09-17

Emergency Department Guidelines

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Skin and Soft Tissue Infection, p.1

MSEC approved 07-12-17

Skin and Soft Tissue infection identified

DO NOT use guideline for the following :
- Diabetic ulcer
-Vascular ulcer
- Necrotizing fasciitis
- Human or animal bite cellulitis
- Thrombophlebitis
- Erythema nodosum
- DVT
- Toxic shock syndrome
- Herpes zoster
- Fish finger
-Bacteremia
-Periorbital or orbital cellulitis
-IV drug use
-perineal/vulvar/perianal infections

If considering an above diagnosis, management must be individualized, and this guideline may not apply.

Abscess present?

Yes → Cutaneous abscess → Perform incision and drainage with local anesthesia. Culture wound and break up loculations. Place fixed Penrose drain if possible. Hot packs/soaks q2-4 hours and rest/elevation if on extremity

No → Purulent drainage or exudate?

Yes → Purulent cellulitis

No → Non-purulent cellulitis → See Page 2

Cellulitis >10 cm or >1% BSA in child (size of child's palm)

No, antibiotics not indicated → Outpatient management with daily follow up until continuous improvement is demonstrated

Yes → Consider empiric oral antibiotic therapy

Empiric oral Antibiotic Therapy
Adults
Septra DS 1-2 tabs PO q12hours (do not give to pregnant women)
Children:
Septra 4-6 mg/kg PO q 12 hours (based on TMP component)
Adults with sulfa allergy:
Doxycycline 100 mg PO q12 hours
Children with sulfa allergy:
>/=8 years: Doxycycline 2 mg/kg PO q12 hours x 10 days (max 100 mg/dose)
<8 years: Clindamycin 10-13 mg/kg PO q8 hours
Pregnant or breastfeeding women:
Clindamycin 450 mg PO TID
***Antibiotic duration 5-7 days**
***Septra and doxycycline do NOT cover strep pyogenes**

Does patient meet all criteria for outpatient management (see Box 2)?

yes → Outpatient management with daily follow up until continuous improvement is demonstrated

Vancomycin:
Strongly consider inpatient admission if vancomycin is considered
Remember, no outpatient vancomycin may be prescribed to patients <18 years old.

No →
- Admission with IV antibiotics. (See Box 3.)
- Recommend blood cultures, CBC, basic metabolic panel.
- Elevation and heating pad.
- Consider IV fluids.
- Address pain control.
- Consider imaging.
- If patient meets criteria for sepsis, follow sepsis guideline

BOX 2: Criteria for Outpatient Management:
- Afebrile and non-toxic
- Ambulatory and able to commute to hospital for outpatient treatment
- Able to care for self
- Tolerating PO fluids
- Pain controlled with oral pain meds
- Doesn't require hospitalization for elevation of extremity

BOX 3: Empiric Antibiotic Options
1. Vancomycin:
   • For adults: load with 30 mg/kg IV, then dose 15 mg/kg q8 or q12 hours.
   • For patients <18 years: 20 mg/kg IV q6 hours. If patient is obese, consider dosing based on ideal body weight.
2. Linezolid 600 mg IV/PO q12 hours. Restricted to known MRSA resistance or vancomycin allergy.
3. In children with rapidly progressing cellulitis/abscess or associated systemic symptoms (fever, listlessness, lethargy, etc.) consider covering Haemophilus influenzae type A/B with ceftriaxone 75 mg/kg IV/IM q24 hours in addition to above.

Patient improving?

Yes → Manage as inpatient until meets criteria for outpatient management

No →
- Review culture and sensitivities
- Consider imaging.
- Consider repeat incision and drainage

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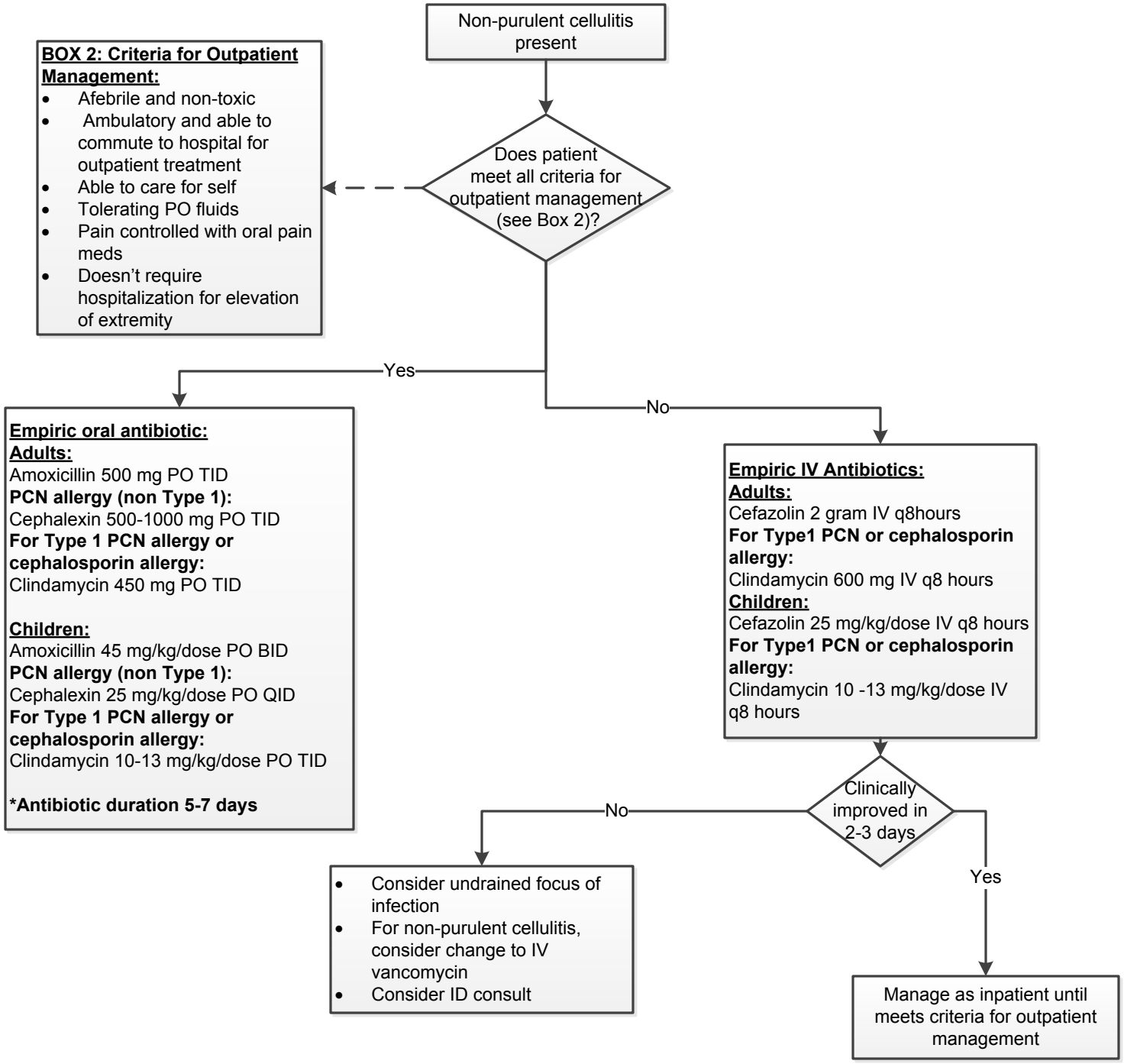
Skin and Soft Tissue Infection, p.2

MSEC approved 07-12-17



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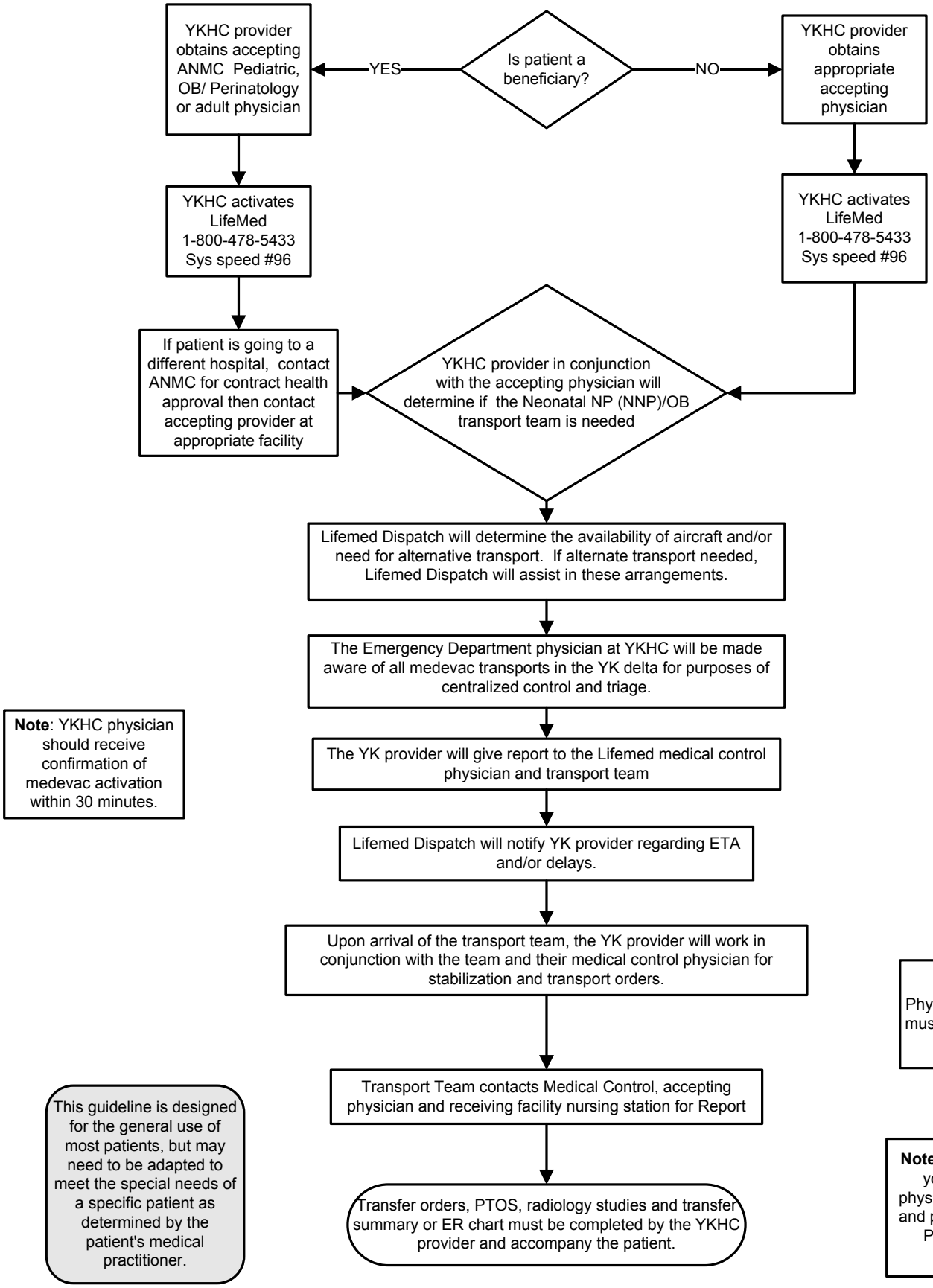
Medevac Activation—Bethel to Anchorage

MSEC approved 06/22/11



Note: YKHC physician should receive confirmation of medevac activation within 30 minutes.

Note: Accepting Physician for Elmendorf must either be a Military or VA Physician

This guideline is designed for the general use of most patients, but may need to be adapted to meet the special needs of a specific patient as determined by the patient's medical practitioner.

Note: ER to ER transport you must notify ER physician of receiving site and put their name on the PTOS as receiving physician

YUKON-KUSKOKWIM HEALTH CORPORATION

Medevac Activation – Village to Bethel

MSEC approved 06/22/11

Village to Bethel Collaboration
Village Health Aide collaborates with provider (RMT provider, Night Float provider, or ER Physician) to make decision if medevac is indicated

Activation of Medevac

Activating provider calls LifeMed Dispatch with patient's name, DOB, village, and diagnosis

LifeMed Dispatch 1-800-478-5433

NOTE: In the event of multiple medevacs, the ER Physician in collaboration with LifeMed must make decision regarding priority

Transfer Care to ER Physician
Activating provider completes PTO and takes PTO and provider notes to ER Physician who assumes care.

Centralized medical control is **critical.** If for any reason, the ER Physician requests an activating provider maintain control, the ER Physician must be kept up to date on patient and medevac status

Bethel-Village Collaboration
ER Physician calls village Health Aide to get updates and continues to keep records on the RMT Form for Village to Bethel Medevacs

In the event that a medevac is cancelled (patient deemed stable to come in on scheduled flight) LifeMed dispatch must be notified by the ER Physician immediately.

LifeMed Dispatch

1. LifeMed Dispatch notifies Grant Aviation/Pilot/LifeMed
If LifeMed cannot launch (weather, runway lights) dispatch notifies ER Physician. Pilot will continue to check weather.

2. ER clerk faxes PTO, health summary, notes to Bethel LifeMed crew quarters

3. LifeMed crew contacts Village Health Aide and ER Physician for additional information prior to flying

4. If there is a prolonged delay (weather) it is crucial that LifeMed crew contacts the ER Physician and Health Aide prior to flying

5. In extenuating circumstances patient may need direct transport to Anchorage from village. After obtaining an accepting physician in Anchorage, YK MD will work with LifeMed for transport logistics.

Consider Ramp Transfer Direct to Anchorage under these circumstances:

1. Obvious need for acute surgical intervention
2. Hemodynamically stable intubated patients
3. Hemodynamically stable acute MI patients
4. Other extenuating circumstances.

LifeMed launches

1. Once in village LifeMed calls ER physician to report, establish treatment plan and gives Estimated Time of Arrival (ETA) to Bethel to ER Physician
2. ER Physician keeps Charge Nurse informed of patient status/ETA of Medevac

Arrival in Bethel
1. Patient care is transferred to ER staff and LifeMed gives report to YK MD and nursing staff
2. Completed transport chart placed in patient's ER chart prior to departure of LifeMed staff*

*Under extenuating circumstances, the LifeMed team may be unable to complete the transport chart prior to departure from ED

This guideline is designed for the general use of most patients, but may need to be adapted to meet the special needs of a specific patient as determined by the patient's medical practitioner.

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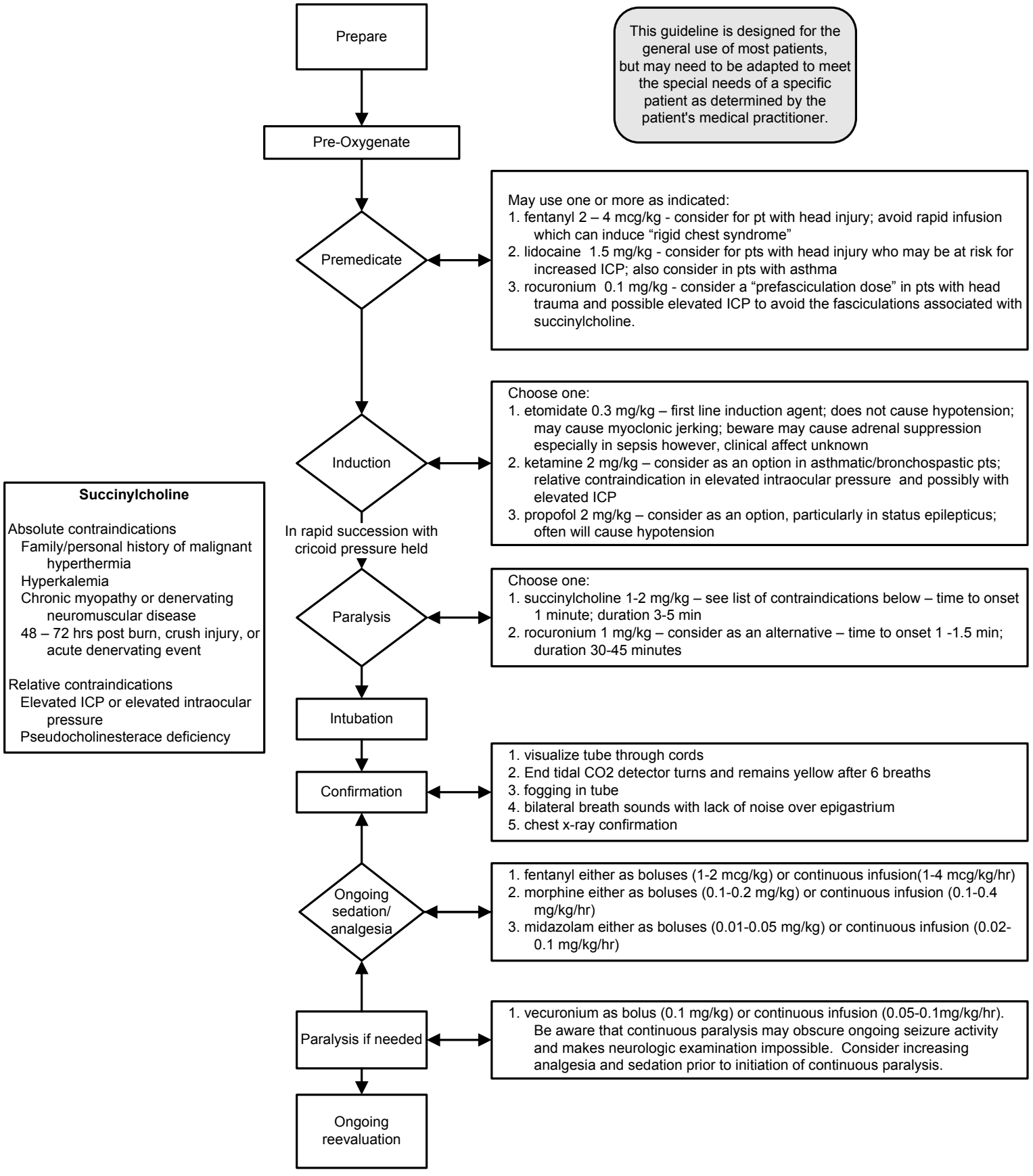
Clinical Guidelines • October 2017

Intubation – Adult

MSEC approved 06/22/11



Succinylcholine

Absolute contraindications
- Family/personal history of malignant hyperthermia
- Hyperkalemia
- Chronic myopathy or denervating neuromuscular disease
- 48 – 72 hrs post burn, crush injury, or acute denervating event

Relative contraindications
- Elevated ICP or elevated intraocular pressure
- Pseudocholinesterace deficiency

YUKON-KUSKOKWIM HEALTH CORPORATION

Sepsis – Adult

MSEC approved 7/12/17

qSOFA – 2 or more of the following:
RR > 22
altered mental status (GCS<15)
SBP < 100

Consider sepsis EARLY in *any* pt with suspected infection

Does pt meet criteria for sepsis or septic shock?

NO → *Reassess after initial evaluation -- consider*
fever, leukocytosis, hypotension?
unexplained altered mental status?
tachypnea? especially if lungs CTA and SaO_2 WNL?
unexplained organ dysfunction?
clinical concern during ongoing care?

YES

Airway stable?

NO → ET intubation
target tidal volume 6 mL/kg for pts without ARDS

YES

Large bore IV x 2
LABS INCLUDING LACTATE, PCT & BLOOD CULTURES
START FLUID RESUSCITATION immediately: Give 1 L NS or LR bolus with target at least 30 ml/kg within 1-3 hr

START EMPIRIC ABX (see guidelines) within 1 hr of recognition of sepsis/septic shock

REASSESS FREQUENTLY
Assess for adequacy of fluid resuscitation or complications from fluid therapy

Monitor vital signs, UOP, shock index (HR/SBP > 0.7), mental status and clinical exam

Use more than one method to assess resuscitation adequacy and use dynamic variables if possible

CONSIDER CONSULT/TRANSFER if unstable or not improving and **ACTIVATE MEDEVAC EARLY** if needed

Is MAP < 65 after 3L of IVF or is patient having complications from volume therapy?

Yes → **START NOREPINEPHRINE** or other vasopressor (see guidelines) and **TITRATE** fluids and pressors to **MAP >65**

Place a central line ASAP but do NOT delay pressors — a well secured large bore peripheral IV may be used to initiate tx

Consider intubation to facilitate appropriate volume resuscitation

Consider hydrocortisone (see guidelines) *only* for septic shock not responsive to adequate fluid resuscitation and vasopressors

No

If initial lactate is > 2:

RECHECK LACTATE 1-2 hrs after starting resuscitation

GUIDE RESUSCITATION TO NORMALIZE LACTATE
Primary goal should be to achieve a relative lactate clearance of at least 10% in 1-2 hours

Lactate > 4 may indicate hypoperfusion and the need for aggressive/continued fluid resuscitation

GET SOURCE CONTROL and obtain additional cultures PRN

Continue to reassess frequently while awaiting admission or transfer

Village Management
- Aggressive hydration, PO if you can't get an IV and the patient is alert enough to drink
- Spplemental oxygen via nasal cannula
- Consider Ceftriaxone 2 grams IM
- Activate medevac
- Consider VTC

SEPSIS 3 & ACEP NOTES

4-6L of total IVF is often needed during the first 6 hrs, after 2L of NS consider switch to LR, remember that if the patient fails to respond after the first 2-3 L, pressors should be considered.

In pts with concern for fluid overload (hx CHF, renal or liver failure) or complications from fluid resuscitation, use less total fluid or smaller boluses with more frequent reassessment of volume status, but **DO NOT DELAY FLUID AND VASOPRESSOR TREATMENT**

Persistence of elevated lactate, even in the absence of hypotension, is associated with poor outcomes

CRP and procalcitonin may be elevated but can not effectively guide ED sepsis care — CHECK (and RECHECK) LACTATE

in the absence of extenuating circumstances (MI, severe hypoxia, acute blood loss, etc) transfusion is no longer recommended unless Hgb < 7

Consider insulin if 2 consecutive blood glucose levels are > 180

Sodium bicarbonate is not recommended to improve hemodynamics or decrease vasopressor requirements in pts with hypoperfusion induced lactic acidemia with pH >= 7.15

Sepsis – Adult Medications p. 1

MSEC approved 07/12/17

EMPIRIC ANTIBIOTIC RECOMMENDATIONS BY SOURCE OF INFECTION

If possible, 1st dose of antibiotics should be administered as a 30 min infusion to reduce time to therapeutic concentration

Source of infection	Medication	Dose	Maximum Dose
unknown	vancomycin[1]	25-30 mg/kg loading dose THEN 20mg/kg Q8-12 hrs	2 grams
	OR		
	linezolid	600 mg IV Q12 hrs	600 mg
	AND		
	piperacillin-tazobactam[2]	4.5 grams IV Q8 hrs	4.5 grams
	OR		
	cefepime	2 grams IV Q8 hrs if in shock	2 grams
	AND		
	gentamicin or tobramycin[3]	7 mg/kg IV Q24 hrs	Consult pharm
	OR		
	levofloxacin	750 mg IV Q24 hrs	750 mg
community acquired pneumonia	ceftriaxone	1 gram IV Q24 hrs (2 gm if > 80 kg)	2 grams
	OR		
	ampicillin-sulbactam	3 gm Q6 hrs	
	AND		
	levofloxacin	750 mg IV Q24 hrs	750 mg
	OR		
	azithromycin	500 mg PO/IV Q24 hrs	500 mg
	if at risk for aspiration CONSIDER		
	Metronidazole	500 mg IV Q8hrs	depends
hospital acquired pneumonia OR high risk for MDR organisms	vancomycin[1]	25-30 mg/kg loading dose THEN 20mg/kg Q8-12 hrs	2 grams
	OR		
	linezolid	600 mg IV Q12 hrs	600 mg
	AND		
	piperacillin-tazobactam[2]	4.5 grams IV Q6 hrs	4.5 grams
	OR		
	cefepime	2 grams IV Q8 hrs	2 grams
	AND		
	levofloxacin	750 mg IV Q24 hrs	750 mg
	OR		
	gentamicin or tobramycin[3]	7 mg/kg IV Q24 hrs	Consult pharm
meningitis	dexamethasone	10 mg IV *PRIOR TO ABX*	
	AND		
	vancomycin[1]	25-30 mg/kg loading dose THEN 20mg/kg Q8-12 hrs	2 grams
	AND		
	ceftriaxone	2 grams IV Q12 hrs	2 grams
	if > 50 y/o ADD		
	ampicillin	2 grams IV Q6 hrs	2 grams

Sepsis – Adult Medications p. 2

MSEC approved 07/12/17

urinary tract	ceftriaxone	1 gm IV Q24 hrs (2 gm if > 80 kg)	2 grams
	AND consider		
	gentamicin	7 mg/kg IV Q24 hrs	Consult pharm
	OR		
	levofloxacin	750 mg IV Q24 hrs	750 mg
	if urological interventions or MDR risk factors CONSIDER		
	piperacillin-tazobactam[2]	3.375 grams IV Q6 hrs	4.5 grams
	OR		
	cefepime	1 gram IV Q6 hrs	2 grams
	If ESBL add		
	Meropenem	500 mg IV q8hrs	1 gram
Intra-abdominal/pelvic	piperacillin-tazobactam[2]	3.375 grams IV Q6 hrs	4.5 grams
	OR		
	cefepime	1 gram IV Q6 hrs	2 grams
	AND		
	metronidazole	500 mg IV Q6 hrs	500 mg
	OR		
	ciprofloxacin	400 mg IV Q12 hrs	400 mg
	AND		
	metronidazole	500 mg IV Q8 hrs	500 mg
skin and soft tissue/necrotizing infections	***if PURULENT***		
	vancomycin[1]	25-30 mg/kg loading dose THEN 20mg/kg Q8-12 hrs	2 grams
	if NONPURULENT		
	cefazolin	2 grams IV Q8 hrs	2 grams
	OR		
	ceftriaxone	1-2 grams IV Q24 hrs	2 grams
	OR		
	ampicillin-sulbactam	3 grams Q6 hrs	3 grams
	if NECROTIZING ADD		
	piperacillin-tazobactam[2]	3.375 grams IV Q6 hrs	4.5 grams
	AND		
	clindamycin	900 mg IV Q8 hrs	900 mg
	OR		
	ceftriaxone	2 grams IV Q12 hrs	2 grams
	AND		
	metronidazole	500 mg IV Q6 hrs	500 mg
neutropenic cancer patients (ANC < 500)	piperacillin-tazobactam[2]	4.5 grams IV Q6-8 hrs	4.5 grams
	OR		
	cefepime	1 gram IV Q6 hrs	2 grams
	AND		
	vancomycin[1]	25-30 mg/kg loading dose THEN 20mg/kg Q8-12 hrs	2 grams
	is suspected/confirmed HSV or VZV CONSIDER		
	acyclovir	10 mg/kg Q8 hrs	Consult pharm

[1] linezolid may be substituted for vancomycin in patients with relative contraindication to vancomycin use or high risk for AKI
[2] gentamicin and tobramycin dosing based on ideal body weight
[3] may substitute ampicillin-sulbactam 3 gm IV Q6 hrs for piperacillin-tazobactam when pseudomonas Is not of concern

VASOPRESSORS

medication	dose	notes
ALL vasoactive medications should be infused via central line with the exception of dopamine, which can be infused via a peripheral IV at rates less than 10 mcg/kg/min		
norepinephrine	8-12 mcg/min IV initial infusion rate	1st line vasopressor of choice in sepsis
epinephrine	1-10 mcg/min initially, titrated to effect	may be added to or used in place of norepinephrine to maintain adequate BP
dopamine	2-20 mcg/kg/min	2nd line option in highly select patients as it causes more tachycardia
phenylephrine	100-180 mcg/min IV initial infusion until stabilized, titrate to goal of 60-200 mcg/min (max dose range 80-360 mcg/min)	can be used as salvage therapy for refractive hypotension associated with tachycardia
vasopressin	0.03-0.04 units/min	may be added to norepinephrine to increase MAP or decrease norepinephrine dose – DO NOT use as a single agent
dobutamine	2-20 mcg/kg/min IV infusion	may be used for inotropic support in the presence of severe myocardial dysfunction or hypoperfusion with depressed cardiac output

CORTICOSTEROIDS

Corticosteroids should NOT be administered for the treatment of sepsis in the absence of shock. Steroids are beneficial in those experiencing adrenal insufficiency in the presence of septic shock, however ACTH testing is not routinely recommended in adult patients. If hemodynamic stability is not achieved after adequate fluid resuscitation and vasopressor therapy, the use of IV hydrocortisone alone at a dose of 200 mg/day can be considered regardless of AI status. Hydrocortisone should be tapered when vasopressors are no longer required.

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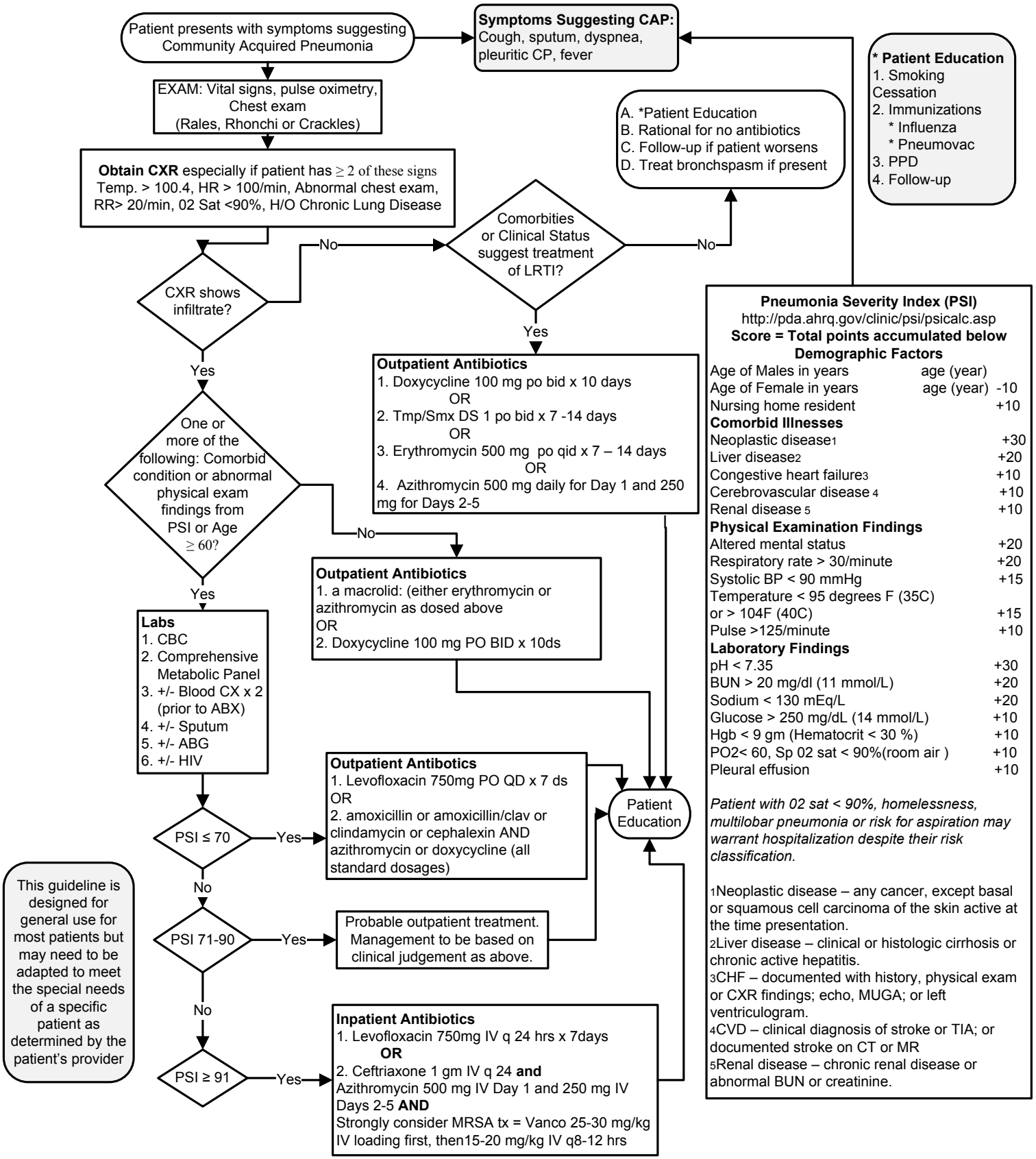
Pneumonia – Adult

MSEC approved 06/22/11



Pneumonia Severity Index (PSI)
http://pda.ahrq.gov/clinic/psi/psicalc.asp
Score = Total points accumulated below

Demographic Factors		
Age of Males in years	age (year)	
Age of Female in years	age (year)	-10
Nursing home resident		+10
Comorbid Illnesses		
Neoplastic disease[1]		+30
Liver disease[2]		+20
Congestive heart failure[3]		+10
Cerebrovascular disease [4]		+10
Renal disease [5]		+10
Physical Examination Findings		
Altered mental status		+20
Respiratory rate > 30/minute		+20
Systolic BP < 90 mmHg		+15
Temperature < 95 degrees F (35C) or > 104F (40C)		+15
Pulse >125/minute		+10
Laboratory Findings		
pH < 7.35		+30
BUN > 20 mg/dl (11 mmol/L)		+20
Sodium < 130 mEq/L		+20
Glucose > 250 mg/dL (14 mmol/L)		+10
Hgb < 9 gm (Hematocrit < 30 %)		+10
PO2< 60, Sp 02 sat < 90%(room air)		+10
Pleural effusion		+10

Patient with 02 sat < 90%, homelessness, multilobar pneumonia or risk for aspiration may warrant hospitalization despite their risk classification.

[1]Neoplastic disease – any cancer, except basal or squamous cell carcinoma of the skin active at the time presentation.
[2]Liver disease – clinical or histologic cirrhosis or chronic active hepatitis.
[3]CHF – documented with history, physical exam or CXR findings; echo, MUGA; or left ventriculogram.
[4]CVD – clinical diagnosis of stroke or TIA; or documented stroke on CT or MR
[5]Renal disease – chronic renal disease or abnormal BUN or creatinine.

Suspect Aspiration: clindamycin 600-900mg IV Q8hrs + ceftriaxone 1gm IV Q24hrs **OR** ampicillin-sulbactam 3gm IV Q6hrs **OR** piperacillin-tazobactam 3.375 gm IV Q6hrs
Suspect Pseudomonas: Piperacillin/Tazobactam (Zosyn) 4.5 gm IV q 6hrs **AND** Levofloxacin 750 mg IV
OR Zosyn 4.5 gm IV q6hrs + gentamicin 7mg/kg IV q24hrs + (levofloxacin 750mg IV or Zithro IV)

Active Pulmonary TB for Patients ≥14 Years

MSEC approved 04-13-16

Hospital, clinic, ER, or SRC patient with infiltrate on CXR

>4 Risk Factors for TB?

Yes

1. Isolate patient.
2. Sputum for Xpert® MTB/RIF
3. Sputum for AFB-send out
4. TST or IGRA if no prior history of positive test

Xpert® MTB/ RIF result

Positive

1. Draw HIV test and LFTs.
2. Begin 4-drug daily treatment if RIF negative.
3. Admit and isolate if PSI** ≥90.
4. Consider admission if PSI 71-90.
5. Discharge home with surgical masks and PHN oversight if reliable and no air travel.
6. Recommend admission and isolation if patient unreliable and/or history of treatment failure.
7. Discuss with hospital TB control officer and/or State Epidemiology.

Negative

1. Discontinue isolation unless admitted with high index of suspicion for TB.
2. Treat as CAP or HAP.
3. Collect two morning sputums for AFB with isolation if admitted.
4. Report to Public Health for follow-up.

No

Treat as CAP or HAP using PSI.

Improvement?

Yes

CXR follow-up in 6-8 weeks for adults.

No

Re-evaluate for antibiotic failure/ TB/cancer/etc.

Yes, and in an SRC

1. Isolate in clinic exam room with surgical face mask.
2. Send sputum to hospital lab for Xpert® MTB/RIF.
3. Send sputum to hospital lab for AFB-send out.
4. TST or IGRA if no prior history of positive test.

Xpert® MTB/ RIF result

Positive

1. Draw HIV test and LFTs.
2. Begin 4-drug daily treatment with DOT and report to Public Health.
3. Discharge home with surgical masks and PHN oversight.
4. After 2 weeks and if AFB negative, may travel by air to hospital for CXR and evaluation.
5. Discuss with hospital TB control officer and/or State Epidemiology.

Negative

1. Discontinue isolation.
2. Evaluate locally or travel to hospital.
3. Collect two morning sputums for AFB.
4. Report to PHN nursing for follow-up.

Village clinic patient (no CXR) with >4 Risk Factors for TB

1. Isolate in clinic exam room with surgical face mask.
2. Send sputum to hospital lab for Xpert® MTB/RIF.
3. Send sputum to hospital lab for AFB-send out.
4. TST or IGRA if no prior history of positive test.

Risk Factors for TB

- persist cough >3wks
- fever
- night sweats
- weight loss
- hemoptysis
- immunosuppression (HIV/DM/other)
- atypical CXR
- foreign born from endemic area
- prior active or latent TB infection
- household contact of active TB
- persistent pneumonia
- born before 1960 and long-term resident of western Alaska or other endemic area

PSI
<www.mdcalc.com/psi-port-score-pneumonia-severity-index-adult-cap/>
PSI ≤70 stable for outpatient therapy
PSI 71-90 likely outpatient therapy but may consider inpatient
PSI ≥91 advise inpatient therapy

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Abbreviations: AFB-acid fast bacilli; CA-cancer; CAP-community acquired pneumonia; CXR-chest x-ray; DM-diabetes mellitus; DOT-direct observational therapy; ER-emergency room; LFTs-liver function tests; HAP-healthcare associated pneumonia; HIV-human immunodeficiency virus; IGRA-interferon gamma release assay; PHN-public health nurse; PSI-pneumonia severity index; SRC-subregional clinic; RIF-rifampin resistance; TB-tuberculosis; TST-tuberculin skin test

YUKON-KUSKOKWIM HEALTH CORPORATION

Ischemic Stroke – Acute

MSEC approved 06/22/11

This guideline is designated for the general use of most patients, but may need to be adapted to meet the special needs of a specific patient as determined by the patient's medical practitioner

Exclusion criteria
Any hemorrhage on CT
BP > 185/110
NIHSS* < 4 or rapidly improving exam
Hx suggestive of SAH even with normal CT
INR > 1.7 or on heparin with elevated PTT
Platelets < 100,000
Seizure at onset of symptoms
History of any of the following:
- intracranial hemmorrhage
- intracranial Neoplasm or AVM
- major surgery <14 days
- head trauma in last 3 months
- arterial puncture at non-compressable site < 7 days
- GI or GU hemorrage <21 days
- LP in last 24 hrs

Glucose <50 or >400 (may continue if symptoms persist after glucose corrected)
Presumed septic emboli

Additional 3-4.5 hr Exclusion Criteria
- age >80 yrs old
- NIHSS* >25
- Prior stroke + DM
- anticoagulation regardless of IHR

Pt presenting with symptoms of acute stroke?

Was the pt seen normal within the last 4.5 hours?
- No → Not Eligible for TPA, continue routine care.
- Yes

1. ABC as appropriate
2. Oxygen 2-4 L N/C
3. Bedside glucose
4. CV monitor
5. Order non-contrast head CT (page 911)
6. Place 2 IVs (at least one 18g)
7. Draw labs: CBC, Comp, INR/PTT, T&C, Troponins
8. IV fluids (consider bolus unless fluid overloaded)
9. perform NIH stroke scale (NIHSS)
10. STAT radiologist interpretation of head CT

Does the pt have hemorrhage
- Yes → Not Eligible for TPA, continue routine care
- No

Evidence of large infarct?
- Yes → Not Eligible for TPA, continue routine care
- No

Is BP > 185/110
- Yes →
  1. apply NTG paste 1", if no effect in 15 min then,
  2. labetolol 10 mg IV if HR > 50, if no effect then,
  3. labetolol 20mg IV if HR > 50

  → Is BP > 185/110
  - Yes → Not Eligible for TPA, continue routine care
  - No → Perform Exclusion check list
- No

Perform Exclusion check list

Does pt meet criteria ?
- Yes → Perform Informed consent with pt and family → Consider consultation with neurologist if available
- No → Not Eligible for TPA, continue routine care

Consider consultation with neurologist if available → Administer ACTIVASE
Total dose of 0.9 mg/kg IV, max dose of 90 mg
Give 10% of total dose over 1 min,
Give remaining 90% over 1 hour
See administration table

Administer ACTIVASE → Medevac patient to appropriate ICU

If pt develops new severe headache, emesis, hypertension or worsening of neurologic exam suspect Intracranial hemorrhage. Stop ACTIVASE. Order STAT repeat head CT.

Ref: 1). FCASS 3 trial. Lancet Newrol 2009; 8: 1095. 2). Uptodate ,www.uptodate.com/contents/reperfusion-therapy-for-acute-stroke>
*NIH Stroke Scale (NIHSS) calculator: <www.mdcalc.com/nih-stroke-scale-score-nihss>

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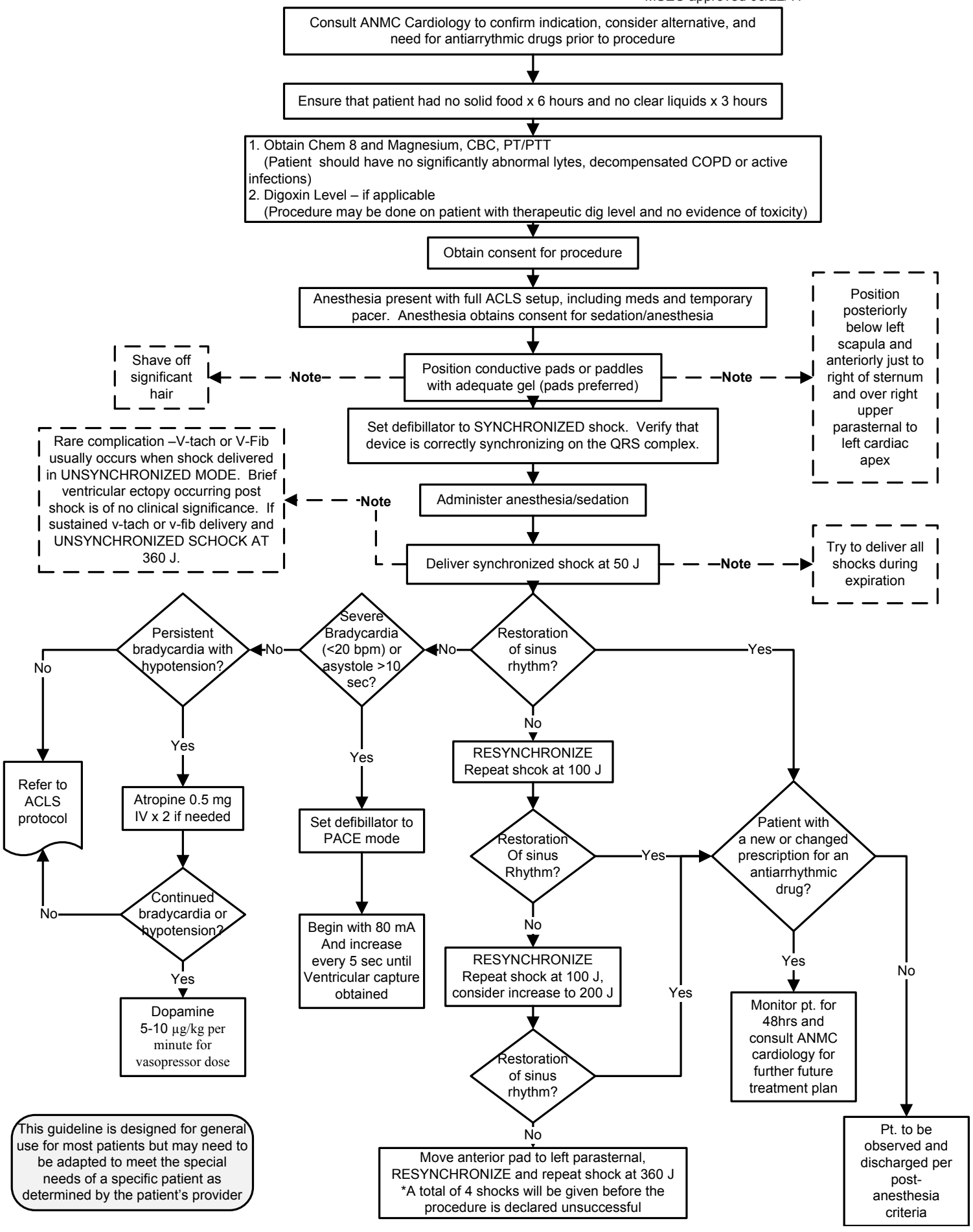
Atrial Fibrillation / Atrial Flutter

MSEC approved 06/22/11

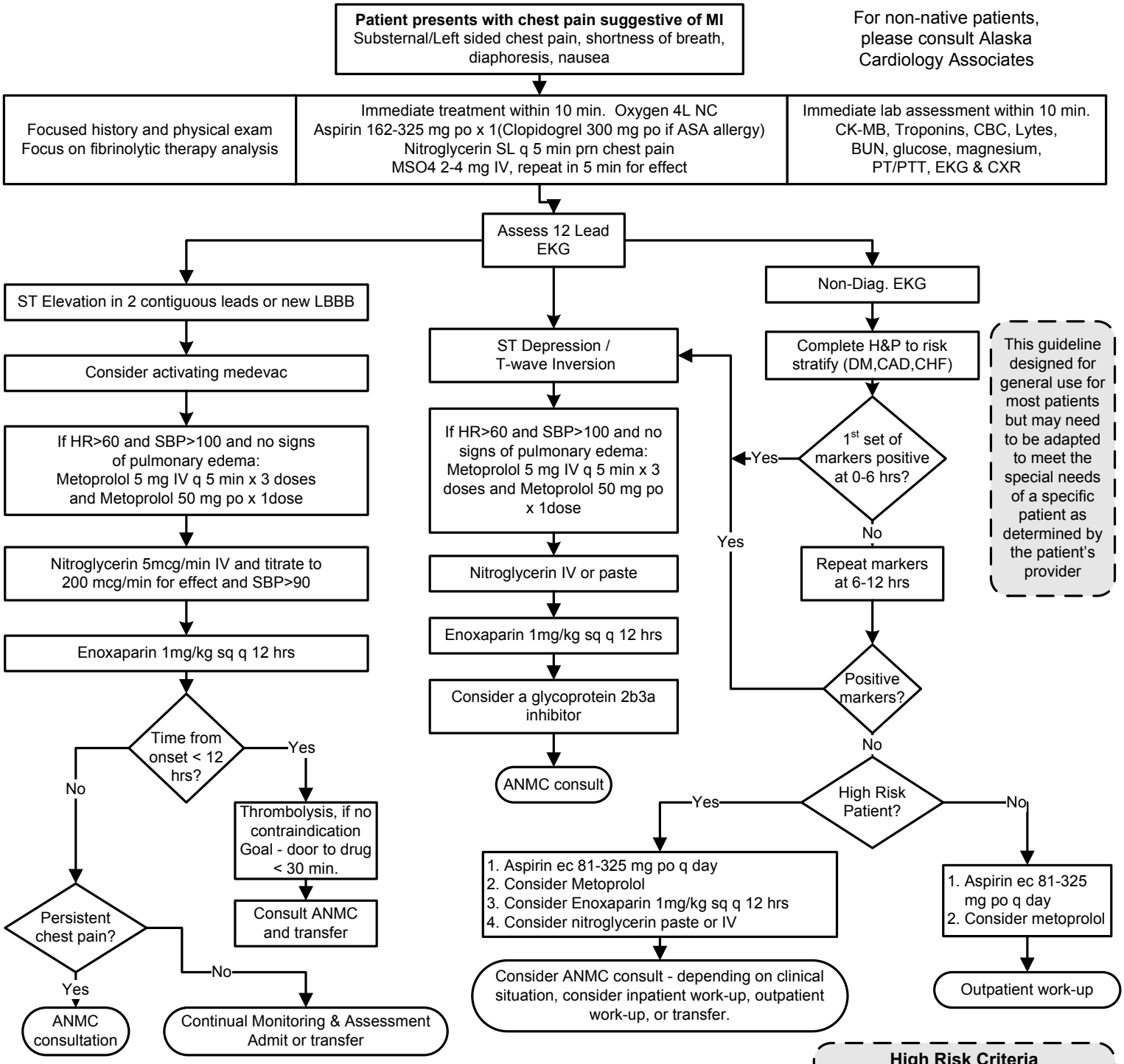


This guideline is designed for general use for most patients but may need to be adapted to meet the special needs of a specific patient as determined by the patient's provider

YUKON-KUSKOKWIM HEALTH CORPORATION

Myocardial Infarction – Acute

MSEC approved 06/22/11



Fibrinolytic Therapy Recommendations

Indications

Chest pain suggesting MI, ST - segment elevation >0.1 mV (1mm) in 2 or more contiguous ECG leads or new LBBB, time to therapy < 12 hours, age < 75 years (age > 75 years Class Iia), evidence of ongoing ischemia

Absolute contraindications

H/O CVA; intracranial or intraspinal surgery/trauma w/in 3 wks; intracranial neoplasm, AVM, or aneurysm; active internal bleeding (menses excluded) w/in 2-4 wks; known bleeding diathesis; severe uncontrolled HTN (>180/110); terminal illness

Cautions

Recent major surgery: cerebrovascular dz; recent GI bleeding, recent trauma; high likelihood of left heart thrombus; acute pericarditis; subacute bacterial endocarditis, renal or hepatic dysfunction; pregnancy; diabetic hemorrhagic retinopathy; septic thrombophlebitis; occluded AV cannula; advanced age > 75; currently on oral anticoagulants (Coumadin); recent gp 2b/3a inhibitor; platelet <100,000, conditions where bleeding would be difficult to manage

High Risk Criteria

- Hypotension
- Persistent CP suggestive of MI
- 2 or more episodes of rest angina in previous 24 hours
- History of 3 or more cardiac risk factors
- History of Diabetes Mellitus
- Known CAD
- Age 65 years or greater
- Congestive heart failure
- New ST deviation > 0.5mm
- New pathological Q waves
- Sustained ventricular tachycardia
- Elevated cardiac makers

YUKON-KUSKOKWIM HEALTH CORPORATION

Title 47 Hold

MSEC approved 06/22/11

Village Referral
Transportation plan and pre-hospital communication plan per Behavioral Health

Emergency Department Triage
- Police/ VPSO or physician to complete form MC-105 (official Title 47)
- Notify behavioral health clinician
- One to one observation, patient undresses and belongings secured
- Behavioral health may assist with obtaining mental health records

ER Physician Evaluation

Assess (1) degree of suicidality, (2) risk of harm to self/others, or (3) grave disability

TITLE 47?
- No → Discharge from Emergency Department once behavioral health plan is in place
- Yes

- Discuss with admitting physician; may transfer to Anchorage directly from ER if necessary
- Complete standardized orders
- Consider chemical sedation if agitated:
  - Haloperidol 2.5 mg - 12 mg IM/PO titrate to effect
  - Lorazapam 2 mg - 5 mg IM/PO titrate to effect
- Consider physical restraints
- Intoxicated patients require repeat evaluation of suicidality once sober
- Conduct lab tests (Utox, tylenol/aspirin levels, EKG)

This guideline is designed for the general use of most patients, but may need to be adapted to meet the special needs of a specific patient as determined by the patient's medical practitioner.

Psychosis present?
- No → Proceed with admission if Title 47
- Yes

- Prevent harm and control disturbed behavior
- Consider consultation and/ or antipsychotic medication
  - Olanzapine 5 mg - 10 mg Po q 24 hours
  - Haloperidol 5 mg IM/PO and lorazepam 2 mg IM/PO titrate to effect
- If first diagnosis of psychosis consider referral for CT/MRI.
- Conduct lab tests (CBC, Chem 8, LFT, TSH, RPR, Utox, HIV)

Admit to NorthWing
- Close observation with behavioral health attendant
- Patient undresses, belongings secured
- Admission to observation room with standardized orders, complete observation/seclusion form
- Understand and anticipate elopement protocols

- Admitting physician to determine treatment setting and plan of treatment; complete H&P within 24 hours
- Collaboration with behavioral health clinician is essential for plan of care
- Address substance use disorders
- Establish a multiaxial diagnosis

Transfer to API, North Star, or Providence?
- No → Establish outpatient treatment and follow-up plan in conjunction with Behavioral Health
- Yes

Discuss case with accepting physician
Complete H&P with transfer plan
Completed transfer packet
Consider chemical sedation in transport
Establish outpatient treatment and follow-up plan

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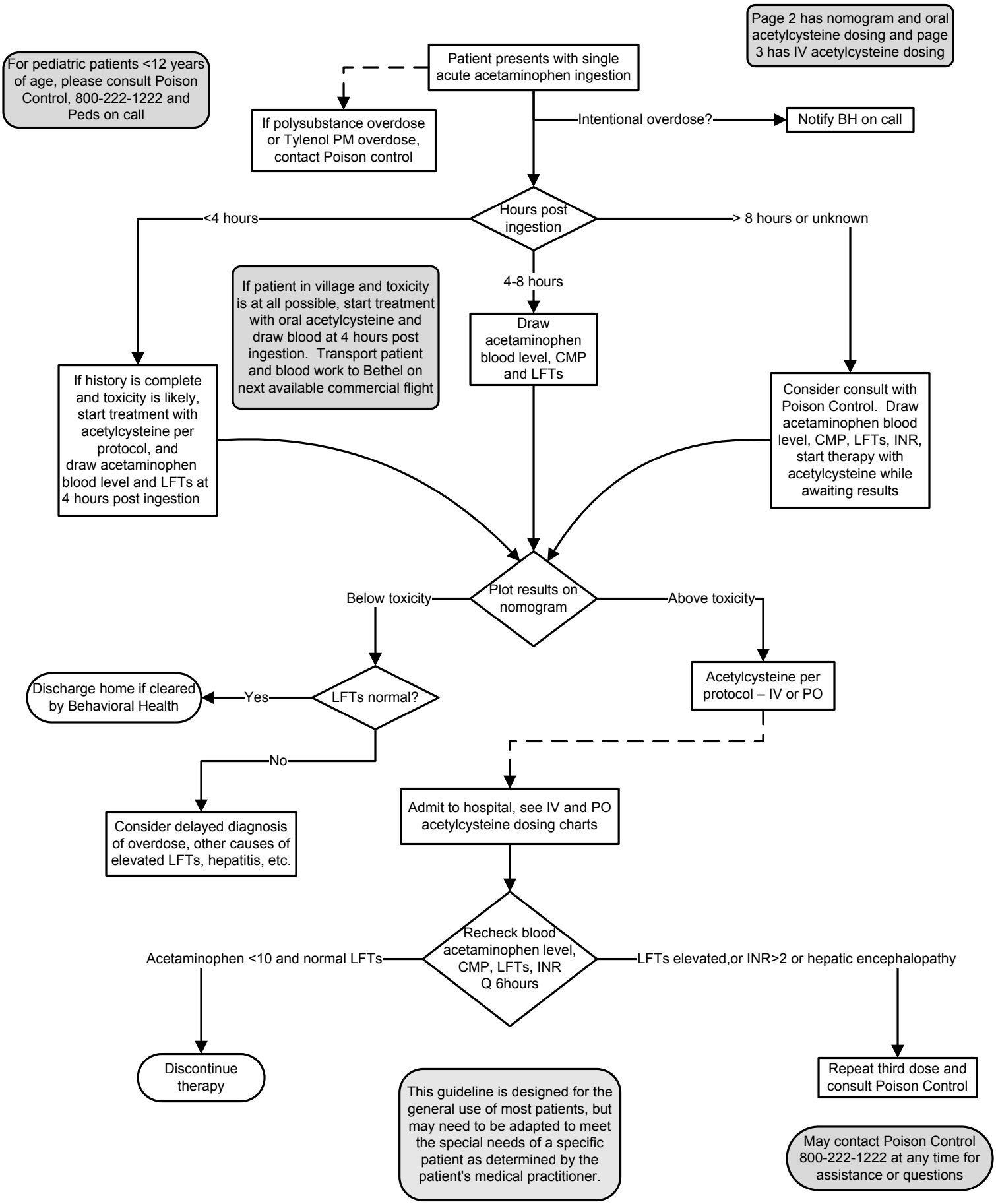
Acetaminophen Overdose, p.1

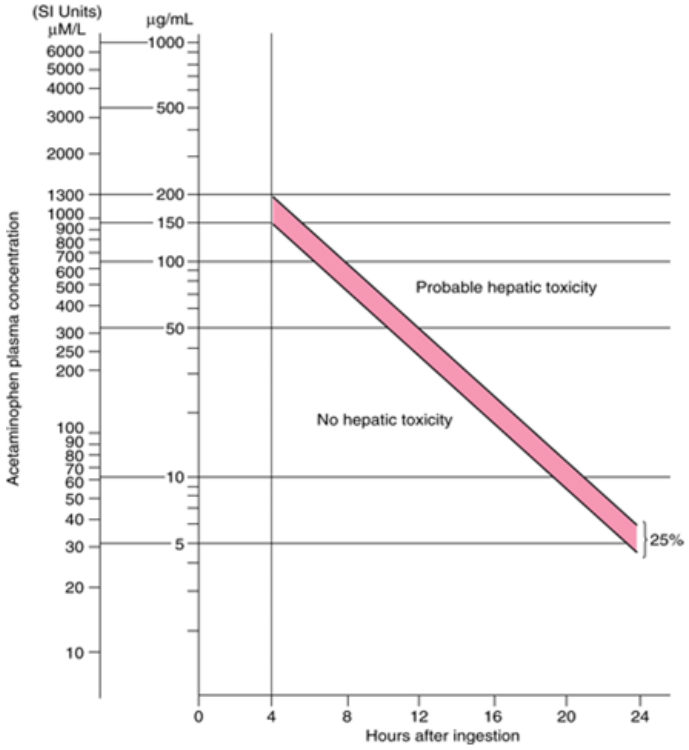
MSEC approved 06/22/11



Acetaminophen Overdose p.2

MSEC approved 06/22/11

Rumack-Matthew nomogram for single acute acetaminophen poisoning



Loading dose for oral acetylcysteine

Body Weight		grams Acetylcysteine	mL of 20% Acetylcysteine Solution	mL of Diluent	Total mL of 5% Solution
(kg)	(lb)				
100-109	220-240	15	75	225	300
90- 99	198-218	14	70	210	280
80- 89	176-196	13	65	195	260
70- 79	154-174	11	55	165	220
60- 69	132-152	10	50	150	200
50- 59	110-130	8	40	120	160
40- 49	88-108	7	35	105	140
30- 39	66- 86	6	30	90	120
20- 29	44- 64	4	20	60	80

Maintenance dose for oral acetylcysteine

Maintenance Dose*					
(kg)	(lb)				
100-109	220-240	7.5	37	113	150
90- 99	198-218	7	35	105	140
80- 89	176-196	6.5	33	97	130
70- 79	154-174	5.5	28	82	110
60- 69	132-152	5	25	75	100
50- 59	110-130	4	20	60	80
40- 49	88-108	3.5	18	52	70
30- 39	66- 86	3	15	45	60
20- 29	44- 64	2	10	30	40

*If patient weighs less than 20 kg (usually patients younger than 6 years), calculate the dose of acetylcysteine. Each mL of 20% acetylcysteine solution contains 200 mg of acetylcysteine. The loading dose is 140 mg per kilogram of body weight. The maintenance dose is 70 mg/kg. Three (3) mL of diluent are added to each mL of 20% acetylcysteine solution. Do not decrease the proportion of diluent.

IV dosing of Acetadote (IV acetylcysteine)

Also go to website ***www.acetadote.net*** and there is a dosing calculator where you can enter the exact weight of the patient and get each of the 3 doses

Table 1. Three-Bag Method Dosage Guide by Weight, patients ≥ 40 kg

Body Weight		LOADING Dose 150 mg/kg in 200 mL diluent ◊ over 60 min	SECOND Dose 50 mg/kg in 500mL diluent over 4 hours	THIRD Dose 100 mg/kg in 1000mL diluent over 16 hours
(kg)	(lb)	Acetadote (mL)	Acetadote (mL)	Acetadote (mL)
100	220	75	25	50
90	198	67.5	22.5	45
80	176	60	20	40
70	154	52.5	17.5	35
60	132	45	15	30
50	110	37.5	12.5	25
40	88	30	10	20

Table 2. Three-Bag Method Dosage Guide by Weight, patients >20 - < 40 kg

Body Weight		LOADING Dose 150 mg/kg over 60 minutes		SECOND Dose 50 mg/kg over 4 hours		THIRD Dose 100 mg/kg over 16 hours	
(kg)	(lb)	Acetadote (mL)	Diluent ◊ (mL)	Acetadote (mL)	Diluent (mL)	Acetadote (mL)	Diluent (mL)
30	66	22.5	100	7.5	250	15	500
25	55	18.75	100	6.25	250	12.5	500

Table 3. Three-Bag Method Dosage Guide by Weight, patients ≤ 20 kg

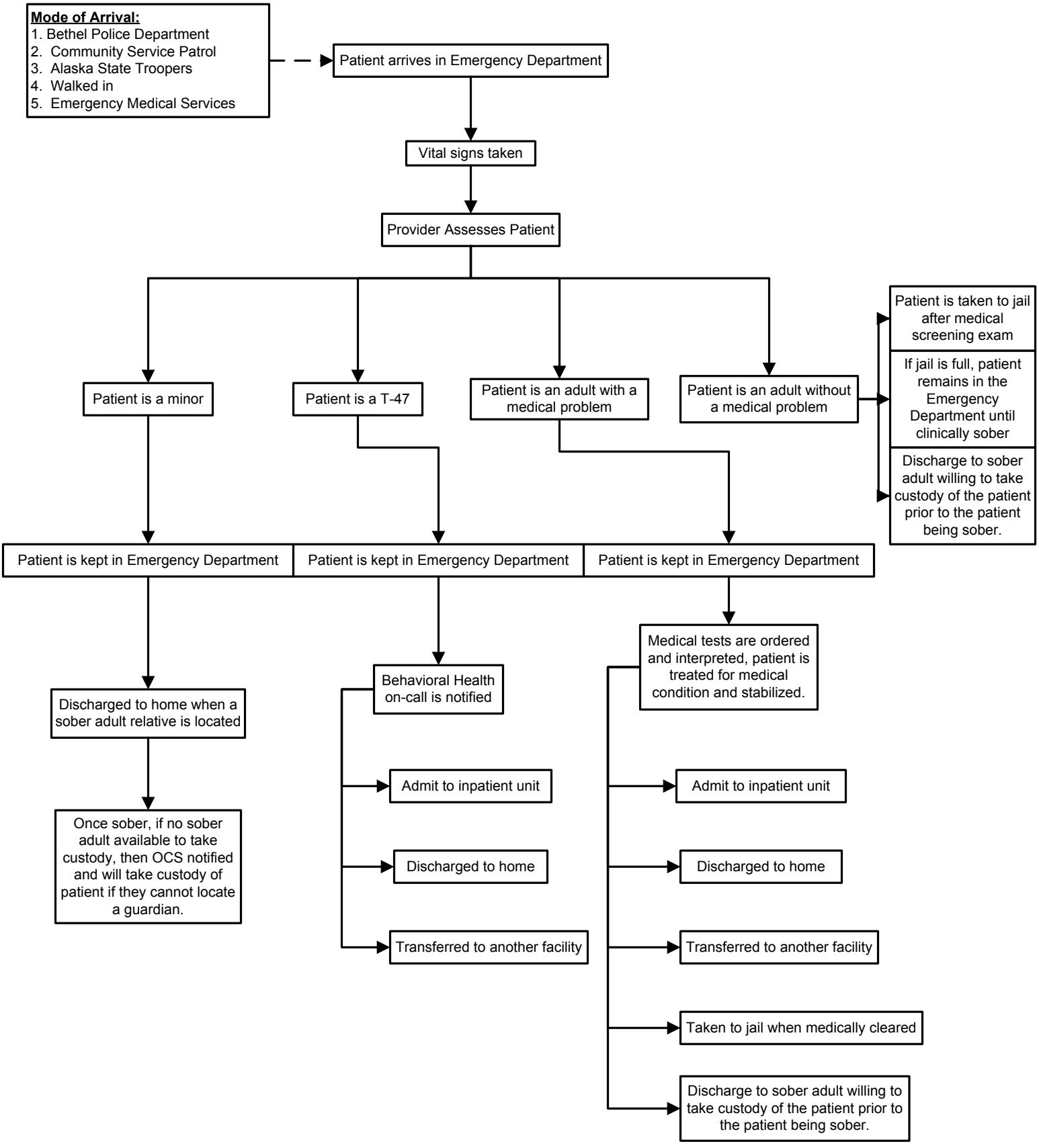
Body Weight		LOADING Dose 150 mg/kg over 60 minutes		SECOND Dose 50 mg/kg over 4 hours		THIRD Dose 100 mg/kg over 16 hours	
(kg)	(lb)	Acetadote (mL)	Diluent ◊ (mL)	Acetadote (mL)	Diluent (mL)	Acetadote (mL)	Diluent (mL)
20	44	15	60	5	140	10	280
15	33	11.25	45	3.75	105	7.5	210
10	22	7.5	30	2.5	70	5	140

◊Acetadote is hyperosmolar (2600 mOsm/L) and is compatible with 5% Dextrose (D5W), ½ Normal Saline (0.45% Sodium Chloride Injection, ½ NS), and Water for Injection (WFI).

YUKON-KUSKOKWIM HEALTH CORPORATION

Intoxicated ER Patient

MSEC approved 06/22/11



Frostbite

MSEC Approved 7/12/17

Patient identified as having potential frostbite

Immediate Emergent Treatment

For patients in village clinic, see CHAM.

STABILIZE PATIENT
Airway, Breathing, Circulation → Assess for and treat hypothermia

RAPID REWARMING of affected area using warm water bath at **98.6-102.2° F**

Consideration should be given for thrombolytics in the first 24 hours, consult with ANMC orthopedics

1. LABS:CBC, CMP
2. IV Fluids for hydration and pain control with IV Morphine

Strongly Consider Hospital Admission, especially with extremity frostbite

Consider Photos
1. Initials, Date and time with tape measure
2. Post Debridement for monitoring

Wound care referral upon admission

DEBRIDEMENT
1. Clear Bulla may be debrided or aspirated at time of admission or initial treatment.
2. Leave hemorrhagic blister and bulla intact as that indicates deeper, more vascular tissue damage.

TOPICAL TREATMENT:
1. Aloe Cream (Dermaide) Q 6 hours
2. Unless infection is strongly suspected **do not use** topical antibiotics
3. If infection is suspected, use bacitracin
4. For exposed skin layers, use adaptic to prevent adhesion and then use Kerlex fluff roll gently wrapped around affected area to protect.
5. Soaking with mild bleach bath: 10-15 min BID – 1.5 mL of 6% sodium hypochlorite per gallon of bath water (60 mL for the 40 gallon tub)

Note: people in crises such as frostbite have lots of time to think and are open to change. ETOH, Nicotine, and behavior modification counseling are very effective during these times.

REFERRALS AND CONSULTS:
1. Behavioral Health referral for severe frostbite or if alcohol is involved.
2. Nutrition consult
3. Tobacco cessation referral

NURSING ORDERS:
1. Elevate area
2. Non weight-bearing – this includes blankets
AVOID ANY PRESSURE

MEDICATION:
1. Pain management
2. Ibuprofen 400 mg QID
3. Protein Supplement, if indicated
4. Vitamin C 500 mg daily
5. Multivitamin one daily
6. Stool softener

LONG TERM CONSIDERATIONS:
1. Neurontin for nerve pain – start with 300 mg TID
2. Grief counseling if loss of body part at appropriate time
3. Physical Therapy for rehabilitative care
4. Referrals as needed for surgery (3 months)
5. DME for supplies.

YUKON-KUSKOKWIM HEALTH CORPORATION

First Trimester Vaginal Bleeding: Ectopic Pregnancy Diagnosis & Treatment of Non-Viable Early Pregnancy

MSEC approved 07/12/17

1
Nomenclature

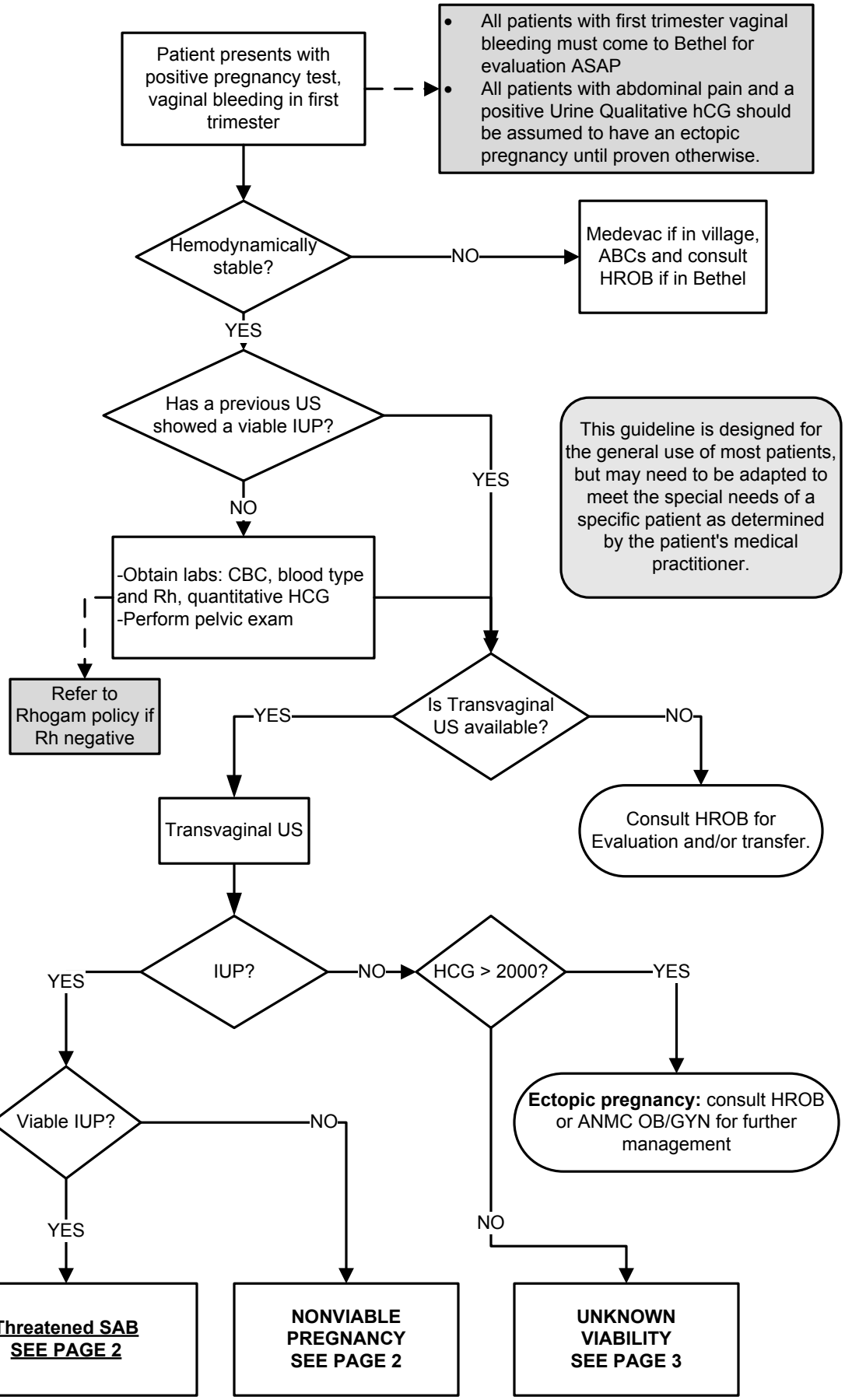
- **Viable** – A pregnancy is vialble if it can potentially result in a liveborn baby.
- **Nonviable** – A pregnancy is nonviable if it cannot possibly result in a liveborn baby. Ectopic pregnancies and failed intrauterine pregnancies are nonviable
- **Intrauterine pregnancy of uncertain viability** – A woman is considered to have this if a transvaginal US shows an intrauterine gestational sac with no embryonic heartbeat and no findings of definite pregnancy failure
- **Pregnancy of unknown location** – A woman is considered to have this if she has a positive urine or serum pregnancy test and no intrauterine or ectopic pregnancy on transvaginal US

2
Findings diagnostic of Pregnancy Failure

- Crown-rump length of ≥7mm and no heartbeat
- Mean sac diameter of ≥25mm and no embryo
- Absence of embryo with heartbeat ≥14 days after an US that showed a gestational sac without a yolk sac
- Absence of embryo with a heartbeat ≥11 days after an US that showed a gestational sac with a yolk sac

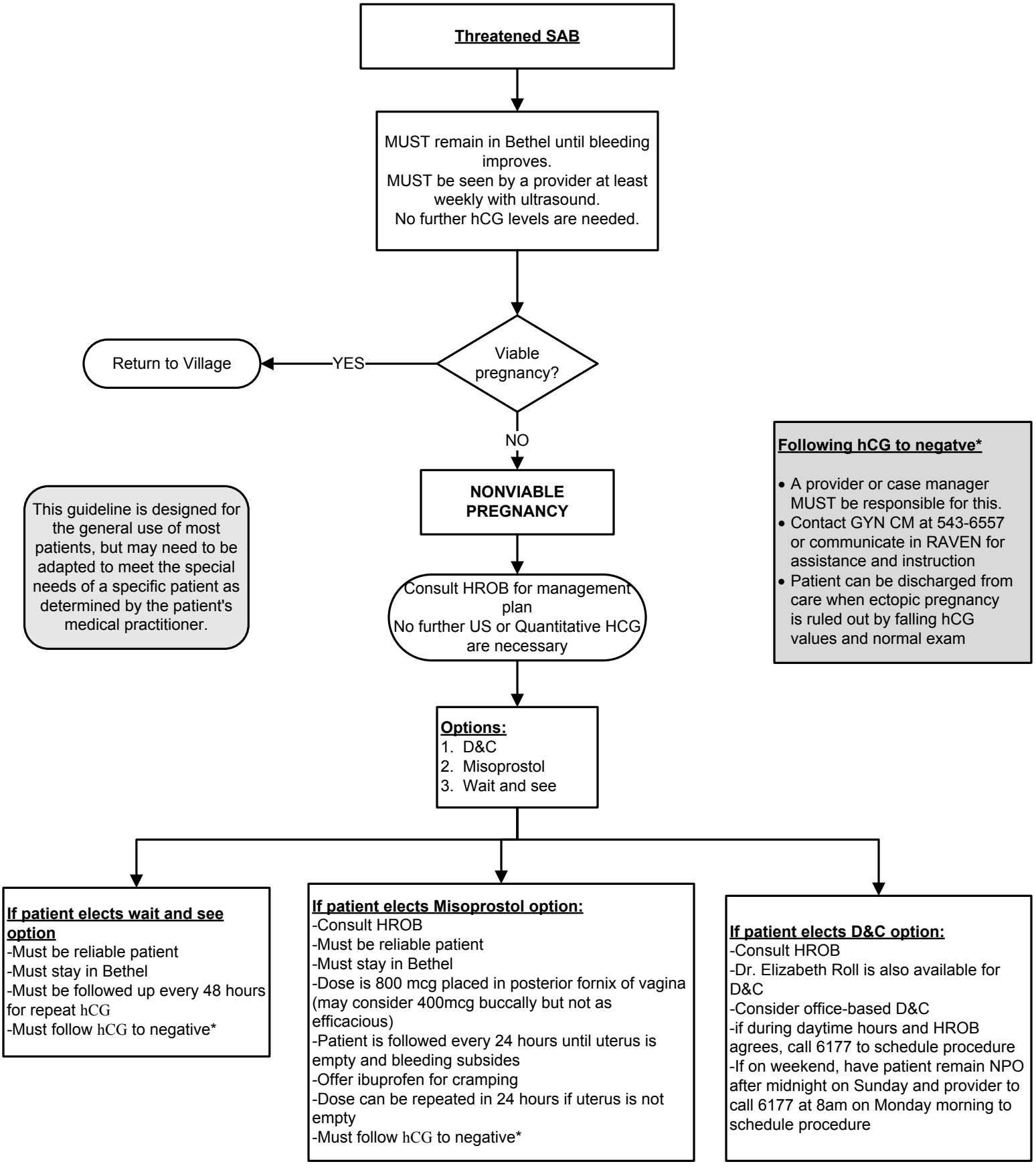
Comments

- In a woman with a positive urine or serum pregnancy test, an intrauterine fluid collection with rounded edges containing no yolk sac is most likely a gestational sac; it is certain to ba a gestational sac if it contains a yolk sac or embryo.
- Transabdominal imaging without transvaginal scanning my be sufficient for diagnosing early pregnancy failure when an embryo whose crown-rump length is 15mm or more has no visible cardiac activity.



First Trimester Vaginal Bleeding: Ectopic Pregnancy Diagnosis & Treatment of Non-Viable Early Pregnancy

MSEC approved 07/12/17



YUKON-KUSKOKWIM HEALTH CORPORATION

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MSEC approved 07/12/17

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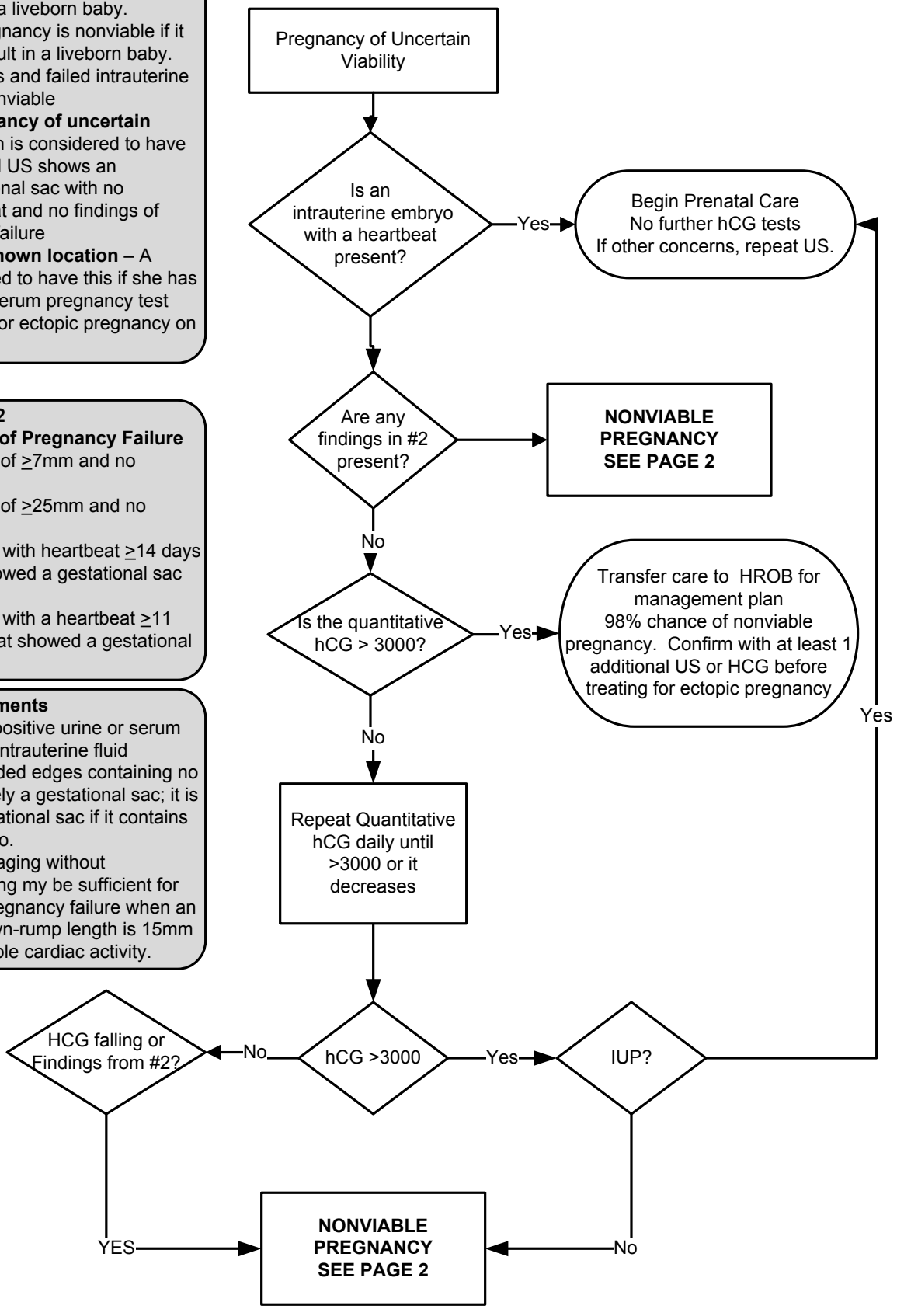

YUKON-KUSKOKWIM HEALTH CORPORATION

CLINICAL GUIDELINES 2017

rev. 10-09-17

Pediatrics Guidelines

Pediatric Emergency Guidelines

(For Pediatric Critical Care Weight-Based Guide, see https://yk-health.org/wiki/File:Pediatric_critical_care_guide.pdf)

YUKON-KUSKOKWIM HEALTH CORPORATION

Critical Care and Medevac Guide – Pediatric

MSEC Approved 9/13/17

Call pediatric hospitalist for all potentially critical pediatric patients.

Remember: non-beneficiary patients are transferred to Providence Alaska Medical Center. Call their PICU at (907) 212-3133 to obtain accepting physician (PICU or hospitalist). Inquire about medevac insurance coverage.

Pediatric patient requires medevac.

Critical pediatric patient (including patients on HFNC, with suspected sepsis, in status epilepticus, with PEWS ≥ 8, etc.)

Pediatric hospitalist (or other physician in consultation with pediatric hospitalist) can call ANMC PICU consultant for advice, management, and accepting physician. (907) 297-8809

YK provider activates LifeMed. *96 or (800) 478-5433

ANMC PICU consultant stays available to support pediatric hospitalist with ongoing patient management as needed.

Pediatric hospitalist may request that ANMC PICU consultant update LifeMed Medical Control if able.

YKHC provider remains in control of management until patient leaves facility.

Trauma, Surgical, Orthopedic Emergency

ER provider calls ANMC for accepting physician via ANMC operator. *97 or (907) 563-2662

For all pediatric trauma cases and surgical cases in children >3 years, call the ANMC general surgeon on call. For surgical cases in children ≤3 years, call the pediatric surgeon on call through the ANMC operator or their office at (907) 717-9871.

Noncritical: for bed space, diagnostic or specialty services not available at YKHC, etc.

ER provider calls ANMC pediatrician for accepting physician via ANMC operator. *97 or (907) 563-2662

Please remember to update the pediatric hospitalist for any CPP patient being transferred.

ER provider activates LifeMed. *96 or (800) 478-5433

ER provider updates LifeMed Medical Control as needed.

Use the Pediatric Critical Care Guide and ED Peds Critical Care PowerPlan.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Intubation – Pediatric

MSEC approved 07/12/17

Prepare
Page pharmacist. Page RT. Prepare several doses of all medications, including an extra dose of paralytic and boluses of post-intubation sedation.

Pre-oxygenate

Premedicate
Atropine – onset <1 minute. Use for younger than 12 months. Consider using in any patient at risk for bradycardia associated with airway manipulation, shock, hypoxia, acidosis, or severe electrolyte abnormalities.

Induce
Midazolam and fentanyl

Paralyze
Rocuronium – onset ~45 seconds. Duration up to 30 minutes.
DO NOT USE SUCCINYLCHOLINE.

Intubate

Confirm placement
1. Direct visualization of tube through cords.
2. CO_2 detector turns yellow and remains yellow after six breaths.
3. Mist in tube.
4. Bilateral equal breath sounds with lack of noise over epigastrium.
5. CXR.

Initiate sedation/ analgesia
• Fentanyl continuous infusion with boluses Q15minutes *prn*. Give bolus prior to starting drip.
CONSIDER:
• Midazolam boluses if needed. Consider continuous infusion if needed. Watch for hypotension.

Place on ventilator
• For ventilator dyssynchrony, give rocuronium boluses as needed.
• Use end-tidal CO_2 monitoring.

Continuously reevaluate

REMEMBER:
Helpful resources include:
• Pharmacist on-call
• Respiratory therapist
• CRNA on-call
• Difficult Airway Drawer with laryngeal mask airway (LMA)
• GlideScope®

Always place NG/OG tube for decompression.

Use the Pediatric Critical Care Guide and ED Peds Critical Care PowerPlan for all medication dosing.

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YUKON-KUSKOKWIM HEALTH CORPORATION

High-Flow Nasal Cannula (HFNC) — Pediatric

MSEC Approved 7/12/17

REMEMBER:
- Any pediatric patient on HFNC must be transferred to the ER except for newborns, who may stay in the nursery.
- Maintain patient on HFNC until medevac crew arrives.
- No pediatric patient may be kept at YKDRH on HFNC unless medevac is on weather-hold.

Patient with moderate to severe sustained retractions or sustained hypoxia <88% not improved with SUPPORTIVE MEASURES (see box) and 2 LPM conventional nasal cannula or infant with apnea responsive to stimulation

↓

Page respiratory therapist.

↓

Page pediatrician on-call.

↓

- Transfer to ER.
- Activate medevac.
- PREPARE PATIENT (see box).

↓

RT to start high-flow nasal cannula with pediatrician consultation.

↓

Initial Settings
Flow 5 LPM, FiO2 50%, 37°C.
For newborns, consult neonatologist.

↓

Titrate flow by 1 LPM increments over first 3 minutes until improvement in WOB.
If patient is worsening on high flow rates, consider a trial of a lower flow rate.

↓

Titrate FiO2 to maintain sats >92%.

↓

Frequent gentle nasal suction

↓

Reassess at least Q20-30 minutes.

↓

Signs of Clinical Improvement
- ↓RR
- ↓retractions
- ↓irritability
- improved air movement

↓

Maintain current settings until medevac arrives.

If no improvement, consider obtaining ANMC PICU consult, checking blood gas, increasing supportive measures, intubation, etc.

SUPPORTIVE MEASURES
- Control fever, as it can be an independent cause of respiratory distress.
- Nasal suction
- IV hydration
- Back-to-back nebs with albuterol or normal saline
- Hypertonic saline nebs q6h

PREPARE PATIENT
- Make patient NPO.
- Ensure reliable IV access.
- Suction nares well.
- Give phenylephrine ophthalmic form 1-2 drops to each nostril once.
- Choose a nasal cannula with prongs that do not occlude more than 50% of the nares.
- Optimal patient position is semi-recumbent, not supine or upright. Use special blue seat (found in ER storage between trauma and ambulance bays) with adjustable angle.
- To prevent condensation causing problems, place patient at a higher level than unit and clip tubing to patient's clothing.

NOTE:
- Low-flow cartridge to be used with neonatal/ infant cannula and produces flow rates of 1-8 LPM. This should only be used in the nursery.
- High-flow cartridge to be used with larger cannula and produces flow rates of 5-40 LPM. In the ER, always start with the high-flow cartridge.

Troubleshooting
- Consider NG/OG-tube for decompression.
- Use a pacifier to keep the patient's mouth closed and prevent loss of pressure.
- Consider mild sedation in consultation with medical control.
- Consider higher levels of flow to improve washout.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

Sepsis – Pediatric

MSEC approved 07/12/17

Shock Criteria

2 or more of the following:
- Temp <96.8 or >100.4
- Abnormal WBC count (<5 or >15)
- Abnormal HR
- Abnormal RR

AND

Signs of End-Organ Involvement:
- Altered mental status
- Delayed cap refill
- Cold/mottled extremities
- Weak pulses
- Difference between central and peripheral pulses
- Significantly decreased UOP
- Hypotension
- Bounding/brisk pulses with rapid cap refill

Patient meets criteria for severe sepsis/shock → Call pediatric hospitalist. Page pharmacist and RT. → Consult PICU by direct line: (907) 297-8809. Activate medevac: *96 or (800) 478-5433

Place on CR monitor.
Start supplemental oxygen. Prepare BVM.
Get access: IV/IO x2.
Bolus: NS 20 mL/kg x2 over ≤ 10 minutes.
Reassess volume status after each bolus.

Use the Pediatric Critical Care Guide and ED Peds Critical Care PowerPlan for all medication dosing.

Labs: bedside glucose, blood culture, electrolytes, CBC, lactate, ionized calcium.

Order empiric antibiotics STAT.

Is patient maintaining airway? — No → Intubate per Pediatric Intubation Guideline.

Yes

If not improving, give third bolus of NS 20 mL/kg.
Correct hypoglycemia.
Correct hypocalcemia.

Is there continuing hypotension, poor pulses, change in mental status, or delayed cap refill?

Yes → Start vasopressor in consultation with PICU. → Continue to give boluses of NS 20 mL/kg unless patient develops rales, respiratory distress, hepatomegaly, or a gallop. → If shock persists, give Solu-Medrol and calcium chloride in consultation with PICU.

No → Monitor closely per Continuing Management Box while awaiting medevac.

Village Management
- Consult pediatric hospitalist.
- Aggressive hydration: IV or PO.
- Supplemental oxygen via nasal cannula.
- Monitor glucose.
- Treat hypoglycemia with Insta-Glucose tubes buccally – NOT rectally.
- Ceftriaxone 100 mg/kg IM.
- Activate medevac.
- Consider VTC.

See Wiki RMT Section for more detailed recommendations.

Place hyperlink

Continuing Management
- VS (including BP) at least Q15min.
- Blood glucose Q30 min.
- Maintenance IVF with D5NS.
- Consider Foley.

Goals
Cap refill <2 sec
Normal BP for age
Normal pulses
Warm extremities
UOP > 1 mL/kg/hour
Normal mental status

Empiric Antibiotic Choice

≤28 days
Ampicillin 100 mg/kg + cefotaxime 50 mg/kg
If concerned about HSV or neurologic impairment, add acyclovir 20 mg/kg

>28 days
Ceftriaxone 100 mg/kg (max 2000 mg)
AND vancomycin 20 mg/kg (max 2000 mg)

If CVL in place, immunocompromised, or significant Hx antibiotics in past 30 days
Cefepime 50 mg/kg (max 2000 mg)
AND vancomycin 20 mg/kg (max 2000 mg)

If allergic to PCN
Meropenem 15 mg/kg (max 500 mg)
AND vancomycin 20 mg/kg (max 2000 mg)

Age	HR (beats/minute)		RR (breaths/minute)		Hypotension (sBP in mmHg)
	Bradycardia	Tachycardia	Low	High	
0 days – 1 week	<100	>200	<30	>70	<60
1 week – 1 month	<100	>200	<30	>70	<60
1 – 3 months	<100	>180	<20	>60	<70
3 – 12 months	<100	>180	<20	>60	<70
1 – 2 years	<90	>160	<20	>40	<70
2 – 6 years	<60	>160		>40	<80
6 – 13 years	<60	>120		>23	<90
13 – 18 years	<60	>110		>23	<90

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

Seizure Evaluation – First Non-Febrile

MSEC approved 11/12/13

Box 1: History
Associated features:
-Age
-Family history
-Development
-Health at onset of seizure
-Precipitating factors (trauma, toxins)

Symptoms during seizure:
-Abnormal jerking/shaking, eye movements or deviation, head positioning, posturing, stiffening, lip smacking, blinking
-Loss of consciousness or decreased responsiveness
-Irregular respirations or cyanosis
-Abnormal vocalizations
-Drooling, incontinence, vomiting
-Aura

Post ictal symptoms:
-Confusion
-Lethargy
-Transient focal weakness (Todd's paralysis)
-Nausea/vomiting
-Irritability

Seizure lasting >5 minutes

Yes

Status Epilepticus:
1. Call Pediatrics
2. Start treatment per Broselow Weight-Based Critical Care Sheet or Pediatric Critical Care PowerPlan.
GET BEDSIDE GLUCOSE
3. If patient is in village, use IV form of diazepam (Valium). Give 0.5 mg/kg RECTALLY.
May repeat q5 minutes up to three total doses.
Prepare bag and mask prior to giving.

No

Obtain detailed history (See Box 1) and perform focused neurologic exam

Perform work-up as appropriate. (See Box 2)

Box 2: Work-up
Labs:
-Obtain bedside glucose and electrolytes, including magnesium
Consider:
-Urine drug screen
-Perform LP if persistent altered mental status, meningitis suspected, or < 12 months of age and delayed return to baseline
-Other labs as indicated by history and physical exam

Radiological studies:
-Obtain head CT if history of trauma or focal neurological findings

Follow-up with pediatrics to consider EEG, MRI, and/or neurology consult.

Differential Diagnosis of Convulsions:
- Breath holding
- Syncope
- Arrhythmia

This guideline is designed for the general use of most patients, but may need to be adapted to meet the special needs of a specific patient as determined by the patient's medical practitioner.

Underlying Causes of Seizures
- Hypoglycemia
- Hyponatremia
- Meningitis
- Trauma
- Metabolic disorder
- Ingestion
- Hypoxia
- Tumor
- Cerebral hemorrhage

At discharge, prescribe Diastat (rectal diazepam gel).
No daily antiepileptics are indicated unless:
-recurrent seizures
-atypical seizures
-recommended by neurology consult

Indications for Admission or Transfer:
-Status epilepticus
-Cluster of seizures
-Increased intracranial pressure
-CNS infection
-Structural lesion
-Patient does not return to baseline mental status

YUKON-KUSKOKWIM HEALTH CORPORATION

Seizure Evaluation – First Febrile

MSEC approved 11/12/13

Box 1
Low risk febrile seizure criteria
1. 6 mo to 3 years of age **AND**
2. Fever present **AND**
3. Seizure generalized (nonfocal) **AND**
4. Seizure duration <15 min **AND**
5. Child has normal neurologic examination **AND**
6. Child has no history of previous neurologic or CNS abnormality **AND**
7. Only one seizure in a 24 hr period.

Seizure lasting >5 minutes

Yes

Status Epilepticus:
1. Call Pediatrics
2. Start treatment per Broselow Weight-Based Critical Care Sheet or Pediatric Critical Care PowerPlan.
GET BEDSIDE GLUCOSE
3. If patient is in village, use IV form of diazepam (Valium). Give 0.5 mg/kg RECTALLY.
May repeat q5 minutes up to three total doses.
Prepare bag and mask prior to giving.

No

Does the presentation meet low risk febrile seizure criteria? (See Box 1)

No

Consult Pediatrics

Yes

Box 2
Meningeal Signs
1. Irritability or inconsolability
2. Nuchal rigidity
3. Bulging fontanelle
4. Lethargy or somnolence
5. Focal neurologic findings

Obtain bedside glucose and electrolytes, including magnesium.
Look for source of fever.
Do not routinely obtain head CT.

Meningeal signs present? (See Box 2)
OR
Patient received antibiotics in the past 72 hours?
OR
Age <6 months?

Yes

Perform a lumbar puncture

No

Is child <18 months?

Yes

Consider performing a lumbar puncture, given that signs and symptoms of meningitis in a child <18 months may be absent or subtle

LP results abnormal

Yes

Start ceftriaxone 100 mg/kg IV
Consult Pediatrics

No

No

Child >18 mo of age without meningeal signs

(Do not routinely perform lumbar puncture or obtain head CT.)

Child with simple febrile seizure

1. Discharge patient with pediatrics follow-up.
2. Educate parents concerning febrile seizure. Give febrile seizure education handout.
3. Treat infection if appropriate.
4. EEG unnecessary.

If bacterial meningitis is suspected by LP and/or history and exam, give dexamethasone 0.15 mg/kg IV BEFORE OR CONCURRENT WITH ANTIBIOTICS.

This guideline is designed for the general use of most patients, but may need to be adapted to meet the special needs of a specific patient as determined by the patient's medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

Fever – Infants 0-90 days

MSEC Approved 2/10/16

Infant 0-90 days with recorded or reported rectal temperature ≥100.4°F

Evaluation and management in Bethel

Sick-appearing

Well-appearing with age-appropriate normal vital signs

0-28 days

29-90 days

Perform full work-up, including:
-CBC with manual differential
-CRP
-Blood culture
-U/A, urine culture
-CXR
-LP if stable
-RSV, flu nasal swabs

Admit or medevac, as appropriate. Give antibiotics (see Treatment Box).

Perform partial work-up:
-CBC with manual differential
-CRP
-Blood culture
-U/A, urine culture
-Consider CXR

Meets all Low Risk Criteria?

No

Strongly consider performing LP if stable.
Consider giving antibiotics (see Treatment box).

Yes

Observe in Bethel with no antibiotics with daily follow-up until cultures are negative at 48 hours.
Inform family of plan.
Patient Education Handout is available (Fever Follow-Up Instructions-PEDS).

Feel free to consult a pediatrician at any time with any questions.

RMT for Febrile Infants 0-90 days
If well-appearing, send to Bethel on next commercial flight.
If travel to Bethel will be delayed or if infant is not well-appearing, consult peds to discuss treatment options.

Low Risk Criteria
-Well-appearing
-Previously healthy
-Full term >37 weeks
-No focal bacterial infection, such as pneumonia or UTI.
-WBC count 5-15
-Absolute band count <1500
-No thrombocytopenia
-U/A with negative nitrites, negative leukocyte esterase, <10 WBC

Treatment
No febrile infant <90 days should receive antibiotics without an LP.
-0-28 days: ampicillin 50 mg/kg IV Q6h AND cefotaxime 50 mg/kg IV Q8h
-29-90 days: ceftriaxone 75 mg/kg IV/IM Q24h OR if worried about meningitis 100 mg/kg IV once then 50 mg/kg IV Q12h
-If worried about HSV, acyclovir 20 mg/kg IV Q8h with IVF and consult pediatrics.

Special Circumstances
1. Immunizations within 24 hours of fever <101 and well-appearing: no work-up necessary but must follow-up in village or Bethel within 12-24 hours. If fevers persist or infant is not well-appearing, perform work-up as above.

2. Pre-treatment with antibiotics with no focal bacterial infection: infant must be observed a full 48 hours off antibiotics. This may require staying in Bethel for 48 hours of antibiotics followed by another 48 hours of observation off antibiotics with daily follow-up.

3. Unsuccessful LP: treat if appropriate and attempt repeat LP in 12-24 hours and determine treatment course based on cell counts. If unsuccessful, either treat for 10 days with meningitic dosing of IV antibiotics or stop antibiotics at 48 hours and observe infant for an additional 48 hours off antibiotics. Consider admission.

HSV Risk Factors
Seizure
Maternal history of oral or genital HSV in infant <28 days who was delivered vaginally

HSV Work-up
-CSF HSV PCR
-Blood HSV PCR
-CMP
-Nasopharyngeal, conjunctival, and anal swabs and vesicle fluid for HSV PCR.

Normal CSF	0-28 days	29-90 days
WBC	<20	<10
Glucose	>40	>40
Protein	<120	<120

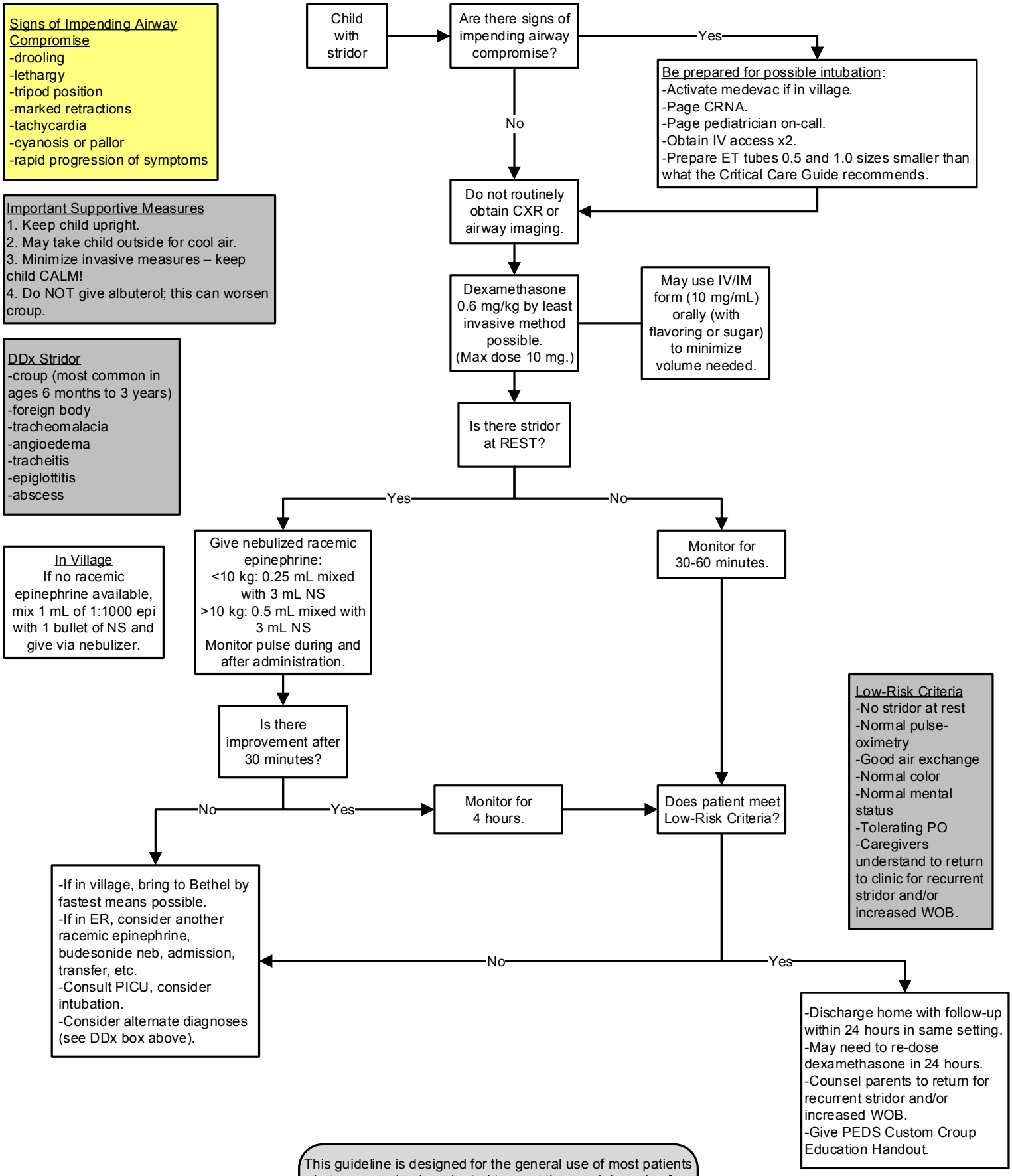
Absence of neutrophils (polys) makes bacterial meningitis unlikely.
CSF Neutrophils (polys) >75% increases likelihood of bacterial meningitis.
Do not use correction formulas for traumatic LPs.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

Croup/Stridor: Evaluation & Treatment

MSEC Approved 7/12/17



This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

Bronchiolitis / Wheezing – 3-24 Months

MSEC Approved 2/11/15

NOTE:
-If <3 months or history of prematurity, keep patient in Bethel and have low threshold for admission.
-RSV increases risk of apnea in these patients.
-If patient is <90 days and febrile, please see fever guidelines.

Wheezing

Institute SUPPORTIVE MEASURES
Then reassess respiratory distress

SUPPORTIVE MEASURES
-control fever, as it can be an independent cause of respiratory distress and tachycardia
-nasal suction with nasal bulb syringe and olive tip plus saline
-hydration
-gentle P&PD/CPT if helpful
-saline neb (0.9%)
-consider albuterol trial, especially in Alaska Native patients as they have high rates of RAD

Tachypnea
0-2 mo: >60
2-12 mo: >50
12-24 mo: >40

Moderate to severe respiratory distress
Sustained tachypnea, increased work of breathing, and/or hypoxia

Mild respiratory distress
Intermittent tachypnea, increased work of breathing, and/or hypoxia

Obtain CXR

Hypoxia
<90% while awake
<88% while asleep
Sustained for >10 minutes

Evidence of pneumonia?

Continue SUPPORTIVE MEASURES with close follow-up as needed

NOTE ABOUT STEROIDS:
National guidelines recommend against systemic steroids as the potential harm is generally greater than the potential benefit.
If considering starting steroids, please consult a pediatrician.

Yes

Please see Pediatric Community-Acquired Pneumonia Clinical Guideline

No

-Requires >2 L supplemental oxygen to prevent hypoxia or improve WOB?
-Requires neb treatments more frequently than Q3-4h for >8 hours?
-Has sustained tachycardia, tachypnea, or respiratory distress despite treatment?

When Admitting, Use PowerPlan to Order:
-nasal suction
-IVF
-prn nebs
-consider scheduled nebs
-no deep (nasopharyngeal) suctioning
-respiratory assessments
-consider hypertonic (3%) saline – may need to use with albuterol

Yes

Transfer to Anchorage. Consider high flow

No

Admit to YKHC Peds Inpatient Unit with IV fluids

After 48-72 hours

No

Improvement ?

Yes

-Patient improving with increased appetite and activity, less WOB, and decreasing fever curve?
-No hypoxia on room air?
-Tolerating home therapy with competent caregivers?
-Immunizations UTD?

Consider:
-nasal steroids or neosynephrine
-more frequent albuterol/ hypertonic saline nebs
-racemic epi neb

No

Yes

Discharge home with close follow-up within a week

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

Pneumonia – Pediatric > 3 Months

MSEC Approved 5/13/15

REMEMBER:
If patient is <90 days and febrile, please see fever guidelines.

Tachypnea
0-2 mo: >60
2-12 mo: >50
12-24 mo: >40

Hypoxia
<90% while awake
<88% while asleep
Sustained for >10 minutes

Cough ± fever

Institute SUPPORTIVE MEASURES
Then reassess respiratory distress

SUPPORTIVE MEASURES
-control fever, as it can be an independent cause of respiratory distress and tachycardia
-nasal suction with nasal bulb syringe and olive tip plus saline
-hydration
-gentle P&PD/CPT if helpful
-saline neb (0.9%)
-consider albuterol trial, especially in Alaska Native patients as they have high rates of RAD

Pneumonia is a clinical diagnosis and does not require X-ray findings.
Any child <5 years with suspected pneumonia should be evaluated in Bethel or an SRC.

Moderate to severe respiratory distress
Sustained tachypnea, increased work of breathing, and/or hypoxia

Mild or no respiratory distress
Intermittent tachypnea, increased work of breathing, and/or hypoxia

- CXR (PA & lateral)
- CBC, CRP, and blood culture
- RSV and flu if <3 years
- Sputum culture if >5 years and able

Consider CXR if <5 years old given high rates of pneumonia in Alaska Native population.

Pneumonia / No pneumonia

Treatment
1st line: ampicillin 50 mg/kg/dose IV Q6h
2nd line: Unasyn 50 mg/kg/dose IV Q6h
3rd line: ceftriaxone 75 mg/kg/dose IV Q24h

Consider other diagnoses: RAD, bronchiolitis, TB, acidosis, toxins, etc.

No pneumonia / Pneumonia

Treatment for 10 days
1st line: amoxicillin 45 mg/kg/dose PO BID
2nd line: Augmentin 45 mg/kg/dose PO BID
3rd line: cefdinir 7 mg/kg/dose PO BID

- Place PPD if older than 6 months and no PPD in past 6 months.
- Discharge home with follow-up within 48-72 hours.

-Requires >2 L supplemental oxygen to prevent hypoxia or improve WOB?
-Requires neb treatments more frequently than Q2-3h for >8 hours?
-Sustained tachycardia, tachypnea, or respiratory distress despite treatment?
-Significant pleural effusion?

Yes / No

Transfer to Anchorage

Admit to YKHC Peds Inpatient Unit, using PED Admission/ Respiratory Infection PowerPlan

After 48-72 hours

- Patient improving with increased appetite and activity, less WOB, and decreasing fever curve?
- No hypoxia on room air?
- Tolerating home therapy with competent caregivers?
- Immunizations UTD?
- Negative PPD?

Improvement? Yes / No

- Consult pediatrics.
- Consider repeating CXR and labs.
- Consider IVF.

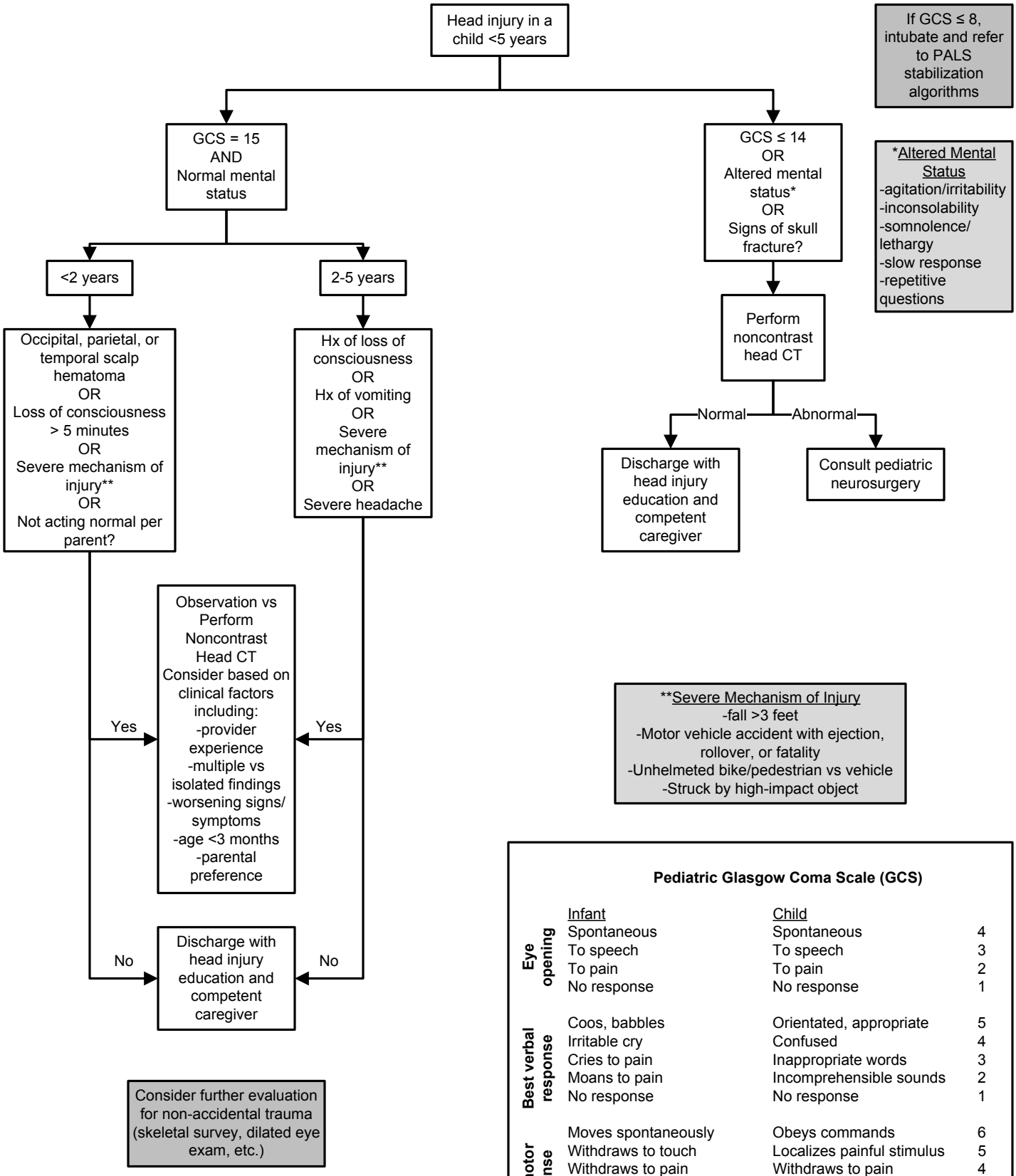
- Change to oral antibiotics for total of 10 days of treatment.
- Discharge home with follow-up within 48-72 hours.

For PCN allergy: If reaction was non-anaphylactic, may trial amoxicillin with monitoring. If reaction was anaphylaxis, treat with a cephalosporin. If any questions, please obtain a pediatrics consult.
Azithromycin: **Do not prescribe azithromycin** unless there is evidence of an atypical pathogen and child is >5 years.
RUL infiltrate: consider starting with Augmentin/ Unasyn to cover for oral anaerobes.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Head Injury in Children < 5 Years

MSEC Approved 4/8/15



Pediatric Glasgow Coma Scale (GCS)

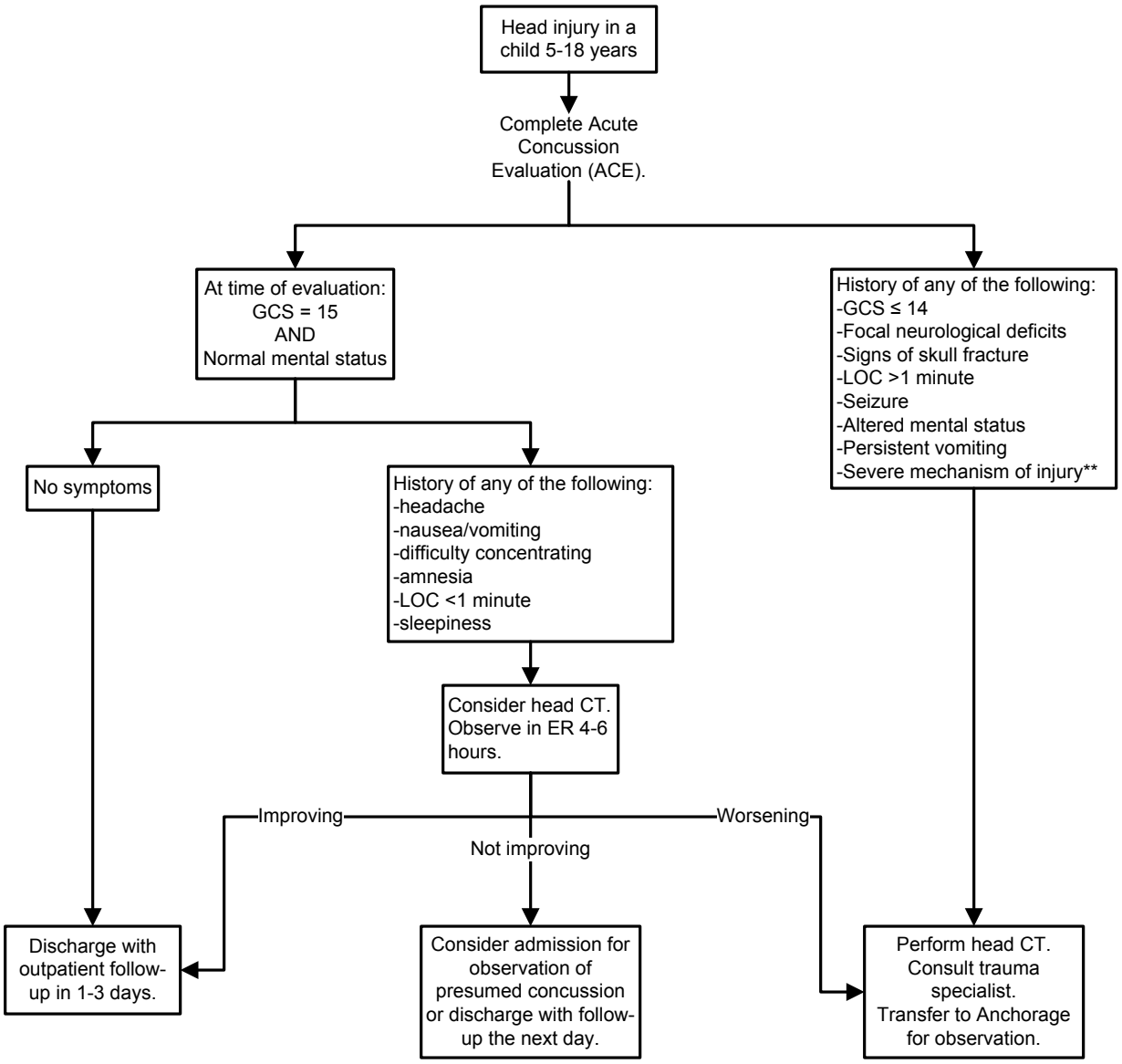
	Infant	Child	
Eye opening	Spontaneous	Spontaneous	4
	To speech	To speech	3
	To pain	To pain	2
	No response	No response	1
Best verbal response	Coos, babbles	Orientated, appropriate	5
	Irritable cry	Confused	4
	Cries to pain	Inappropriate words	3
	Moans to pain	Incomprehensible sounds	2
	No response	No response	1
Best motor response	Moves spontaneously	Obeys commands	6
	Withdraws to touch	Localizes painful stimulus	5
	Withdraws to pain	Withdraws to pain	4
	Flexion to pain	Flexion to pain	3
	Extension to pain	Extension to pain	2
	No response	No response	1

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

Head Injury/Concussion 5-18 Years

MSEC Approved 9/14/16



Avoid medications that can worsen somnolence. Consider prescribing acetaminophen, ibuprofen, and ondansetron as needed.

Outpatient Follow-Up
-Complete ACE at every visit.
-Consider balance testing.
-Return to school per CDC Heads Up Protocol. (http://www.cdc.gov/headsup/index.html)
-Return to play per ASAA Guidelines.
-If symptoms persist >3-4 weeks, consider referral to neurologist, psychologist, physical therapy, etc.

**Severe Mechanism of Injury
-Fall >3 feet
-Motor vehicle accident with ejection, rollover, or fatality
-Unhelmeted bike/pedestrian vs vehicle
-Struck by high-impact object

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

CLINICAL GUIDELINES 2017

rev. 10-09-17

Pediatric Outpatient Guidelines

UTI – Children 3 Months–5 Years

MSEC Approved 9/14/16

Signs and Symptoms of UTI
-fever
-dysuria
-vomiting
-abdominal pain
-new daytime or nighttime wetting
-increased frequency of voiding
-malodorous urine

Differential Dx for Dysuria
-UTI
-vulvovaginitis
-Candida infection
-poor hygiene
-sexual abuse
-age-appropriate self-exploration

Child less than 5 years of age with concern for UTI

Obtain catheterized or true clean catch urine sample for urinalysis (UA) AND culture.

UA positive for leukocyte esterase and/or nitrites and/or microscopy >5 WBC/HPF.

If RMT from village refer to Bethel for further evaluation.

Ensure urine culture is sent.

Patient appearing toxic?

Yes

Empiric antibiotic treatment: ceftriaxone 75mg/kg/day IV

No

Consider empiric treatment with cephalexin 30 mg/kg/dose Q8h x10 days.
May defer empiric treatment and await culture sensitivities.

Positive urine culture with single species ≥50,000 CFU/mL in a catheterized sample or ≥100,000 CFU/mL in a clean catch sample?

No

No UTI.
Stop antibiotics.

Yes

Treat per sensitivities.
May narrow coverage.

Once clinically improved and sensitivities established, switch to oral antibiotics

If first UTI, renal ultrasound when available to evaluate anatomy.

Renal abnormality identified.

Second febrile UTI.

VCUG when radiologist in Bethel.

NOTE: DO NOT treat any child under 5 years of age empirically in the village.
-If patient has dysuria, increased frequency, enuresis, and/or abnormal clean catch urinalysis, consider further evaluation in Bethel.
-Do not routinely collect urine via bag.
-Do not treat a UTI without a culture in progress.
-Do not routinely perform a test of cure.
-Do not routinely start UTI prophylaxis.

Resistance
-Increasing local resistance patterns makes empiric treatment challenging.
-If urine culture grows an Extended-Spectrum Beta-Lactamase (ESBL) producing organism, please obtain a pediatrics consult.

NOTE: Any infant with a fever <90 days must go to the Emergency Department for evaluation.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Otitis Media 3 Months–12 Years

MSEC Approved 9/14/16

Table 1: AOM Decision-Making Principles
- Try not to give antibiotics if observation is warranted.
- Always treat pain.
- If patient has not received amoxicillin within 30 days, start with amoxicillin to treat new infection.
- For AOM with otorrhea, use otic drops if >6 months. Do not use oral antibiotics unless the other ear is infected without perforation.
- Do not treat fluid that develops after AOM if child is asymptomatic – observe up to 3 months.
- Do not use azithromycin, erythromycin, cephalexin (Keflex), or Septra for AOM.
- Do not use antibiotic prophylaxis.

AOM ≥3 months
Acute onset of:
- Fever and ear pain
- Bulging TM and decreased mobility

See Table 1.

Always address pain:
- acetaminophen if >3 months old
- acetaminophen and/or ibuprofen if >6 months old

Is observation appropriate? (See Table 2.)

Yes → Child is observed for 48-72 hours with follow-up

No → Start antibiotics per Table 3.

Did patient improve within 48-72 hours?

Yes → Follow-up as appropriate.

No → Reassess to confirm diagnosis of AOM.

Is diagnosis of AOM confirmed?

Yes → Initiate or change antibiotics per Table 3.

No → Assess for other causes of illness and manage appropriately.

Consider **Otitis Media with Effusion (OME)** if no acute symptoms but decreased TM mobility. Non-infected fluid may persist for 3 months after AOM. If present ≥3 months, evaluate hearing.

AOM <3 Months Old
If suspecting AOM <3 months old, patient must be seen by provider within 24 hours.
- ≤28 days old: patient must be seen in the ER for full lab work-up including LP and treatment with IV antibiotics.
- 29-60 days old with or without fever, patient must be seen in the ER for full lab work-up including LP.
  - -If febrile, follow fever < 90 days clinical guideline.
  - -If afebrile and reassuring work-up, may treat with oral antibiotics as appropriate.
- 61-90 days old:
  - -If febrile, follow fever < 90 days clinical guideline.
  - -If afebrile and sick-appearing, perform work-up as clinically appropriate. May consult peds as needed.
  - -If afebrile and well-appearing, lab work-up not necessary. May treat with oral or otic antibiotics as appropriate.

Table 2: Eligibility for Observation for 48-72 hours
- 6-24 month old with mild, uncertain, or unilateral AOM
- >24 month old with mild/moderate (non-bulging) AOM
- Caregiver comfortable withholding antibiotics
- Follow-up assured
- Antibiotics can be started promptly if symptoms persist or worsen
- No fever >102°F and only mild otalgia

Table 3: AOM Treatment
1st line: amoxicillin 45 mg/kg/dose PO BID for 10 days
2nd line: Augmentin 45 mg/kg/dose PO BID for 10 days
3rd line: cefdinir 7 mg/kg/dose PO BID for 10 days
4th line: ceftriaxone 75 mg/kg IV/IM QD for 3 days

Otitis-conjunctivitis syndrome
Augmentin 45 mg/kg/dose PO BID for 10 days

Try to avoid using cephalosporins. They are less effective at treating the most common organisms that cause OM. Additionally, cefdinir takes 3-5 days to reach the villages.

For PCN allergy: Please obtain a pediatrics consult.

For ruptured TM/tube drainage:
Wick ears prior to giving drops.
Ofloxacin 3-5 drops BID x10 days
Ciprodex 3-5 drops BID x10 days

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

When to Refer to ENT
- 3 episodes of AOM in 6 months
- 4 episodes of AOM in 12 months
- OME or otorrhea for ≥3 months
- Hearing loss >20 dB

Sinusitis > 5 Years

MSEC Approved 4/8/15

Differential Diagnosis
-foreign body
-seasonal/environmental allergies
-recurrent/back-to-back viral rhinitis or nasopharyngitis

Fever and rhinorrhea in **>5 years old**

If considering the diagnosis of sinusitis in a child younger than 5, please consult a pediatrician.

Consider sinusitis

Persistent Illness
Nasal discharge and daytime cough for >10 days **with no improvement**

Observe for 3 days. Follow-up by phone or by appointment.

Worsening Course
One week of worsening nasal discharge, daytime cough, and fever after initial improvement

Severe Onset
Fever >102 and purulent nasal discharge for >3 consecutive days

If no improvement

Treatment
1st line High-dose amoxicillin 45 mg/kg/dose PO BID for 14 days
2nd line High-dose Augmentin 45 mg/kg/dose PO BID for 14 days
3rd line Cefdinir 14 mg/kg/day PO for 14 days
Try to avoid using cephalosporins. They are less effective at treating the most common organisms that cause sinusitis. Additionally, cefdinir thakes 3-5 days to reach the villages.
For PCN allergy: Please obtain a pediatrics consult.
Do not prescribe azithromycin or Septra. The most common pathogens in pediatric sinusitis have high resistance rates to these antibiotics.

Follow-up by phone or by appointment at 3 days. If no improvement, consider broadening to next line of treatment.

Follow-up 10-14 days after starting treatment. If still symptomatic, consider lengthening course to total 21-28 days of treatment.

Imaging
Do not routinely obtain imaging studies in suspected sinusitis unless there is concern for a complication like orbital or CNS involvement. Do not treat sinusitis, in the absence of symptoms, if it is an incidental finding on an imaging study.

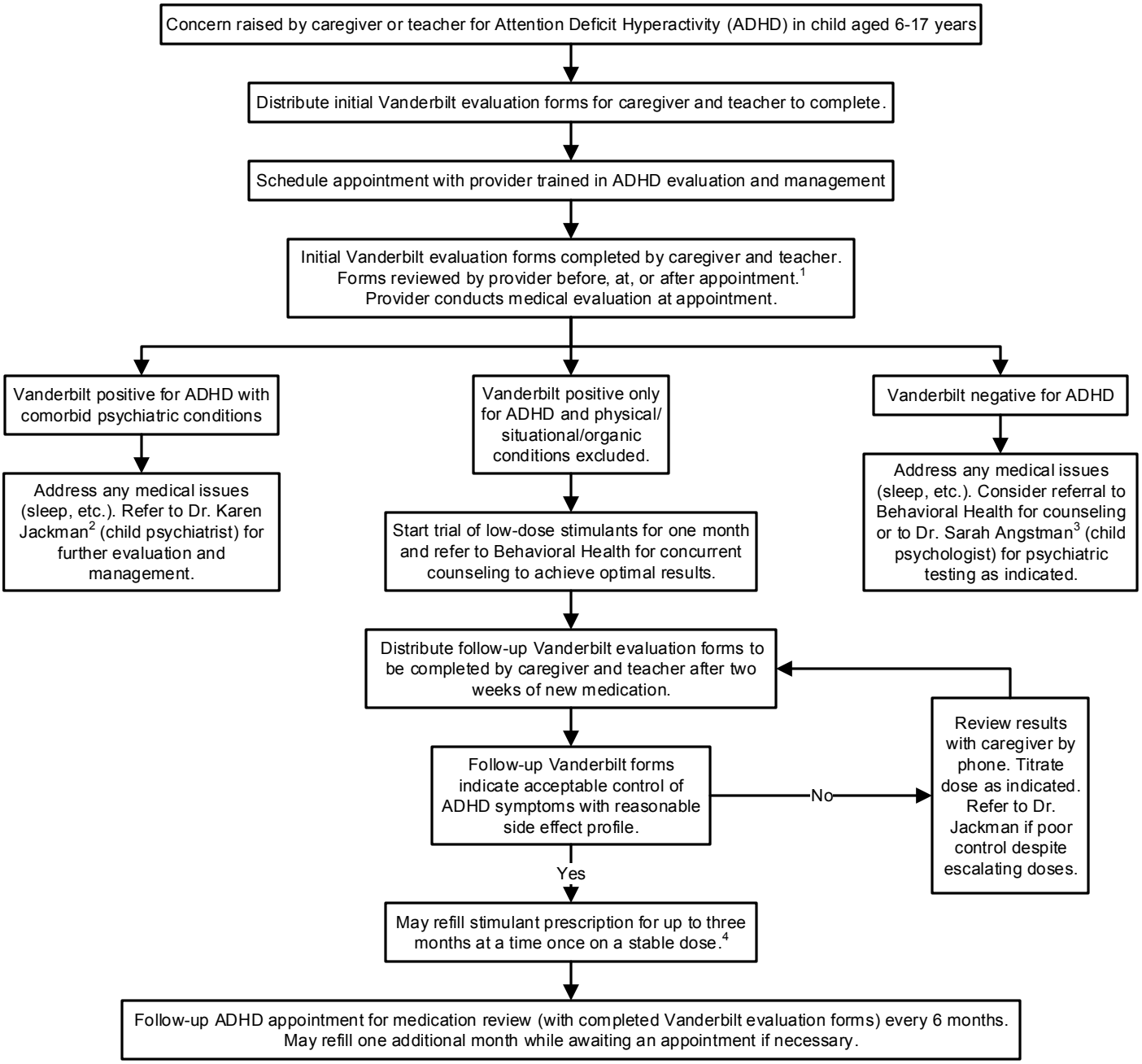
Adjuvant Therapies
-Saline nasal spray
-Steam
-Oral hydration
-Tylenol and ibuprofen
-Do not routinely give decongestants and antihistamines (especially Benadryl). They have been proven ineffective in children and are unsafe under 6 years old.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

Attention Deficit Hyperactivity Disorder in Children

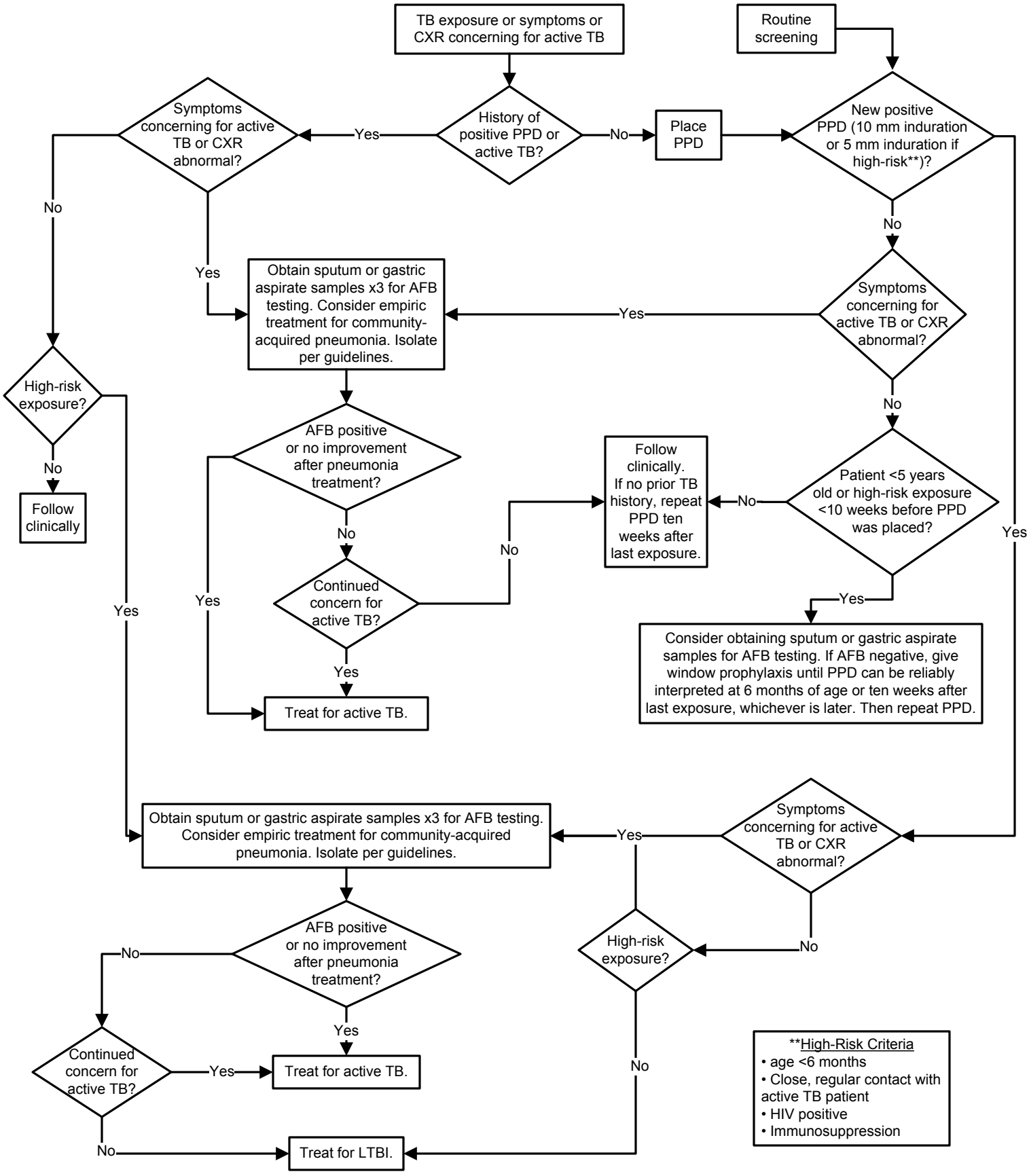
MSEC approved 07/12/17



1. Scan completed Vanderbilt forms into MultiMedia Manager under "Continuity of Care."
2. Use "Refer to Peds Psychiatry Internal" order. Dr. Jackman may be contacted at (907) 230-3765 or jackman@alaska.net.
Her case manager is Patricia Sipary at ext 6466.
3. Use "Refer to Other External" order and send a message to the case manager to process the referral. Dr. Angstman may be contacted at (907) 545-5330.
4. Write three separate 30 day prescriptions. In the Special Instructions box of the two additional prescriptions, enter the earliest date the prescription may be filled (e.g. "Fill on/after 2/1" and "Fill on/after 3/1"). Bring the two additional prescriptions to case manager to be held until refill is requested by caregiver.

TB Evaluation & Treatment – Pediatric

MSEC Approved 9/14/16



Abbreviations: TB- tuberculosis; CXR- chest X-ray; PPD- purified protein derivative; AFB- acid-fast bacilli; HIV- human immunodeficiency virus

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

Suspected Prepubescent Child Sexual Abuse Procedure, p.1

MSEC Approved 9/21/17

A suspicion, allegation, disclosure, or confession of prepubescent child sexual abuse occurs.

No further questioning or examination of child unless medical emergency.

For emergency medical concerns including active bleeding, copious discharge, or significant pain, AST or BPD will arrange to bring patient to ER for emergent evaluation and treatment.

Mandatory reporters must report to:
Office of Children's Services
AND law enforcement
(AST if incident occurred in village or BPD if incident occurred in Bethel)

• Mandatory Reporters include: Medical providers, nurses, health aides, teachers, social workers, law enforcement officers, and mental health professionals.
• Report should be made by the professional who was made aware of the concern.

Law enforcement will contact CAC to arrange interview if indicated and coordinate travel arrangements to Bethel.

Interview will be conducted by CAC forensic interviewer at CAC.

<96 hours since abuse

Call SARU on-call phone to see if there is a pediatric-certified SARU examiner available.
If not, law enforcement will arrange travel to Alaska CARES for acute exam.

>96 hours since abuse

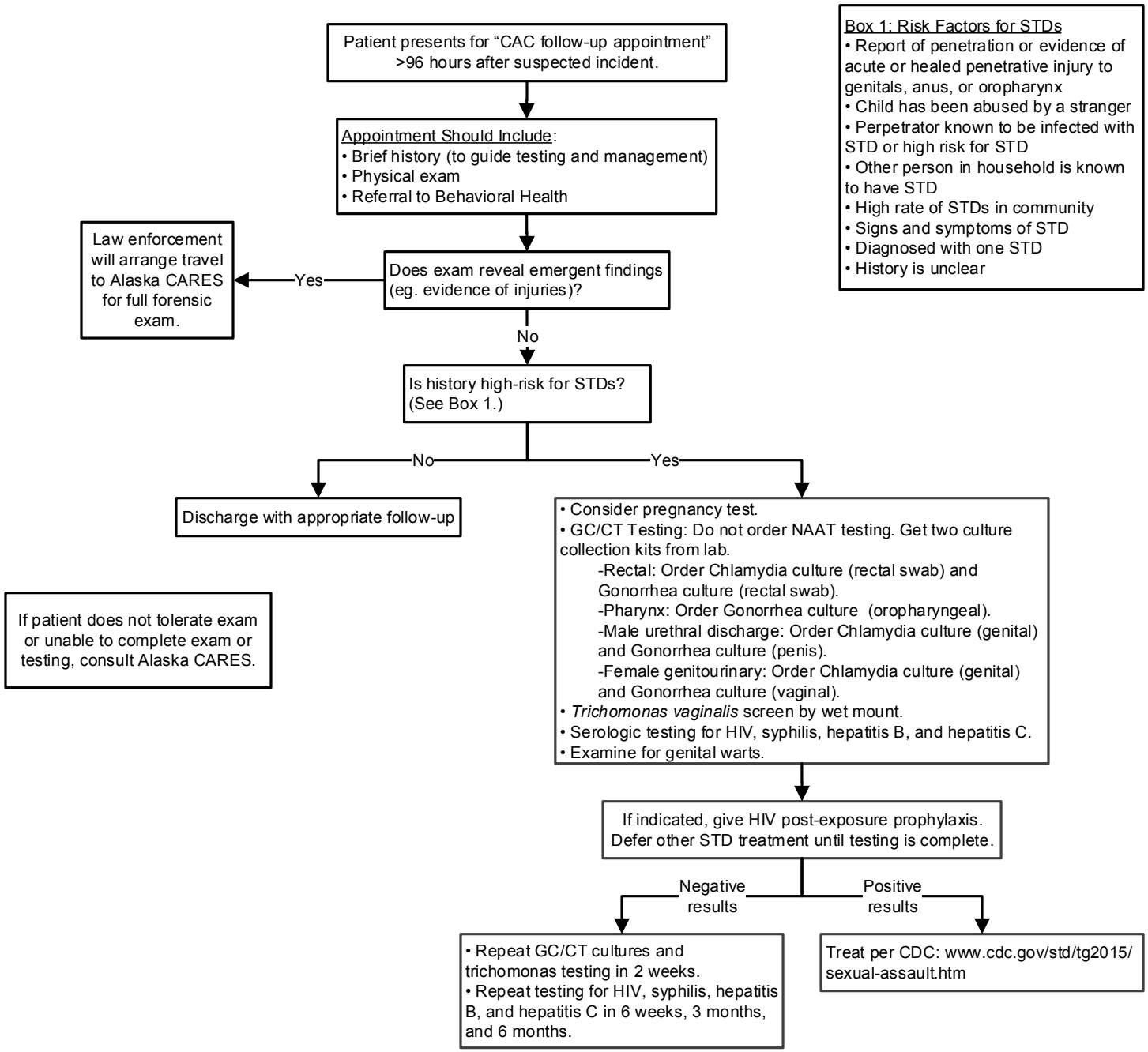
• The CAC will call Scheduling department at 543-6442 during business hours to arrange a one-hour "CAC Follow-up" appointment with a pediatric provider during regular clinic hours.
• This will be the next available appointment.
• The Scheduling Manager can assist if problems arise.
• Patient may return for a future appointment.

See page 2 for appointment recommendations.

Phone Numbers
• Sexual Abuse Response Unit (SARU) on-call phone: 545-4273 (if no answer, ER can page the on-call SARU nurse)
• Office of Children's Services (OCS): (800) 478-4444
• Alaska State Troopers (AST): 543-2294
• Bethel Police Department (BPD): 543-3781
• Child Advocacy Center (CAC): 543-3144 or 543-3456
• Alaska CARES: (907) 561-8301

Suspected Prepubescent Child Sexual Abuse Procedure, p.2

MSEC Approved 9/21/17



This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Adapted from the National Protocol for Sexual Abuse Medical Forensic Examinations – Pediatric.
See Kidsta.org for more details.

YUKON-KUSKOKWIM HEALTH CORPORATION

CLINICAL GUIDELINES 2017

rev. 10-09-17

Pediatric Neonatal Guidelines

YUKON-KUSKOKWIM HEALTH CORPORATION

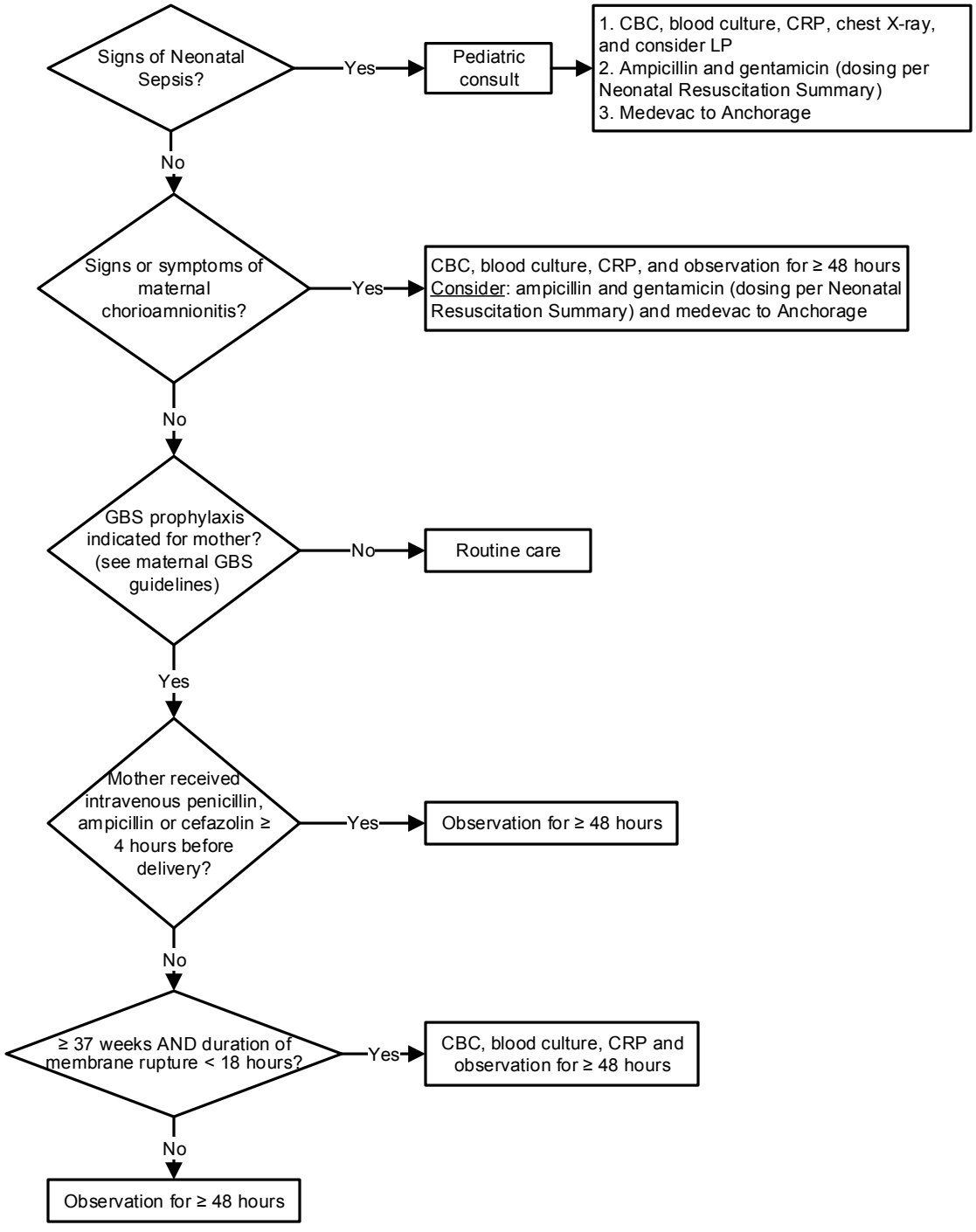
Newborn GBS & Infection Evaluation and Treatment

MSEC approved 09/21/17

Signs of Neonatal Sepsis
- Temp ≥ 100.4
- Irritability
- Poor Feeding
- Hypoglycemia
- Hypothermia
- Tachypnea
- Tachycardia
- "not acting right"

Intrapartum Maternal GBS Risk Factors

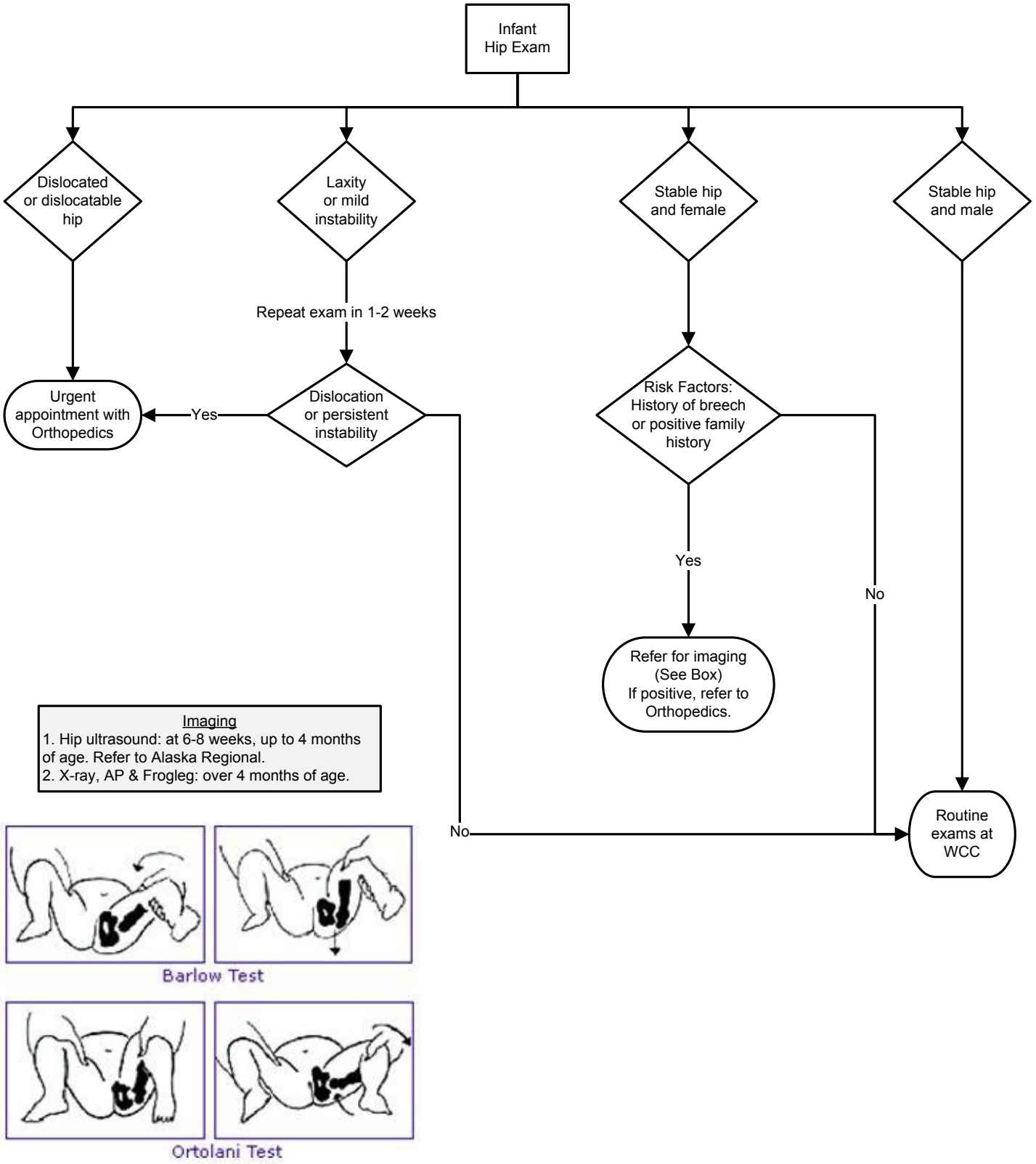
- Chorioamnionitis
- Previous infant with invasive GBS disease
- GBS during current pregnancy
- GBS status unknown
- Labor at < 37 weeks gestation
- Rupture of membranes ≥ 18 hours
- Intrapartum temperature > 100.4
- GBS bacteriuria



Note: If mother receives "inadequate prophylaxis" (eg. clindamycin, vancomycin, or erythromycin) for GBS status, provider may consider a limited work up of the neonate

Hip Dysplasia – Infant

MSEC approved 04/18/15



Imaging

1. Hip ultrasound: at 6-8 weeks, up to 4 months of age. Refer to Alaska Regional.
2. X-ray, AP & Frogleg: over 4 months of age.

Barlow Test

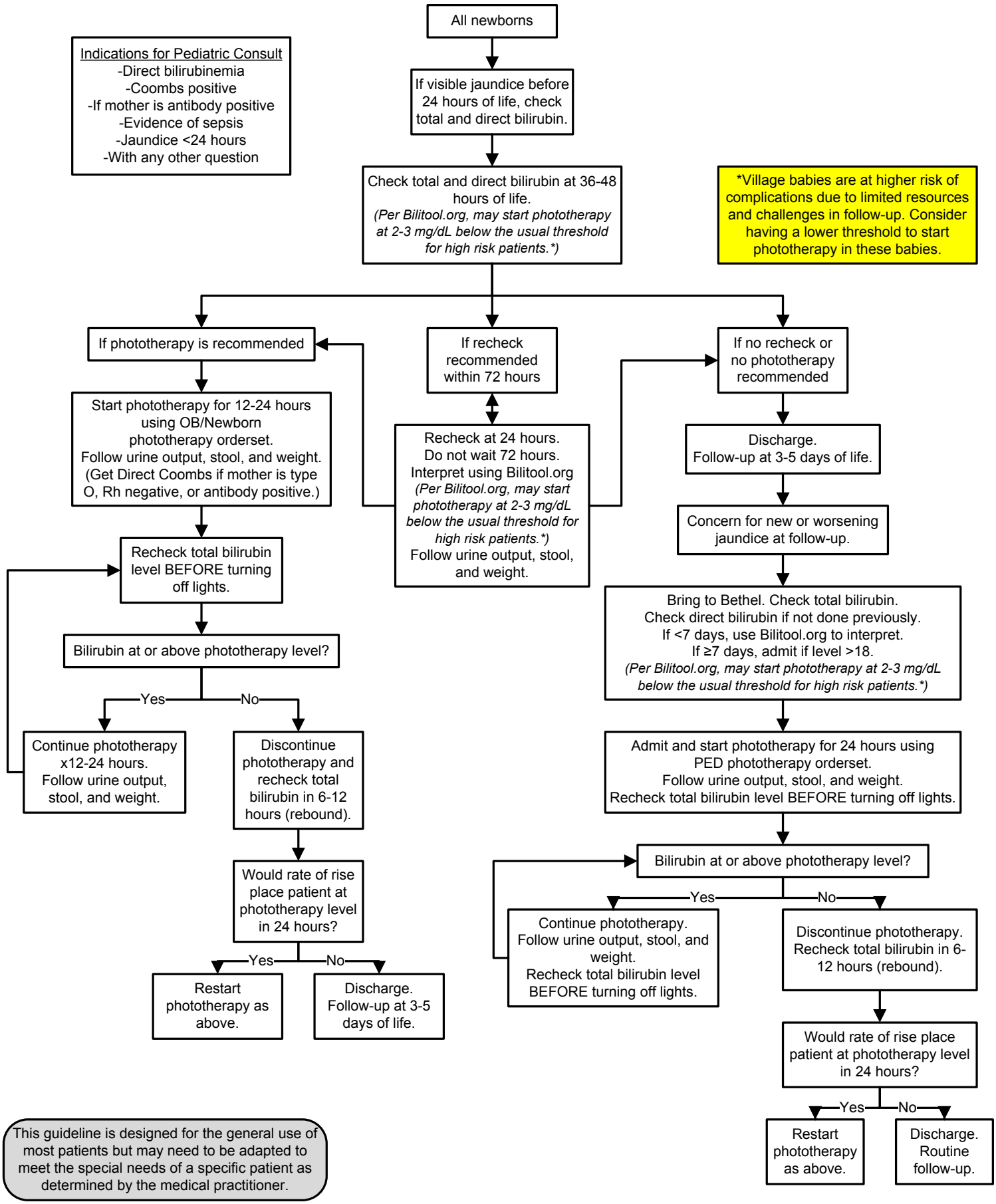
Ortolani Test

The Barlow test is an attempt to dislocate the hip. If positive, you will feel the hip sublux or dislocate. The Ortolani test is the maneuver to reduce a dislocated hip. If positive, you will feel a clunk.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

Jaundice – Neonatal Evaluation & Treatment

MSEC approved 04/08/15



This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.

YUKON-KUSKOKWIM HEALTH CORPORATION

CLINICAL GUIDELINES 2017

rev. 10-09-17

Pediatric Protocols/Reference

Acute Concussion Evaluation
(Ace) ED Version

A. Injury Characteristics **Date/Time of Injury**_____ **Reporter: __Patient __Parent __Spouse __Other**_____

1. Injury Description _____

_____

_____

1a. Is there evidence of a forcible blow to the head (direct or indirect)? __Yes __No __Unknown

1b. Is there evidence of intracranial injury or skull fracture? __Yes __No __Unknown

1c. Location of Impact: __Frontal __Lft Temporal __Rt Temporal __Lft Parietal __Rt Parietal __Occipital __Neck __Indirect Force

2. Cause: __MVC __Pedestrian-MVC __Fall __Assault __Sports (specify)_____ Other_____

3. Amnesia Before (Retrograde) Are there any events just BEFORE the injury that you/ person has no memory of (even brief)? __ Yes __No Duration_____

4. Amnesia After (Anterograde) Are there any events just AFTER the injury that you/ person has no memory of (even brief)? __ Yes __No Duration_____

5. Loss of Consciousness: Did you/ person lose consciousness? __ Yes __No Duration_____

6. EARLY SIGNS: __Appears dazed or stunned __Is confused about events __Answers questions slowly __Repeats Questions __Forgetful (recent info)

7. Seizures: Were seizures observed? No__ Yes___ Detail_____

B. Symptom Check List* Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day?

Indicate presence of each symptom (0=No, 1=Yes). ***Lovell & Collins, 1998 JHTR***

PHYSICAL (10)		COGNITIVE (4)		SLEEP (4)		
Headache	0 1	Feeling mentally foggy	0 1	Drowsiness	0 1	
Nausea	0 1	Feeling slowed down	0 1	Sleeping less than usual	0 1	N/A
Vomiting	0 1	Difficulty concentrating	0 1	Sleeping more than usual	0 1	N/A
Balance problems	0 1	Difficulty remembering	0 1	Trouble falling asleep	0 1	N/A
Dizziness	0 1	**COGNITIVE Total (0-4)** ____		**SLEEP Total (0-4)** ____		
Visual problems	0 1	**EMOTIONAL (4)**				
Fatigue	0 1	Irritability	0 1			
Sensitivity to light	0 1	Sadness	0 1			
Sensitivity to noise	0 1	More emotional	0 1			
Numbness/Tingling	0 1	Nervousness	0 1			
PHYSICAL Total (0-10) ____		**EMOTIONAL Total (0-4)** ____				
(Add Physical, Cognitive, Emotion, Sleep totals) Total Symptom Score (0-22)		____				

Other Observations

_____

_____

_____

_____

_____

_____

_____

_____

Patient Participation: Full__ Partial __ None __

Reason for Partial/None: Young Age__ Confused__ Inattentive__ Low arousal__ Emotional Upset__ In Pain__ Other_____

C. Concussion History: *Previous# 0 1 2 3 4 5 Date(s)*_____

Headache History: *Prior treatment for headache N___ Y___ Details*_____

D. Diagnosis (ICD): __Concussion w/o LOC 850.0 __Concussion w/ LOC 850.1 __Concussion (Unspecified) 850.9 __Other (854)_____

__No diagnosis

E. Follow-Up Action Plan _√_ **Referral to PCP for Office Monitoring** **MD Name**_____

___ Neuropsychological Testing (recommended for Return to Sport decisions and academic/ behavioral management)

___ Physician: Neurosurgery____ Neurology____ Sports Medicine____ Physiatry____ Psychiatry____

___ Other_____

ACE-ED Completed by: _____ MD RN NP DO

A concussion is an injury to the brain as a result of a force or jolt applied directly or indirectly to the head, which produces a range of possible symptoms, and may or may not involve a loss of consciousness. It is a complex pathophysiologic process affecting the brain, induced by traumatic biomechanical forces secondary to direct or indirect forces to the head. Disturbance of brain function is related to neurometabolic dysfunction, rather than structural injury, and is typically associated with normal structural neuroimaging findings (i.e., CT scan, MRI). Concussion may or may not involve a loss of consciousness (LOC). Concussion results in a constellation of cognitive, somatic, emotional and sleep-related symptoms. Duration of symptoms are variable and may last for as short as several minutes and last as long as several days, weeks, months or even longer in some cases.

ACE ED Instructions

A. Injury Characteristics

1. **Injury Description:** Ask for **description of events** resulting in the injury; how the injury occurred, type of force, location on head.
2. **Cause:** Indicate the cause of injury or write in Other cause.

3/4. **Amnesia:** Determine whether child was not registering memories (amnesia) – before (retrograde) and after (anterograde) injury. Estimate length of time for each (Retrograde amnesia "What is the last thing you remember before your injury?" Anterograde amnesia "What is the first thing you remember after your injury?")

5. **Loss of consciousness (LOC)** - If occurs, determine length of LOC.

6. **Early signs observed by others.** Ask the individuals who know the patient (parent, spouse, friend, etc.) about signs of the concussion/ mTBI that they may have observed. Signs are typically observed early after the injury.

7. **Seizures:** Inquire whether **seizures** were observed or not.

B. Symptom Check List:

- Ask patient (and/ or parent, if child) to report presence of the 4 categories of symptoms since injury. It is important to assess all listed symptoms as different parts of the brain control different functions. One or all symptoms may be present depending upon mechanisms of injury. If the symptom is not present, circle "0" on the scale. Circle "1" if present.
- Note: Most sleep symptoms are only applicable after a night has passed since the injury. If not applicable, circle N/A. Drowsiness may be present on the day of injury.
- Since symptoms can be present premorbidly/ at baseline (e.g., inattention, headaches, sleep, sadness), it is important to assess change from its typical presentation. For any symptom - if Patient/ Parent indicates "I/ He usually has that problem/symptom" – Ask *"Are you/ they experiencing this symptom more than usual or in a different manner than usual?"* If "Yes" circle "1".

Scoring: Sum total number of symptoms present per area, and sum all 4 areas into Total Symptom Score. (Note: Most sleep symptoms are only applicable after a night has passed since the injury. Drowsiness may be present on the day of injury.) If symptoms are new and present, there is no lower limit symptom score. Any score > 0 indicates positive symptom history.

- **General Impression:** Ask how different the person is acting than usual. Circle 0 (No difference) to 6 (Major) to rate degree.
- **Patient Participation:** Indicate the extent to which the patient is able to participate in the evaluation and, if less than fully, give reason for Partial or No participation.

C. Concussion history: Assess the number and date(s) of prior concussions.[4-8] History of prior concussions, especially recent (within past several weeks or months) would suggest the need for more conservative decision-making regarding Return to Play, and general post-injury management.

Headache history: Assess personal history of diagnosis/treatment for headaches. Recent research indicates headache (migraine in particular) can result in protracted recovery from concussion.[8-11]

D. Diagnosis: Assign the most appropriate diagnosis given the following:

850.0 (Concussion, with no loss of consciousness) – Positive Injury Description (A1), i.e., forcible direct/ indirect blow to the head; plus evidence of active symptoms (B) of any type and number related to the trauma; no evidence of LOC (A5), skull fracture, or other intracranial injury.

850.1 (Concussion, with brief loss of consciousness < 1 hour) - Positive Injury Description (A1), i.e., forcible direct/ indirect blow to the head; plus evidence of active symptoms (B) of any type and number related to the trauma; positive evidence of LOC (A5); no skull fracture, or other intracranial injury.

850.9 (Concussion, unspecified) - Positive Injury Description (A1), i.e., forcible direct/ indirect blow to the head; plus evidence of active symptoms (B) of any type and number related to the trauma; unclear/unknown injury details; unclear evidence of LOC (A5), no skull fracture, or other intracranial injury.

NOTE: If there is evidence of skull fracture of structural intracranial injury to the brain, consider 854 (*Intracranial injury* of other and unspecified nature; 854.0 Without mention of open intracranial wound, 854.1 With open intracranial wound). Avoid using nonspecific H*ead injury NOS (959.01)* whenever possible.

E. Follow-Up Action: Determine a plan of action for follow-up of symptomatic patients. Serial evaluation of the concussion is critical as symptoms may resolve, worsen, or ebb and flow depending upon a variety of factors (e.g., cognitive/ physical exertion, comorbidities). Referral to a specialist can be particularly valuable to help manage certain aspects of the patient's condition.

(a) Patient monitoring in the primary care physician office.

(b) Referral to a specialist: particularly valuable to help manage certain aspects of the patient's condition.

- Neuropsychological Testing is particularly relevant for cognitive and/or behavioral dysfunction affecting school, home or work activities, for purpose of treatment planning. Testing is also recommended when a patient may be returning to sports or other at-risk activities.
- Physician Evaluation is particularly relevant for medical evaluation and management of concussion. Also, critical for evaluation and management of focal neurologic, sensory, vestibular, and motor concerns. May be useful for medication management (e.g., headaches, sleep disturbance, depression) if post-concussive problems persist.

Acute Concussion Evaluation (ACE)
OP Version

A. Injury Characteristics **Date/Time of Injury**_____ **Reporter: __Patient __Parent __Spouse __Other**_____

1. Injury Description _____

_____

1a. Is there evidence of a forcible blow to the head (direct or indirect)? __Yes __No __Unknown
1b. Is there evidence of intracranial injury or skull fracture? __Yes __No __Unknown
1c. Location of Impact: __Frontal __Lft Temporal __Rt Temporal __Lft Parietal __Rt Parietal __Occipital __Neck __Indirect Force

2. Cause: __MVC __Pedestrian-MVC __Fall __Assault __Sports (*specify)*_____Other_____

3. Amnesia Before (Retrograde) Are there any events just BEFORE the injury that you/ person has no memory of (even brief)? __ Yes __No Duration

4. Amnesia After (Anterograde) Are there any events just AFTER the injury that you/ person has no memory of (even brief)? __ Yes __No Duration

5. Loss of Consciousness: Did you/ person lose consciousness? __ Yes __No Duration

6. EARLY SIGNS: __Appears dazed or stunned __Is confused about events __Answers questions slowly __Repeats Questions __Forgetful (recent info)

7. Seizures: Were seizures observed? No__ Yes___ Detail_____

B. Symptom Check List* Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day?

Indicate presence of each symptom (0=No, 1=Yes). ***Lovell & Collins, 1998 JHTR***

PHYSICAL (10)		COGNITIVE (4)		SLEEP (4)	
Headache	0 1	Feeling mentally foggy	0 1	Drowsiness	0 1
Nausea	0 1	Feeling slowed down	0 1	Sleeping less than usual	0 1 N/A
Vomiting	0 1	Difficulty concentrating	0 1	Sleeping more than usual	0 1 N/A
Balance problems	0 1	Difficulty remembering	0 1	Trouble falling asleep	0 1 N/A
Dizziness	0 1	**COGNITIVE Total (0-4)** _____		**SLEEP Total (0-4)** _____	
Visual problems	0 1	**EMOTIONAL (4)**			
Fatigue	0 1	Irritability	0 1		
Sensitivity to light	0 1	Sadness	0 1		
Sensitivity to noise	0 1	More emotional	0 1		
Numbness/Tingling	0 1	Nervousness	0 1		
PHYSICAL Total (0-10) _____		**EMOTIONAL Total (0-4)** _____			
(Add Physical, Cognitive, Emotion, Sleep totals) Total Symptom Score (0-22)		_____			

Exertion: Do these symptoms worsen with:
Physical Activity __Yes __No __N/A
Cognitive Activity __Yes __No __N/A

Overall Rating: How different is the person acting compared to his/her usual self? (circle)

Normal 0 1 2 3 4 5 6 Very Different

C. Risk Factors for Protracted Recovery *(check all that apply)*

Concussion History? Y ___ N___	√	**Headache History?** Y ___ N___	√	**Developmental History**	√	**Psychiatric History**
Previous # 1 2 3 4 5 6+		Prior treatment for headache		Learning disabilities		Anxiety
Longest symptom duration Days__ Weeks__ Months__ Years__		History of migraine headache __ Personal __ Family_____		Attention-Deficit/ Hyperactivity Disorder		Depression
						Sleep disorder
If multiple concussions, less force caused reinjury? Yes__ No__				Other developmental disorder_____		Other psychiatric disorder _____

List other comorbid medical disorders or medication usage (e.g., hypothyroid, seizures)_____

_____

D. RED FLAGS for acute emergency management: Refer to the emergency department with sudden onset of any of the following:

*** Headaches that worsen**	*** Looks very drowsy/ can't be awakened**	*** Can't recognize people or places**	*** Neck pain**
*** Seizures**	*** Repeated vomiting**	*** Increasing confusion or irritability**	*** Unusual behavioral change**
*** Focal neurologic signs**	*** Slurred speech**	*** Weakness or numbness in arms/legs**	*** Change in state of consciousness**

E. Diagnosis (ICD): __Concussion w/o LOC 850.0 __Concussion w/ LOC 850.1 __Concussion (Unspecified) 850.9 ___Other (854) _____
__No diagnosis

F. Follow-Up Action Plan **Complete *ACE Care Plan* and provide copy to patient/family.**

___ **No Follow-Up Needed**
___ **Physician/Clinician Office Monitoring**: Date of next follow-up _____
___ **Referral:**
___ Neuropsychological Testing
___ Physician: Neurosurgery____ Neurology____ Sports Medicine____ Physiatrist____ Psychiatrist____ Other_____
___ Emergency Department

ACE Completed by:_____ **MD RN NP PhD ATC**

This form is part of the "Heads Up: Brain Injury in Your Practice" tool kit developed by the Centers for Disease Control and Prevention (CDC).

A concussion (or mild traumatic brain injury (MTBI)) is a complex pathophysiologic process affecting the brain, induced by traumatic biomechanical forces secondary to direct or indirect forces to the head. Disturbance of brain function is related to neurometabolic dysfunction, rather than structural injury, and is typically associated with normal structural neuroimaging findings (i.e., CT scan, MRI). Concussion may or may not involve a loss of consciousness (LOC). Concussion results in a constellation of physical, cognitive, emotional, and sleep-related symptoms. Symptoms may last from several minutes to days, weeks, months or even longer in some cases.

ACE Instructions

The ACE is intended to provide an evidence-based clinical protocol to conduct an initial evaluation and diagnosis of patients (both children and adults) with known or suspected MTBI. The research evidence documenting the importance of these components in the evaluation of an MTBI is provided in the reference list.

A. Injury Characteristics:

1. Obtain **description of the injury** – how injury occurred, type of force, location on the head or body (if force transmitted to head). Different biomechanics of injury may result in differential symptom patterns (e.g., occipital blow may result in visual changes, balance difficulties).
2. Indicate the **cause of injury**. Greater forces associated with the trauma are likely to result in more severe presentation of symptoms.

3/4. **Amnesia:** Amnesia is defined as the failure to form new memories. Determine whether amnesia has occurred and attempt to determine length of time of memory dysfunction – before (retrograde) and after (anterograde) injury. Even seconds to minutes of memory loss can be predictive of outcome. Recent research has indicated that amnesia may be up to 4-10 times more predictive of symptoms and cognitive deficits following concussion than is LOC (less than 1 minute).[1]

5. **Loss of consciousness (LOC)** – If occurs, determine length of LOC.
6. **Early signs.** If present, ask the individuals who know the patient (parent, spouse, friend, etc) about specific signs of the concussion that may have been observed. These signs are typically observed early after the injury.
7. Inquire whether **seizures** were observed or not.

B. Symptom Checklist: [2]

1. Ask patient (and/or parent, if child) to report presence of the four categories of symptoms since injury. It is important to assess all listed symptoms as different parts of the brain control different functions. One or all symptoms may be present depending upon mechanisms of injury.[3] Record "1" for Yes or "0" for No for their presence or absence, respectively.
2. For all symptoms, indicate presence of symptoms as experienced within the past 24 hours. Since symptoms can be present premorbidly/at baseline (e.g., inattention, headaches, sleep, sadness), it is important to assess change from their usual presentation.
3. **Scoring**: Sum total number of symptoms present per area, and sum all four areas into Total Symptom Score (score range 0-22). (Note: most sleep symptoms are only applicable after a night has passed since the injury. Drowsiness may be present on the day of injury.) If symptoms are new and present, there is no lower limit symptom score. Any score > 0 indicates positive symptom history.
4. **Exertion:** Inquire whether any symptoms worsen with physical (e.g., running, climbing stairs, bike riding) and/or cognitive (e.g., academic studies, multi-tasking at work, reading or other tasks requiring focused concentration) exertion. Clinicians should be aware that symptoms will typically worsen or re-emerge with exertion, indicating incomplete recovery. Over-exertion may protract recovery.
5. **Overall Rating:** Determine how different the person is acting from their usual self. Circle "0" (Normal) to "6" (Very Different).

C. Risk Factors for Protracted Recovery: Assess the following risk factors as possible complicating factors in the recovery process.

1. **Concussion history:** Assess the number and date(s) of prior concussions, the duration of symptoms for each injury, and whether less biomechanical force resulted in re-injury. Research indicates that cognitive and symptom effects of concussion may be cumulative, especially if there is minimal duration of time between injuries and less biomechanical force results in subsequent concussion (which may indicate incomplete recovery from initial trauma).[4-8]
2. **Headache history:** Assess personal and/or family history of diagnosis/treatment for headaches. Research indicates headache (migraine in particular) can result in protracted recovery from concussion.[8-11]
3. **Developmental history**: Assess history of learning disabilities, Attention-Deficit/Hyperactivity Disorder or other developmental disorders. Research indicates that there is the possibility of a longer period of recovery with these conditions.[12]
4. **Psychiatric history**: Assess for history of depression/mood disorder, anxiety, and/or sleep disorder.[13-16]

D. Red Flags: The patient should be carefully observed over the first 24-48 hours for these serious signs. Red flags are to be assessed as possible signs of deteriorating neurological functioning. Any positive report should prompt strong consideration of referral for emergency medical evaluation (e.g. CT Scan to rule out intracranial bleed or other structural pathology).[17]

E. Diagnosis: The following ICD diagnostic codes may be applicable.

850.0 (Concussion, with no loss of consciousness) – Positive injury description with evidence of forcible direct/ indirect blow to the head (A1a); plus evidence of active symptoms (B) of any type and number related to the trauma (Total Symptom Score >0); no evidence of LOC (A5), skull fracture or intracranial injury (A1b).

850.1 (Concussion, with brief loss of consciousness < 1 hour) – Positive injury description with evidence of forcible direct/ indirect blow to the head (A1a); plus evidence of active symptoms (B) of any type and number related to the trauma (Total Symptom Score >0); positive evidence of LOC (A5), skull fracture or intracranial injury (A1b).

850.9 (Concussion, unspecified) – Positive injury description with evidence of forcible direct/ indirect blow to the head (A1a); plus evidence of active symptoms (B) of any type and number related to the trauma (Total Symptom Score >0); unclear/unknown injury details; unclear evidence of LOC (A5), no skull fracture or intracranial injury.

Other Diagnoses – If the patient presents with a positive injury description and associated symptoms, but additional evidence of intracranial injury (A 1b) such as from neuroimaging, a moderate TBI and the diagnostic category of 854 (Intracranial injury) should be considered.

F. Follow-Up Action Plan: Develop a follow-up plan of action for symptomatic patients. The physician/clinician may decide to (1) monitor the patient in the office or (2) refer them to a specialist. Serial evaluation of the concussion is critical as symptoms may resolve, worsen, or ebb and flow depending upon many factors (e.g., cognitive/physical exertion, comorbidities). Referral to a specialist can be particularly valuable to help manage certain aspects of the patient's condition. (Physician/Clinician should also complete the ACE Care Plan included in this tool kit.)

1. **Physician/Clinician serial monitoring –** Particularly appropriate if number and severity of symptoms are steadily decreasing over time and/or fully resolve within 3-5 days. If steady reduction is not evident, referral to a specialist is warranted.
2. **Referral to a specialist –** Appropriate if symptom reduction is not evident in 3-5 days, or sooner if symptom profile is concerning in type/severity.
   - Neuropsychological Testing can provide valuable information to help assess a patient's brain function and impairment and assist with treatment planning, such as return to play decisions.
   - Physician Evaluation is particularly relevant for medical evaluation and management of concussion. It is also critical for evaluating and managing focal neurologic, sensory, vestibular, and motor concerns. It may be useful for medication management (e.g., headaches, sleep disturbance, depression) if post-concussive problems persist.

ASAA HEALTHCARE PROVIDER RELEASE AND RETURN TO PLAY PROTOCOL (RTP)

Student Name: _____

Sport: _____ **School:** _____ **Birthdate:** _____

Date of Injury: _____ **Description:** _____

IMPORTANT NOTE TO HEALTHCARE PROVIDER

Per AS 14.30.142, as amended, a student who has been removed from participation in a practice or game for suspicion of concussion may not return to play until the student has been evaluated and cleared for participation by an Athletic Trainer OR by a qualified person who verifies that he or she is currently trained in the evaluation and management of concussions.
"Qualified person" means either:

1) A health care provider licensed in Alaska, or exempt from licensure under Alaska law(AS 08.64.370(1), (2), or (4), **OR**
2) a person acting at the direction and under the supervision of a physician licensed in Alaska, or exempt from licensure.

As interpreted by ASAA, Athletic Trainer means a Certified Athletic Trainer.
As interpreted by ASAA, "Trained" means that the provider:

1) Has completed the online CDC Concussion Course for Clinicians (www.preventingconcussions.org) in the last two years, **AND**
2) Has **a)** completed 2 hours of CME in Sports Concussion Management in the last 2 years, or **b)** has completed a one-year Sports Medicine Fellowship, a Certifacte of Added Qualifications in Sports Medicine, or a Residency in Neurology or Neurosurgery.

IF YOU DO NOT MEET THESE CRITERIA, PLEASE REFER THE STUDENT ATHLETE TO A HEALTHCARE PROVIDER WHO DOES

If an athlete is removed from participation in an activity because of a suspected concussion:

BUT is found **not to have a concussion**, the athlete's return to play should be determined by the athlete's medical provider in accordance with the provider's assessment of the athlete's condition and readiness to participate;

AND is **determined to have sustained a concussion**, the athlete's readiness to return to participation should be assessed in accordance with the Alaska School Activities Association's graduated Return to Play (RTP) protocol. All student athletes with a concussion must successfully complete an appropriate RTP Protocol that lasts a minimum of six days before resuming full athletic activity. The Return to Play protocol recommended by ASAA's Sports Medicine Advisory Committee is described below.

Students should begin with a period of complete rest in which they avoid cognitive and physical exertion. As symptoms diminish, and the athlete feels able, he/she can begin trials of cognitive work, e.g. reading, texting, computer, TV, school. The introduction of cognitive work should be in short increments which increase progressively in length and intensity so long as concussion symptoms do not recur or worsen. When several hours of cognitive work are well tolerated at home, then attendance at a half day of school is appropriate. When a full day of school is tolerated, then homework may be added. Academic accommodations may be necessary for student athletes as they return to school following a concussion. If cognitive work at any time provokes or exacerbates symptoms, then the work should be discontinued, additional cognitive work should be minimized until symptoms regress, and the student can attempt to advance cognitive work again on the following day.

Only when the concussion symptoms have been entirely absent for 24 hours, does Day 1 of the progressive return to physical activity begin. The ***Return To Play Protocol*** is to take place over a ***minimum of six days, with at least 24 hours between each step.*** The rate of progression through the steps in the program should be individualized. Factors which may slow the rate are young age, history of previous concussions, number/severity/duration of concussion symptoms, medical risk factors, and the concussion risk of the sports to which the athlete will return. Physical or cognitive activity that provokes recurrence of concussive symptoms will delay recovery and increase the risk of future concussion. Therefore, if symptoms recur at any step, then physical activity should stop until 24 hours after resolution of the symptoms, and then resume at the previous step.

ASAA HEALTHCARE PROVIDER RELEASE AND RETURN TO PLAY PROTOCOL (RTP)

Student Name: _____

SYMPTOMATIC STAGE: Physical and Cognitive Rest; Then Incremental Cognitive Work, without Provoking Symptoms.	
Day 1	Begin when symptom free for 24 hours. 15 min of light aerobic activity: walk, swim, stationary bike. **NO** resistance training.
Day 2	30 min light-moderate aerobic activity: jog, more intense walk, swim, stationary bike. **NO** resistance training. START PE class at previous day's activity level. As RTP Protocol activity level increases, PE activity level remains 1 day behind
Day 3	30 min mod-heavy aerobic activity: run, swim, cycle, skate, Nordic ski. **NO** resistance training.
Day 4	30 min heavy aerobic activity: hard run, swim, cycle, skate, Nordic ski. 15 min Resistance Training: push-up, sit-up, weightlifting
Day 5	Return to Practice, Non-contact Limited Participation: Routine sport-specific drills
Day 6	Return to Full-Contact Practice
Day 7	Medically Eligible for Competition after completing RTP Protocol and is cleared by Healthcare Professional. ASAA Eligibility Criteria must be met before return to competition.

SECTION 1: THE CONCUSSED ATHLETE - to be completed by Healthcare Provider

☐ Student has sustained a concussion and is not yet ready to begin the Return to Play Protocol.

☐ Student is cleared to begin ASAA's **Return to Play Protocol** with any modifications noted below. *This clearance is no longer effective if student's symptoms return and persist.*

☐ **Student is entirely free of concussion symptoms and has completed the ASAA Return to Play Protocol as described above. The athlete is medically eligible to return to competition.**

Please note any additional modifications to ASAA's Return to Play Protocol below [attach more pages if needed]:

SECTION 2: THE NON-CONCUSSED ATHLETE - to be completed by Healthcare Provider

☐ Student has **NOT** sustained a concussion. The **Medical Diagnosis** which explains his/her symptoms is:
This is **REQUIRED** if checking the first box:_____

☐ Student is cleared to return to full sports participation. Medical Dx:_____

☐ Student is cleared for limited participation with the following restrictions [attach more pages if needed]:

SECTION 3: HEALTHCARE PROFESSIONAL ATTESTATION

By signing this form, I attest that I am a **Qualified Healthcare provider authorized under AS 14.30.142** and that I meet the ASAA definition of "Currently Trained" in the evaluation and management of concussion, as explained above. I do hereby take responsibility for the daily monitoring and decision making in managing this student athlete's concussion.

_____
Healthcare Provider Signature | HCP Printed Name | AK License Number | Date

SECTION 3: ATHLETE AND PARENT CONSENT

The **Return to Play Protocol** incorporates an internationally recognized process by which concussed athletes are returned to athletic participation as safely as possible. Participation in athletics is accompanied by the risk of injury, permanent disability, and death. Having recently sustained a concussion, an athlete is at more risk for another head injury with risk of permanent disability or death. By signing this form, the athlete and the parent indicate their understanding that the completion of the **Return to Play Protocol** is not a guarantee of safe return to athletic participation. The parent accepts the risk of additional injury in requesting and consenting to the athlete's return to athletic participation.

_____ _____
Student Athlete Signature | Date — Parent Signature | Date

_____ _____
Student Athlete Printed Name — Parent Printed Name

YUKON-KUSKOKWIM HEALTH CORPORATION

CLINICAL GUIDELINES 2017

rev. 10-09-17

OB Guidelines

YUKON-KUSKOKWIM HEALTH CORPORATION

First Trimester Vaginal Bleeding: Ectopic Pregnancy Diagnosis & Treatment of Non-Viable Early Pregnancy, p.1

MSEC approved 07/12/17

1
Nomenclature

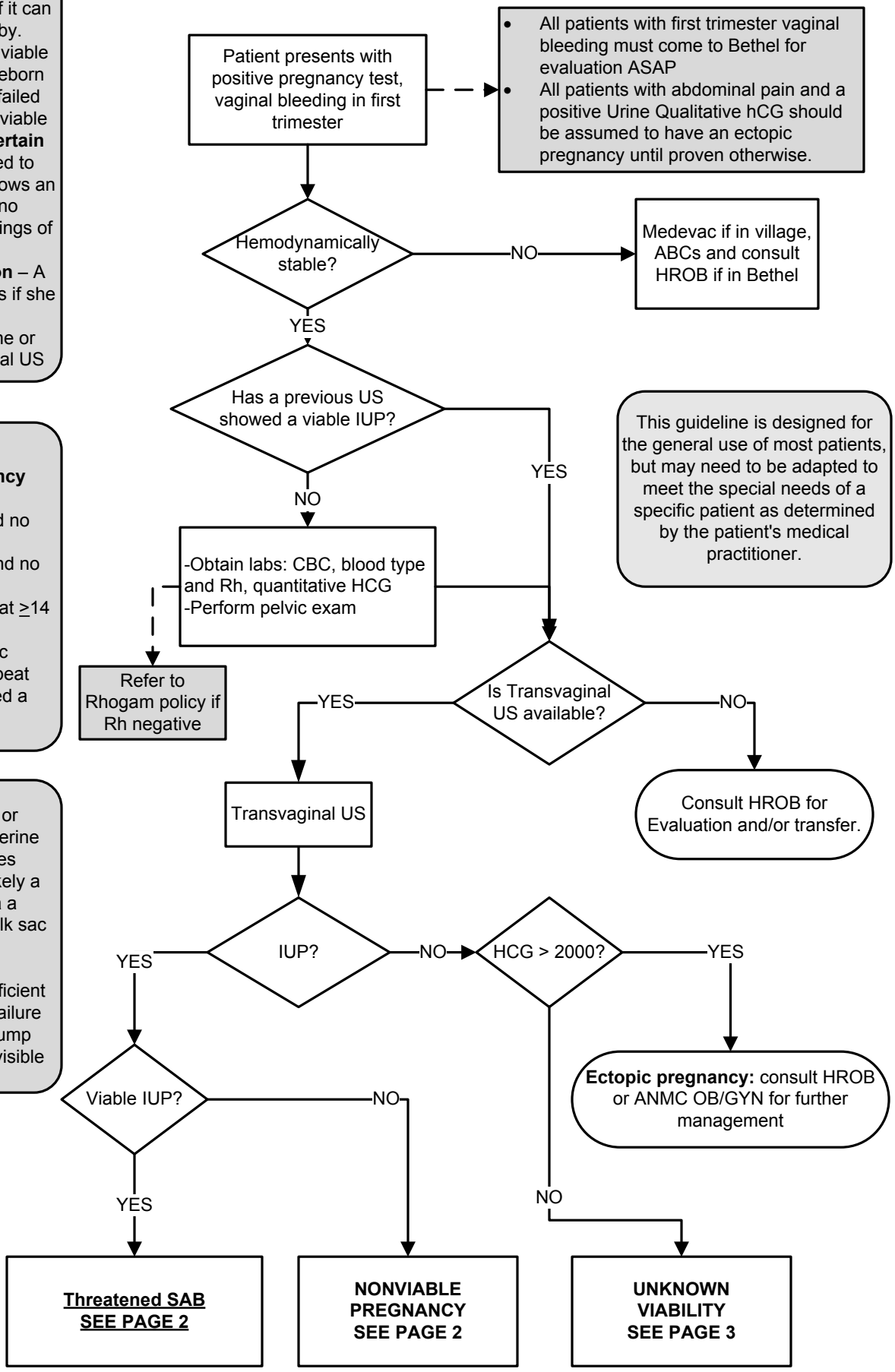
- **Viable** – A pregnancy is vialble if it can potentially result in a liveborn baby.
- **Nonviable** – A pregnancy is nonviable if it cannot possibly result in a liveborn baby. Ectopic pregnancies and failed intrauterine pregnancies are nonviable
- **Intrauterine pregnancy of uncertain viability** – A woman is considered to have this if a transvaginal US shows an intrauterine gestational sac with no embryonic heartbeat and no findings of definite pregnancy failure
- **Pregnancy of unknown location** – A woman is considered to have this if she has a positive urine or serum pregnancy test and no intrauterine or ectopic pregnancy on transvaginal US

2
Findings diagnostic of Pregnancy Failure

- Crown-rump length of ≥7mm and no heartbeat
- Mean sac diameter of ≥25mm and no embryo
- Absence of embryo with heartbeat ≥14 days after an US that showed a gestational sac without a yolk sac
- Absence of embryo with a heartbeat ≥11 days after an US that showed a gestational sac with a yolk sac

Comments

- In a woman with a positive urine or serum pregnancy test, an intrauterine fluid collection with rounded edges containing no yolk sac is most likely a gestational sac; it is certain to ba a gestational sac if it contains a yolk sac or embryo.
- Transabdominal imaging without transvaginal scanning my be sufficient for diagnosing early pregnancy failure when an embryo whose crown-rump length is 15mm or more has no visible cardiac activity.



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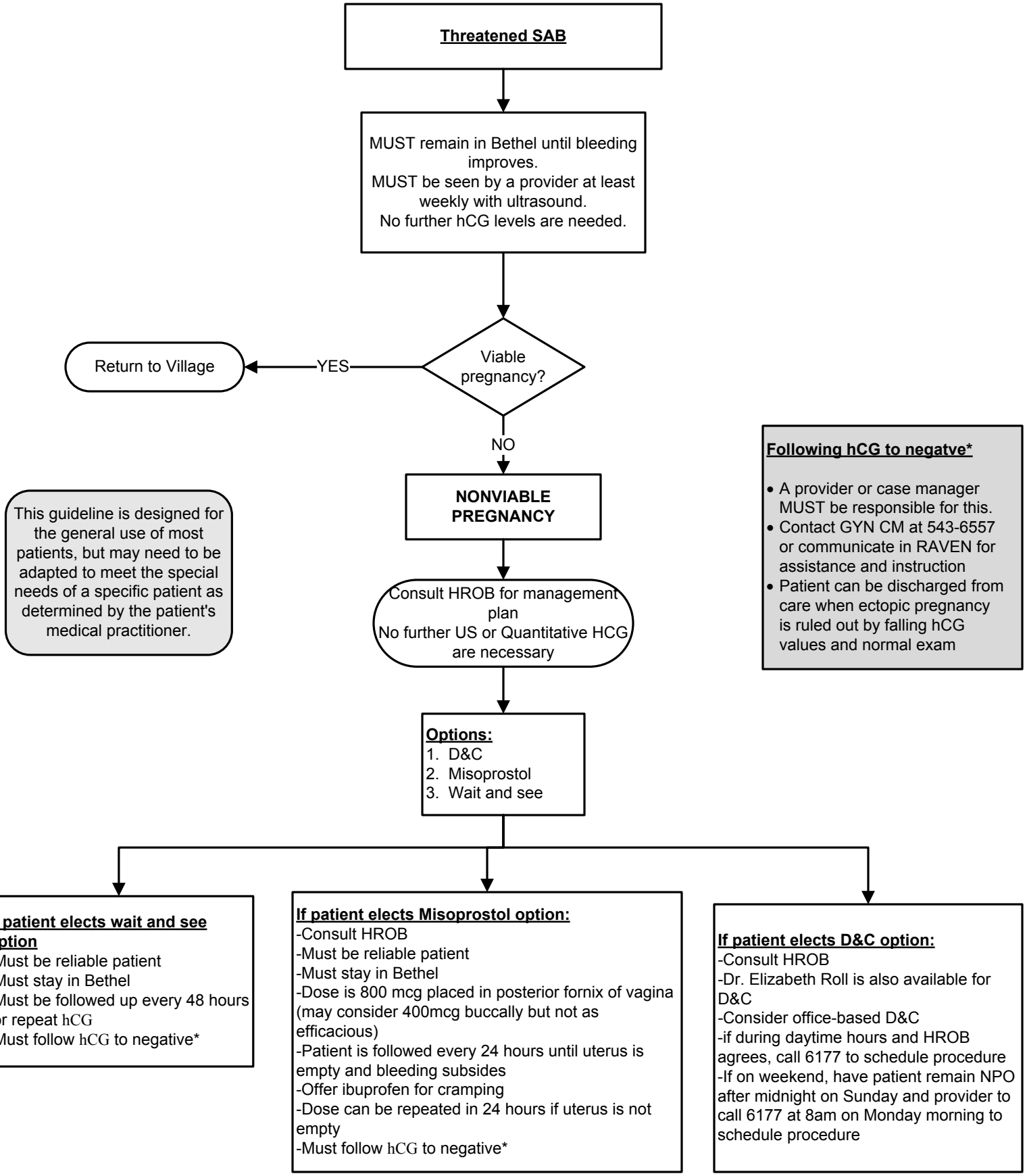
First Trimester Vaginal Bleeding: Ectopic Pregnancy Diagnosis & Treatment of Non-Viable Early Pregnancy, p.2

MSEC approved 07/12/17



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First Trimester Vaginal Bleeding: Ectopic Pregnancy Diagnosis & Treatment of Non-Viable Early Pregnancy, p.3

MSEC approved 07/12/17

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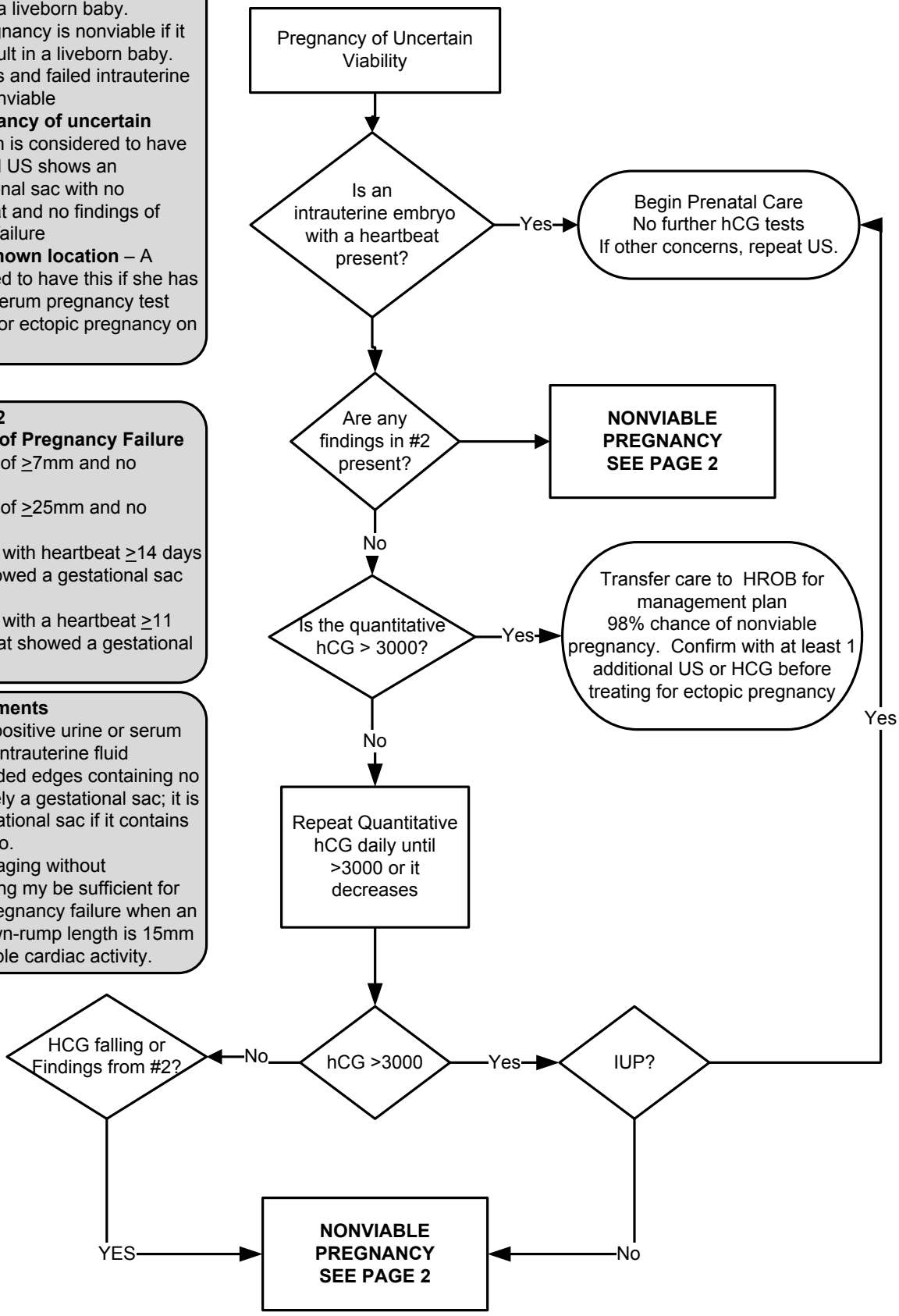

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Ectopic Pregnancy – Treatment

MSEC approved 07/12/17

D&C Prior to Methotrexate?

This is NOT necessary prior to treatment with Methotrexate (MTX) for a plateau or abnormally rising HCG level. MTX will treat an abnormal pregnancy in the uterus or any other location.

Typical side effects of MTX.

Less than 30% of patients will experience side effects from the medication and those are minor and self limited. These include: nausea, mouth ulcers GI cramps. Most patients have some lower abdominal pain on the 3-6th day after treatment. This is not a problem if ibuprofen or acetaminophen relieves the pain.

Contraindication to MTX.

Absolute contraindications

Breast Feeding
Overt or Laboratory evidence of immunodeficiency
Alcoholism, alcoholic liver disease, or other chronic liver disease
Preexisting blood dyscrasias, such as bone marrow hypoplasia, leukopenia, thrombocytopenia or significant anemia
Known sensitivity to MTX
Active pulmonary disease
Peptic ulcer disease
Hepatic, renal or hematologic dysfunction

Relative contraindications

Gestational sac larger that 3.5cm
Embryonic cardiac motion

Ectopic Pregnancy diagnosed after consultation with HROB or OB/GYN

Obtain:
- Quantitative HCG
- Type and Screen
- CBC
- Comp Chem.
- Transvaginal Pelvic Ultrasound (US)

Hemodynamically stable? — No → Consult HROB for immediate surgery or transfer

Yes

Adnexal Mass ≥ 3cm Cardiac activity Pregnancy in location other than a tube — yes → Consult HROB for immediate surgery or transfer

no

Platelets, Kidney and Liver function Normal? — No → Consult HROB for immediate surgery or transfer

YES

Is the hCG >5000?

NO

Single-dose regimen
- Single dose MTX 50mg/m2 IM day 1
- Measure hCG level on post treatment days 4 and 7
- Check for 15% hCG decrease between days 4 and 7
- Then measure hCG level weekly until reaching the nonpregnant level
- If results are less than the expected 15% decrease, readminister MTX 50mg/m2 and repeat hCG measurement on days 4 and 7 after second dose.

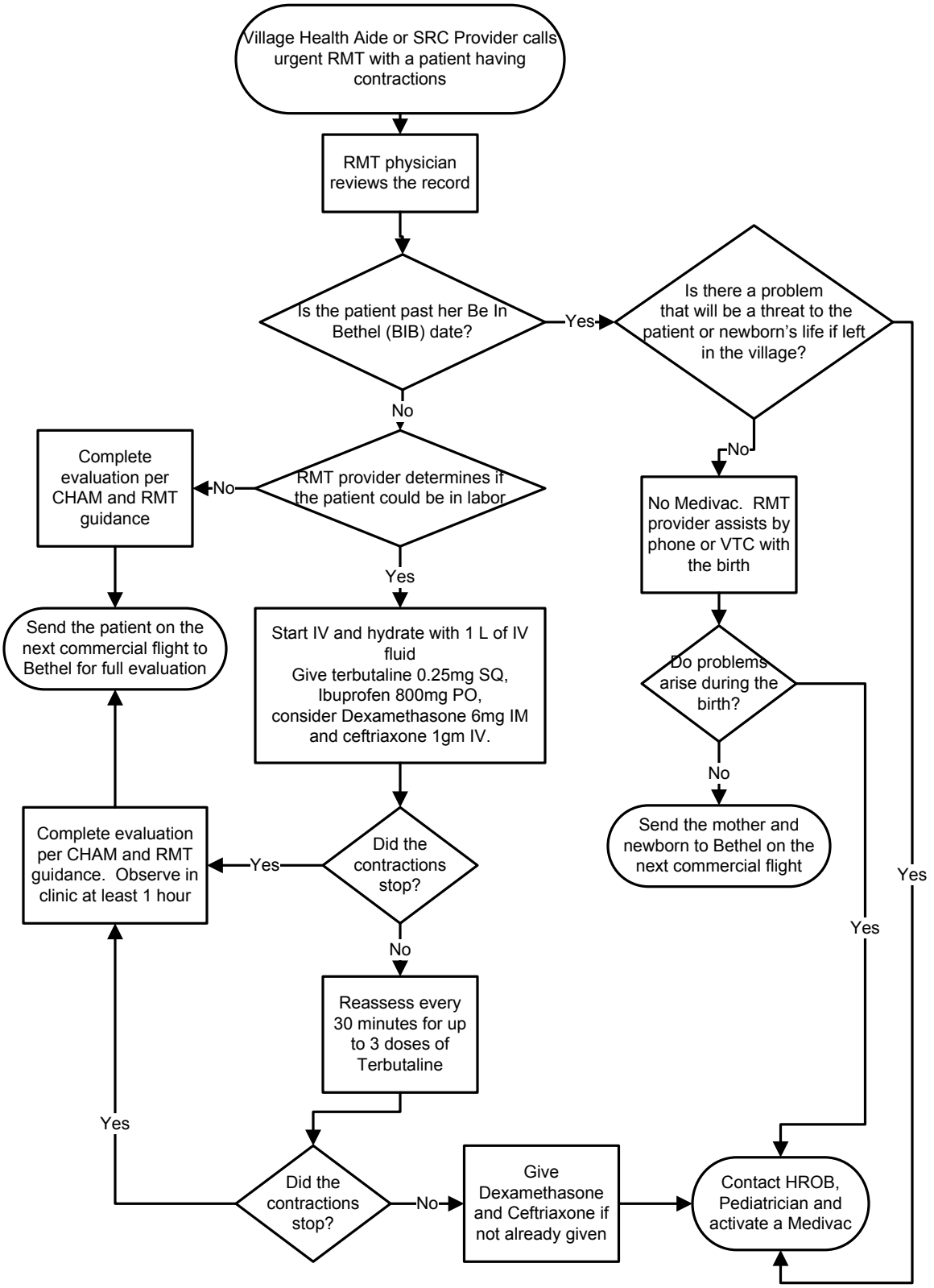
YES

Two-dose regimen
- Administer 50 mg/m2 on day 0.
- Repeat 50mg/m2 on day 4.
- Measure hCG levels on days 4 and 7, and expect a 15% decrease between days 4 and 7.
- If the decrease is greater than 15%, measure hCG levels weekly until reaching non pregnant level.
- If less than a 15% decrease in hCG levels, readminister MTX 50mg/m2 on days 7 and 11, measuring hCG levels.
- If hCG levels decrease 15% between days 7 and 11, continue to monitor weekly until non pregnant hCG levels are reached.

If at any time the hCG level rises during the monitoring of weekly hCG levels, consult a GYN Oncologist for further treatment.

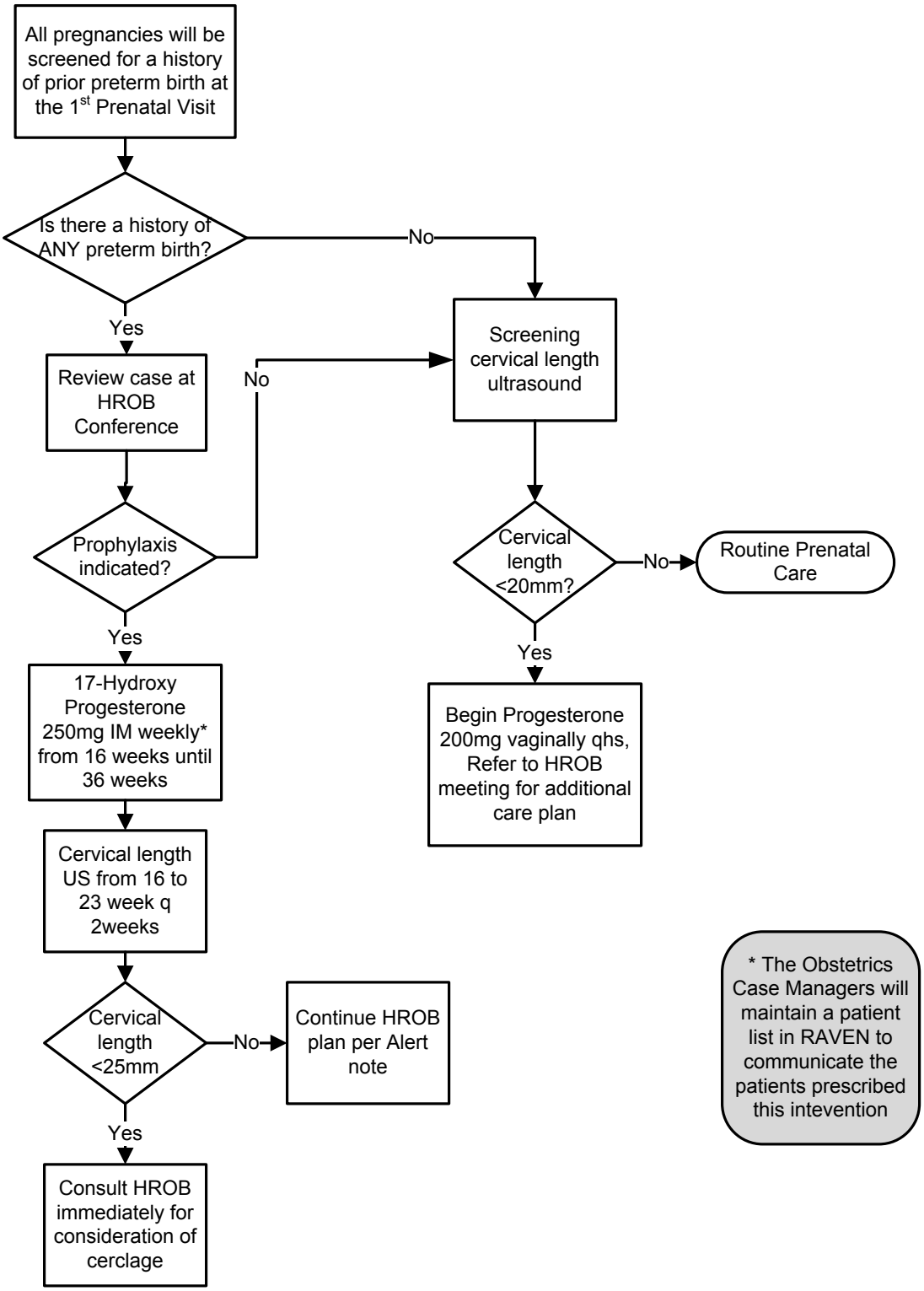
Labor Patient – Village

MSEC approved 12/14/16



Preterm Labor – Screening and Prevention

MSEC approved 8/24/16



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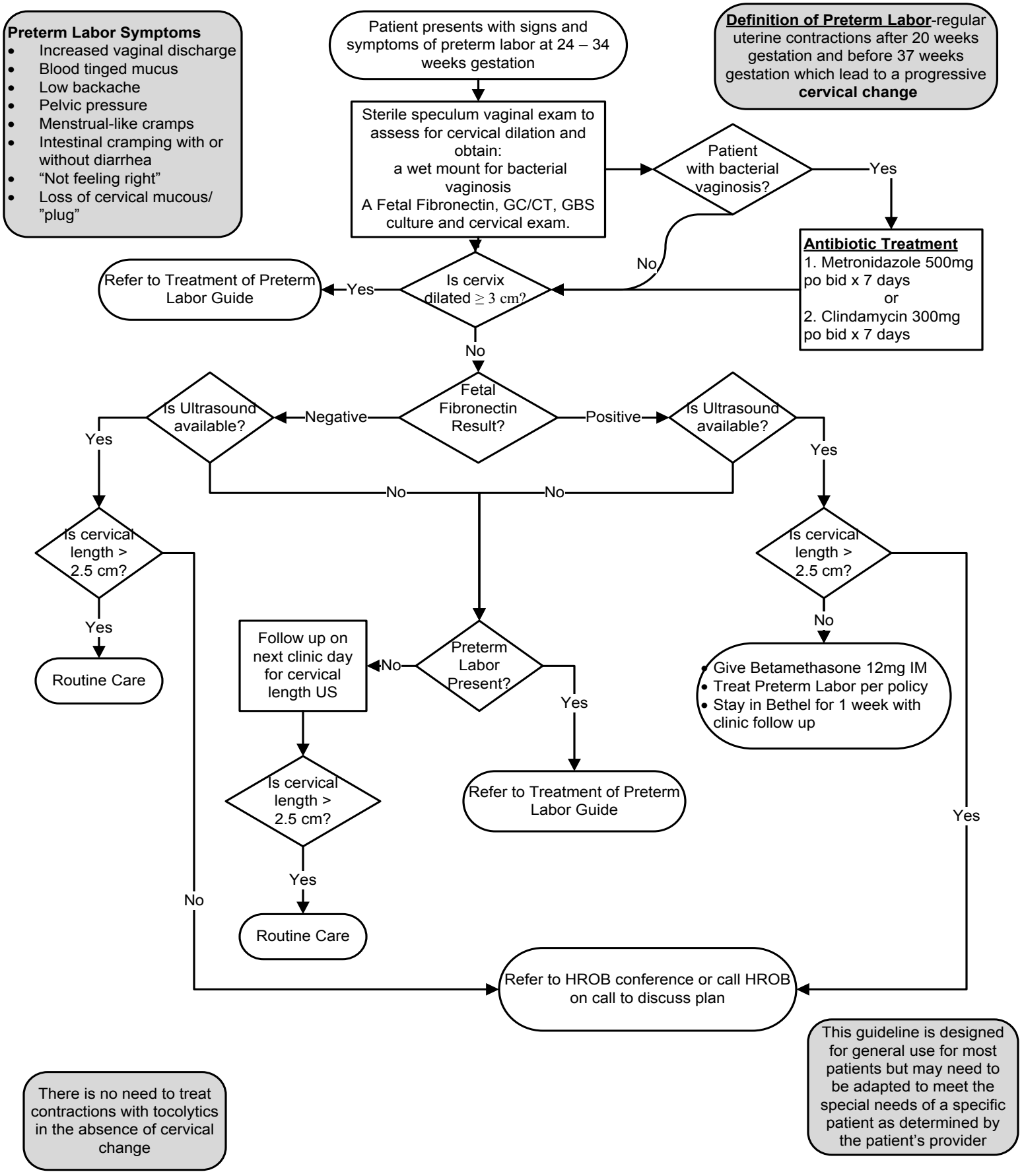
Preterm Labor – Evaluation

MSEC approved 07-12-17



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Preterm Labor – Treatment

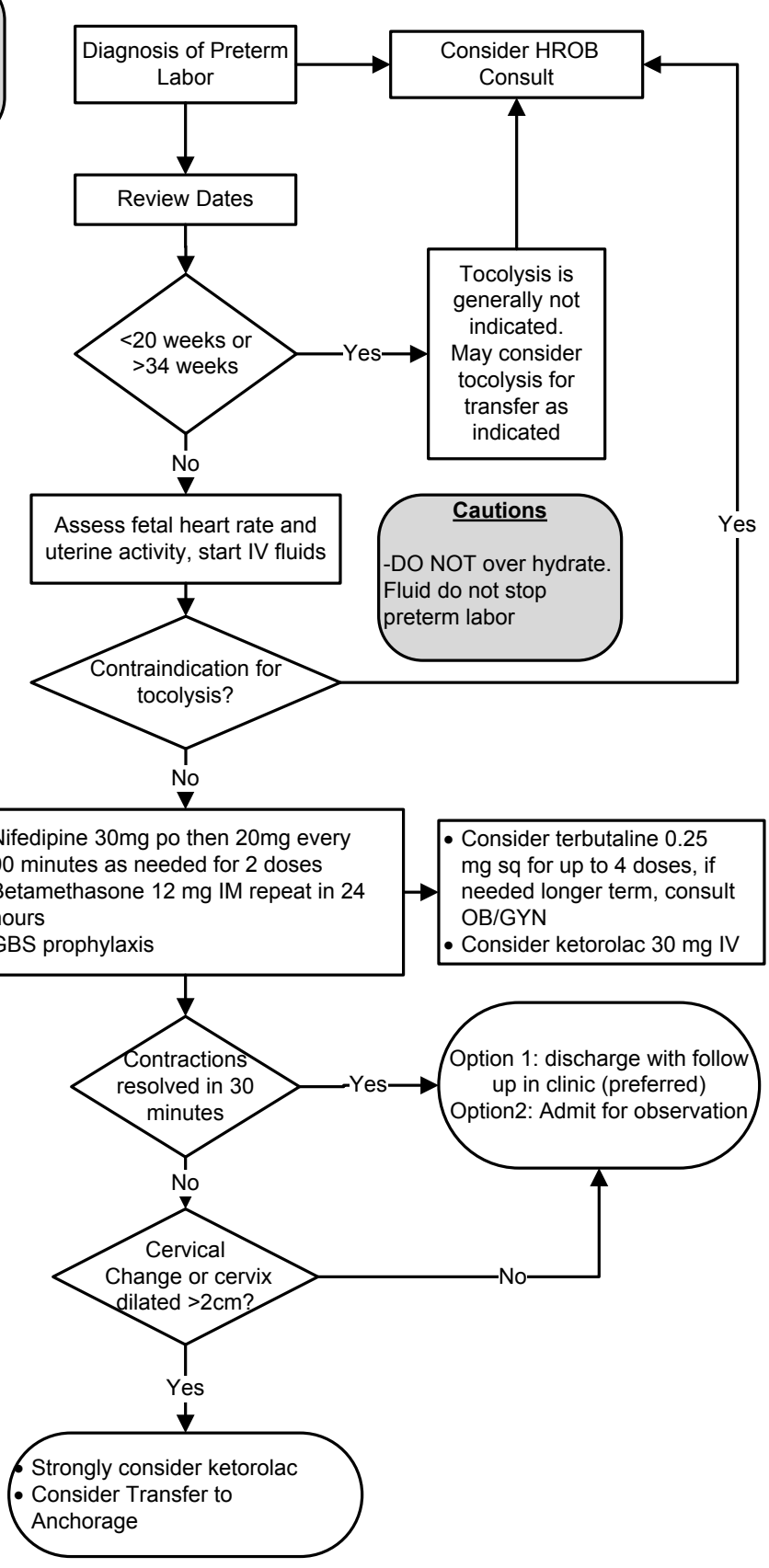
MSEC approved 7/12/17

Definition of Preterm Labor-regular uterine contractions after 20 weeks gestation and before 37 weeks gestation which lead to a progressive **cervical change**

Contraindications to tocolysis:
- IUFD
- Lethal fetal anomaly
- Non-reassuring fetal assessment
- Severe IUGR
- Chorioamnionitis, relative
- Maternal hemorrhage with hemodynamic instability
- Severe preeclampsia or eclampsia
- PPROM

Contraindications to terbutaline
- Diabetes
- HTN
- Suspected placental abruption (relative)

This guideline is designed for the general use of most patients, but may need to be adapted to meet the special needs of a specific patient as determined by the patient's medical practitioner.



Gestational Diabetes

MSEC approved 07-12-17

This guideline is designed for the general use of most patients, but may need to be adapted to meet the special needs of a specific patient as determined by the patient's medical practitioner.

First prenatal visit: Screen all women with a HgbA1C

≥6.5% → Add diagnosis of diabetes

<6.4 %

If the first prenatal screen is before 24-28 weeks and is negative, at 24-28 weeks screen below

Screening test: fasting or fed Plasma glucose Value 1 hour post 50 gram glucose load

≥180 → Go direct to SMBG or offer GTT if patient resists testing

140 - 179 mg/dL

Fasting 2 hour Oral glucose Tolerance Test: 75 gram load
scheduled within one week

Diagnostic Criteria for GDM utilizing two hour 75g GTT

Gestational Diabetes Mellitus	Fasting ≥ 92 mg/dL
Pregnancy with one or more of the following levels:	1 hour glucose ≥ 180 mg/dL
	2 hour glucose ≥ 153 mg/dL

- Add appropriate diagnosis to problem list i.e. GDM or pre-gestational diabetes
- Give patient log book to document goals, blood glucose, and food plan.
- Dispense glucose meter and supplies
- Refer to DM educator (543-6133) for education and Medical Nutrition Therapy
- Consider referral to diabetes department for Continuous Glucose Monitor placement
- Patient will record blood glucose levels fasting and 2 hours after 3 meals
- Nutrition and physical activity goals reviewed

75% of Self-Monitoring Blood glucose (SMBG)Targets (fasting glucose < 95 mg/dL and 2 hour post-prandial glucose < 120 mg/dL) within target range after 1-2 weeks?

Yes →
- Weekly phone follow up by DM educators
- Weekly review at high risk OB (HROB) rounds
- HROB team will change testing and treatment plans as needed.

No

Non-Adherent Patients
- Send letter after 2 weeks of not sending in sugar logs or 2 weeks of <25 % of expected readings
- Consider Northwing admission to monitor blood sugars
- Consider transfer of care to ANTHC at 32 weeks

Initiate Medical Therapy
Consult OB/GYN for assistance
Refer to Anchorage for delivery

All patients with GDM get tested at the 6 week post-partum visit with two hour 75g GTT. A1C can be performed as an alternative at >12 weeks post-partum.

Patient to record SMBG levels before breakfast and 2 hours after start of 3 meals. Weekly follow-up by DM educators and Weekly review at HROB rounds

SMBG targets reached after 1 week?

Yes → Fetal Monitoring
- **Diet-controlled**: kick counts at 28 weeks
  Normal labor management
- **Diet-poor control**: kick counts at 28 weeks
  Biweekly NST and weekly AFI after 32 weeks
  Consult OB and consider induction at 38 weeks
- **Insulin-controlled**:kick counts at 28 weeks
  Biweekly NST and AFI after 32 weeks
  Consult OB for induction at 38 weeks

No → Reassess medication dose and choice and consult DM education team/OBGYN

GBS Prophylaxis of the Mother at Term

Use the
GBS App
to determine need for prophylaxis and antibiotic of choice for GBS prevention
Web version: https://www2a.cdc.gov/vaccines/m/gbs3/gbs.html
Or
Download for your smartphone

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Molar Pregnancy

MSEC approved 07/12/17

-Quantitative βhCG >100,000
-Vaginal bleeding
-Hyperemesis
-Cystic enlargement of ovaries

Suspect Molar Pregnancy: no intrauterine embryo or ultrasound suspicious for Molar Pregnancy.

Testing:
CBC, CMP, PT/PTT, Blood type and Rh factor, Quantitative HCG, pelvic ultrasound, chest x-ray, consider TSH, Free T4 if signs/symptoms of hyperthyroidism

Administer Rhogam if Rh negative

Signs or symptoms of medical complications, hyperthyroid, severe anemia, coagulopathy, PIH

Yes → Stabilize, consult with ANMC OB/GYN service and transfer to ANMC via medevac

No

Suction D&C, consider transfer if uterus is >16 week size due to increase risk of complications

Confirm pathology molar pregnancy, complete or partial

Yes

Quantitative βhCG 48 hours after D&C and weekly

Plateau ± 10%
over 3 weeks rise ≥ 10% over 2 weeks
Quantitative HCG + at 6 months

Yes → **Post molar GTN**
-CT chest, CBC, PT/PTT, CMP, Consult GYN ONC in Anchorage

No

Weekly Quantitative βhCG until negative x3 (<5)

Monthly Quantitative βhCG for 6 months

Contraception:
Encourage Depo Provera, Implanon, Mirena

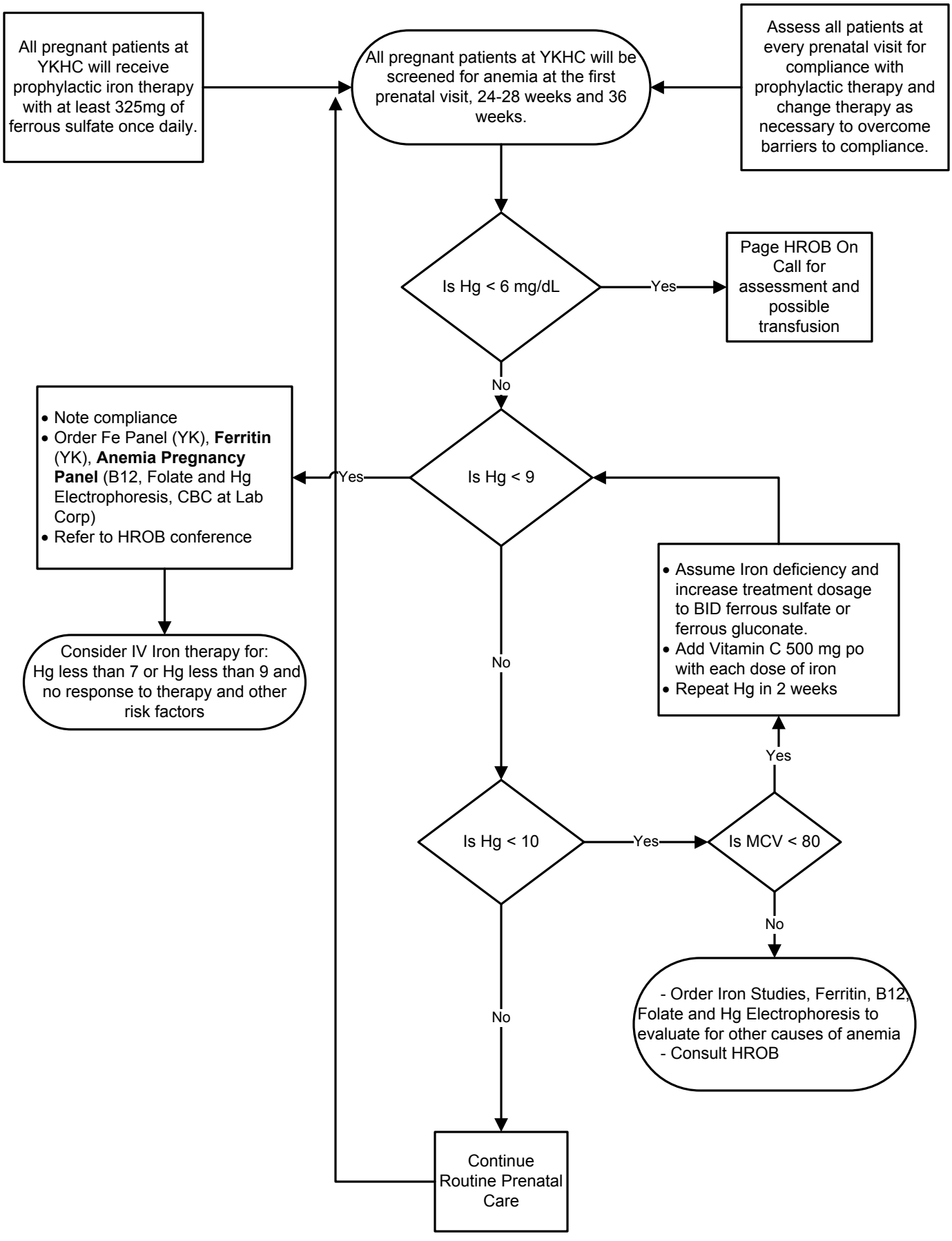
Definitions

GTN = gestational trophoblastic neoplasm
Complete Mole – a form of aberrant fertilization with proliferation of trophoblastic tissue with a normal karotype, no fetus, diffuse villous edema and diffuse proliferation.
Partial Mole – a form of aberrant fertilization with proliferation of trophoblastic tissue with triploid karotype, a fetus may be present, focal villous edema and focal proliferation.
Choriocarcinoma – a malignant neoplasm arising from cytotrophoblast
Placental site trophoblastic tumor – a malignant neoplasma arising from intermediate trophoblast
Post Molar GTN – persistent hCG detection after the treatment of a complete or partial molar pregnancy.
Invasive Mole – Detection of tumors within the uterus on imaging.
Malignant GTN = post molar gestational trophoblastic neoplasm
Metastatic GTN – post molar GTN with imaging evidence of distance metastasis. The most common sites are vagina, lung and brain.

This guideline is designed for general
use for most patients but may need to be adapted to meet the special
needs of a specific patient as determined by the patient's provider

Anemia in Pregnancy

MSEC approved 07/12/17



IV Iron

MSEC approved 06/22/11

This Policy is adapted from ANMC policy, Internal Medicine Clinic Iron Deficiency Anemia Orders Approved 6/18/08

A provider identifies a patient with Iron deficiency anemia who can benefit from IV Iron therapy

Calculate Iron Deficit (ID)
ID=3.3(Hemoglobin deficit x blood volume)
ID = 3.3((14 - Hg) x ((weight in Kg x 65 ml/Kg)/100))
Example: Pt with Hg of 7 and weight 100 Kg.
ID = 3.3((14-7)x(100 x 65)/100))
ID = 1501 mg

Divide the ID to give as 300 – 500mg doses

Provider completes an IV Iron PCC for each planned dose as an outpatient or writes the appropriate orders if the patient is admitted.

Nursing staff complete the infusion and schedule any follow up doses

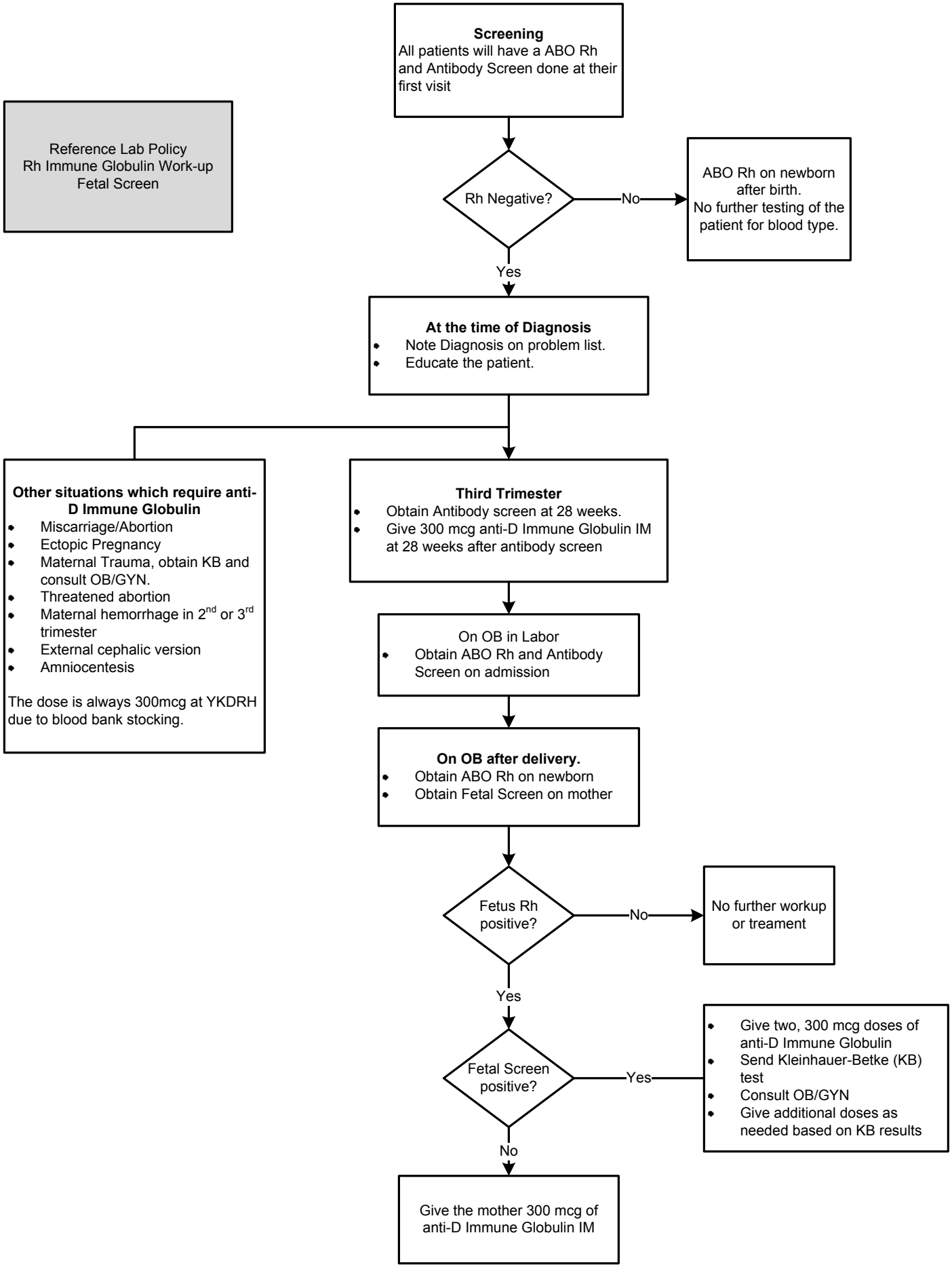
Can the patient remain in Bethel?

YES → Give doses weekly until ID corrected.

NO → Give doses daily until ID corrected.

Anti-D Immune Globulin

MSEC approved 06/22/11



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Intrauterine Growth Restriction (IUGR)

MSEC approved 07/12/17

Risk Factors for Intrauterine Growth Restriction

- **Maternal medical conditions**
- Hypertension
- Renal disease
- Restrictive lung disease
- Diabetes (with microvascular disease)
- Cyanotic heart disease
- Antiphospholipid syndrome
- Auto-immune disease
- Smoking and substance use and abuse
- Severe malnutrition
- Primary placental disease
- Multiple gestation
- Infections (viral, protozoal)
- Genetic disorders
- Exposure to teratogens

IUGR is suspected by physical examination (fundal height 3cm or more smaller that dates) and/or risk factors

Definition of IUGR

Estimated Fetal Weight by ultrasound < 10th percentile by gestational age

Obtain an US:

- Include all growth measurements with EFW and percentile
- Include reflex Doppler parameters:
- Systolic to diastolic ratio of umbilical artery (S/D-UA)
- Pulsatility index of the umbilical artery (PI-UA)

IUGR?

Yes → Gestational age < 24 weeks?

Yes → Refer to Perinatology for DAFUS, consider NIPT (See Box 1)

No → Is patient term?

Yes → Routine Prenatal Care

No → Repeat US in 4 weeks. Consider weekly fetal monitoring with BPP if EFW > 10th percentile but < 25th percentile

Gestational age < 24 weeks? No → Consult HROB or Anchorage OB to discuss induction, monitoring, or transfer

IUGR?

No → Routine Prenatal Care

Yes → Consult HROB or Anchorage OB to discuss induction, monitoring, or transfer

Box 1
NIPT – Non-invasive prenatal testing is a way to detect Fetal chromosome abnormalites from a maternal blood draw. Our current test is the InformaSeq from LabCorp.

Oligohydramnios

MSEC approved 07/12/17

Differential Diagnosis by Trimenster

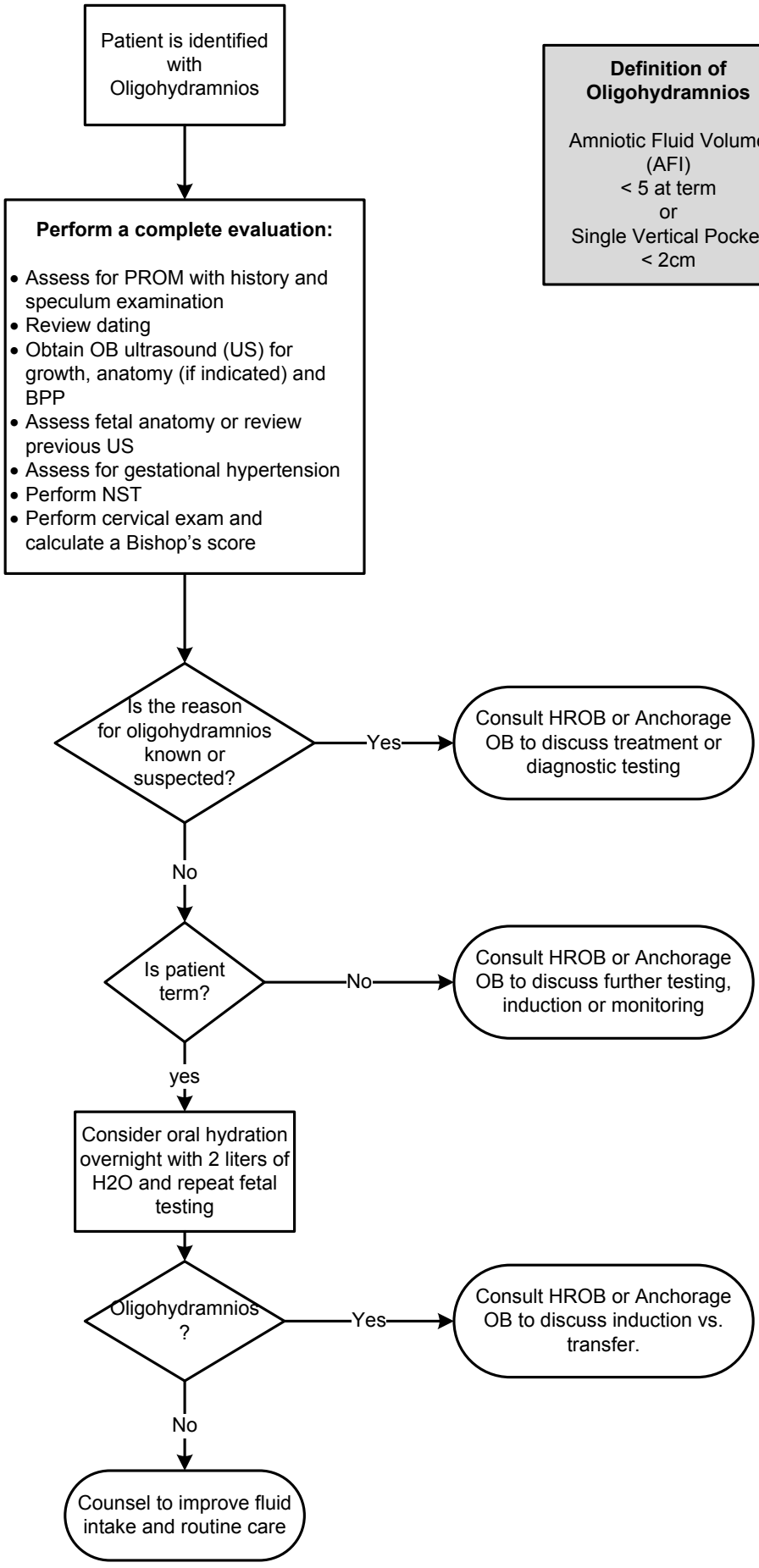
First
- Aneuploidy
- Fetal Anomaly

Second
- Aneuploidy
- Fetal Anomaly
- Preterm premature rupture of membranes (PPROM)
- Placental abruption
- Fetal growth restriction
- Amniocentesis
- Elevated maternal serum alpha fetoprotein

Third
- Preterm premature rupture of membranes
- Placental abruption
- Fetal growth restriction
- Utero-placental insufficiency
- Preeclampsia
- Maternal vascular diseases
- Fetal anomaly
- Post-term
- Suboptimal maternal hydration

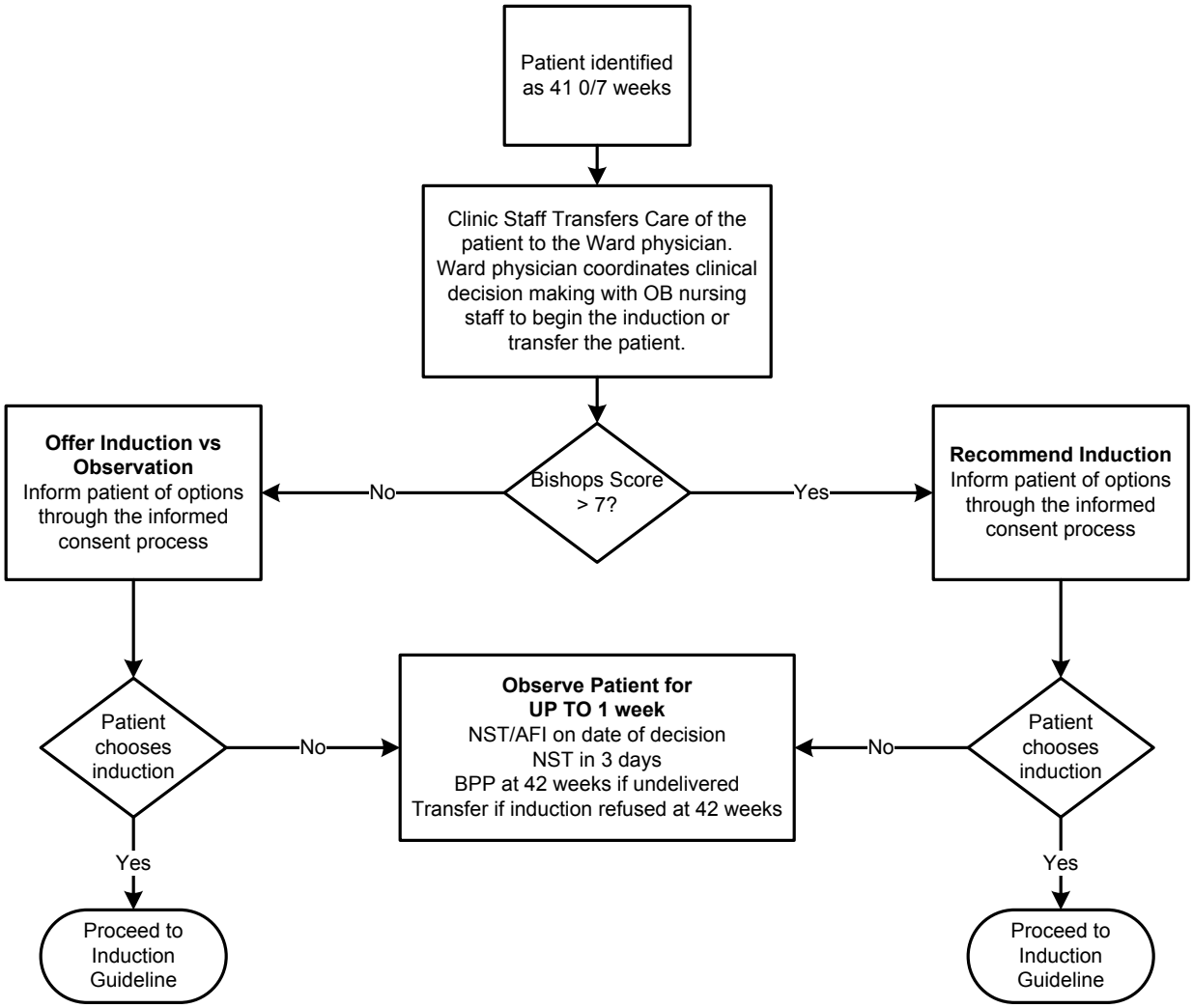
Definition of Oligohydramnios

Amniotic Fluid Volume (AFI)
< 5 at term
or
Single Vertical Pocket
< 2cm



Post Dates Pregnancy

MSEC approved 06/22/11



Bishops Score

Score	Dilatation	Effacement	Station	Position	Consistency
0	closed	0 – 30%	-3	posterior	firm
1	1-2 cm	40 -50%	-2	mid-position	medium
2	3-4 cm	60 -70%	-1,0	anterior	soft
3	5+ cm	80+%	+1,+2		

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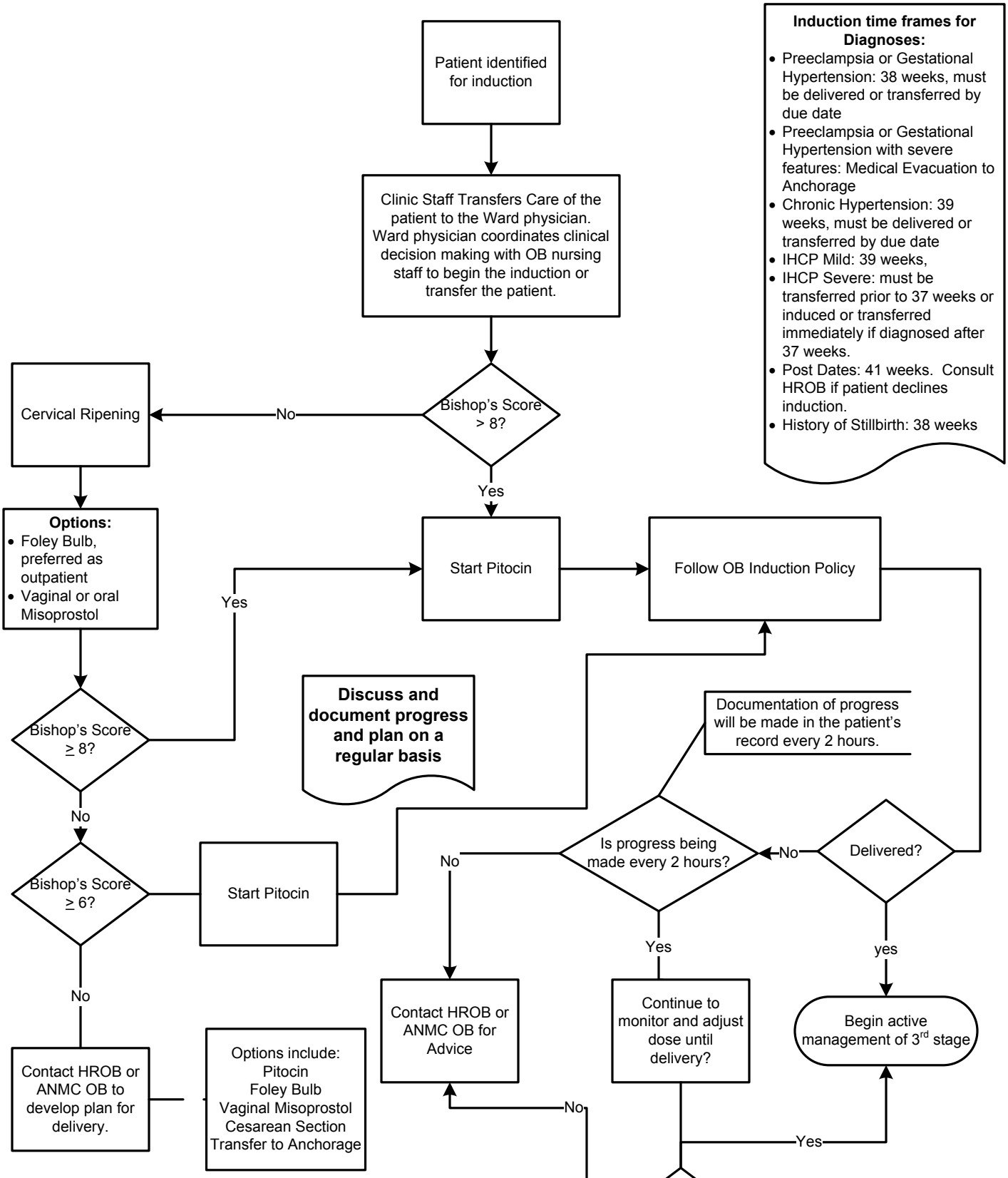
Induction of Labor

MSEC approved 12/14/16



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3	5+ cm	80+%	+1,+2		

YUKON-KUSKOKWIM HEALTH CORPORATION

Clinical Guidelines • October 2017

Intrahepatic Cholestatis of Pregnancy (IHCP)

MSEC approved 12/14/16

Intrahepatic Cholestasis of Pregnancy (IHCP)
- Abnormal Bile Acids (BA) metabolism in pregnancy resulting in severe pruritus without rash
- Mostly genetic etiology
- 5% incidence in Yup'k population
- 5% incidence of Stillbirth
- MUST have elevated bile acids or LFTs
- 40-70% recurrence in subsequent pregnancies

Early Pregnancy: Consider the diagnosis if:
- History of severe pruritus in past pregnancy
- Unexplained stillbirth
- Hx of IHCP

This guideline is designed for the general use of most patients, but may need to be adapted to meet the special needs of a specific patient as determined by the patient's medical practitioner.

Severe Pruritus:
- Insomnia
- Worse on palms of hands and soles of feet
- Excoriation present
- Scratching during the exam.

Draw baseline BA & LFT

Abnormal

Normal

IHCP:
- Begin Ursodiol 15mg/kg/day
- Schedule antenatal surveillance at 32 weeks

Repeat BA at 32 weeks or at onset of pruritus

2nd or 3rd Trimester with pruritus

Is the pruritus severe?

Yes

No

Are the Bile Acids and LFTs Normal?

Yes

- Stop Ursodiol if started
- Repeat BA & LFT in 2 weeks

No

IHCP
- Begin Ursodiol 15mg/kg/day
- Increase to 25mg/kg/day in one week if still itching
- Antihistamines for sleep
- Eucerin cream for itching

Are the Bile Acids and LFTs Normal?

No

Yes

Pruritus Gravidarum:
- Weekly BPP after 32 weeks
- Symptomatic treatment
- Deliver for usual indications
- Recheck Bile Acids and LFTs weekly

HROB meeting referral & Begin Fetal Surveillance at 32 weeks
- BPP weekly, may stay in village and return weekly
- Fetal Kick Counts 3X per day

Are TBA >40?

NO

Mild IHCP Induce at 39 weeks.

YES

SEVERE IHCP Transfer to Anchorage for Delivery at 37 weeks.

Biophysical Profile (BPP)
- NST
- US including: Fetal Breathing, Tone, Gross body motion and AFI

Abnormal Lab levels

Total Bile Acids (TBA)-	>10 µmol/L
Cholic Acid -	> 3 µmol/L
AST/ALT -	>40 units/L
Bilirubin -	> 1 mg/dl
Alkaline Phosphatase -	>300 units/L

Chronic Hypertension in Pregnancy

MSEC approved 07/12/17

Diagnostic Criteria
History of hypertension (BP≥140/90) prior to pregnancy
or
Persistent hypertension (BP>140/90) prior to 20 weeks gestation
or
Hypertension (BP>140/90) persisting beyond 12 weeks post-partum

First Prenatal Visit with history of Chronic Hypertension
Obtain GH labs†. Refer to HROB meeting for discussion.

First Trimester
1. Monitor BP every 2-4 weeks.
2. Fetal ultrasound to confirm EDC prior to 14 weeks gestation .

Second Trimester
1. Monitor BP every 2-4 weeks.
2. If patient with symptoms of severe features of preeclampsia‡, obtain GH labs†
3. Aspirin 81 mg daily between 12-37 weeks gestation to prevent complications

Serial fetal U/S every 4 weeks after 28 weeks to evaluate growth.

Superimposed Preeclampsia present?*
- Yes → Refer to Gestational Hypertension Guideline
- No →

Third Trimester
1. Monitor BP every two weeks.
2. If patient demonstrates severe features of preeclampsia‡, obtain GH labs.
3. BPP weekly after 34 weeks gestation.
4. NST/AFI anytime patient is in Bethel between 28-36 weeks.

Severe HTN, renal, cardiac, or connective tissue disorders?
- Yes → Refer to ANMC OB Service.
- No →

Consult OB/GYN at 37 weeks for timing of delivery.MUST be delivered by the EDC or transferred to Anchorage

†GH labs:
CBC, creatinine, ALT, AST, uric acid, Urine Protein/ Creatinine Ratio, CCUA

‡ Severe Features of Preeclampsia
- Severe hypertension (160/ 110)
- Thrombocytopenia (<100K)
- Impaired liver function
- Progressive renal insufficiency
- Pulmonary edema
- New onset cerebral or visual disturbances
- Oligohydramnios

*** Signs/Symptoms of Superimposed Preeclampsia**
- Any signs/symptoms of severe features
- Worsening proteinuria
- Worsening hypertension

Any patient with hypertension in pregnancy should have blood pressure monitored for at least 2 weeks post partum

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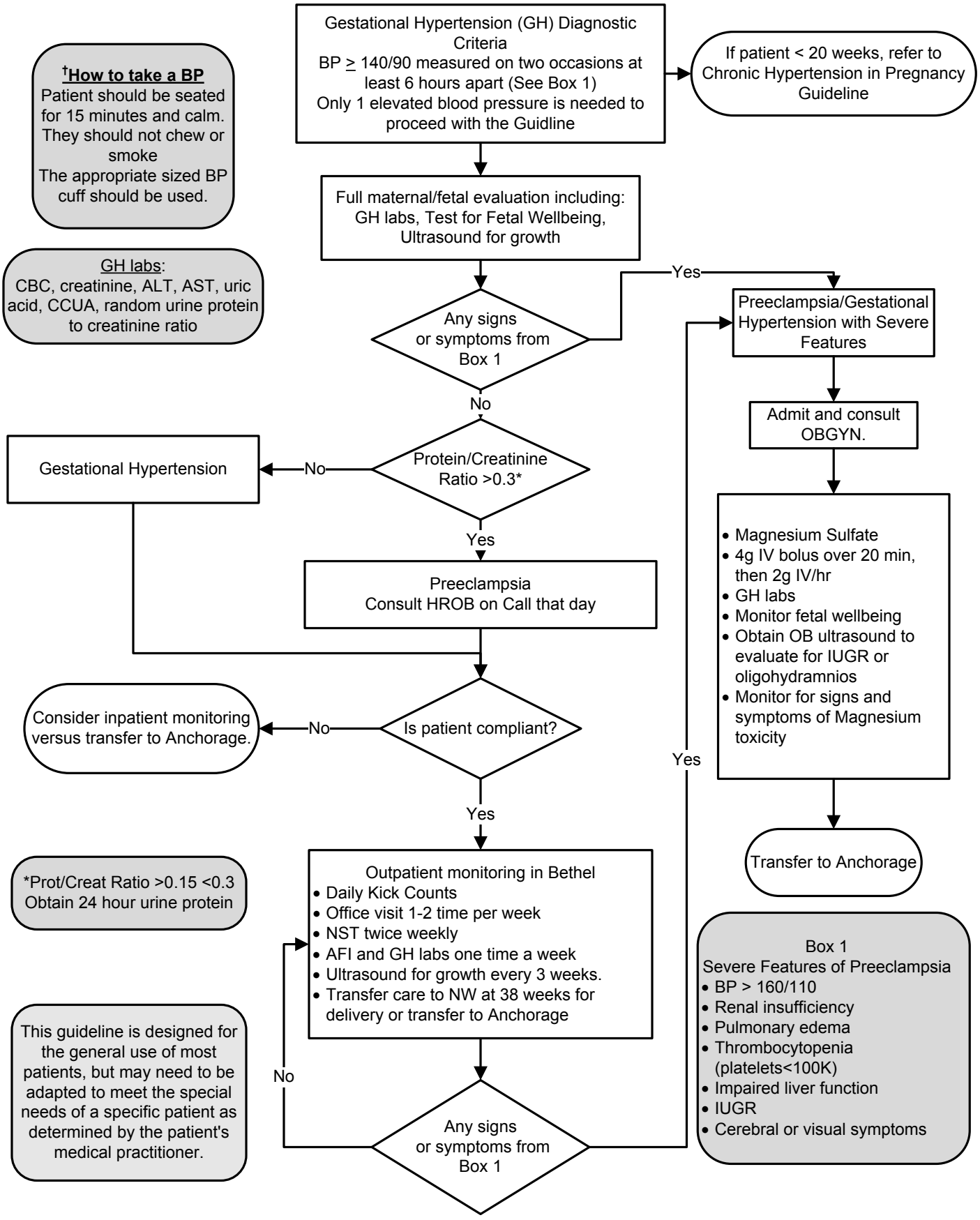
YUKON-KUSKOKWIM HEALTH CORPORATION

Gestational Hypertension

MSEC approved 07-12-17



YUKON-KUSKOKWIM HEALTH CORPORATION

CLINICAL GUIDELINES 2017

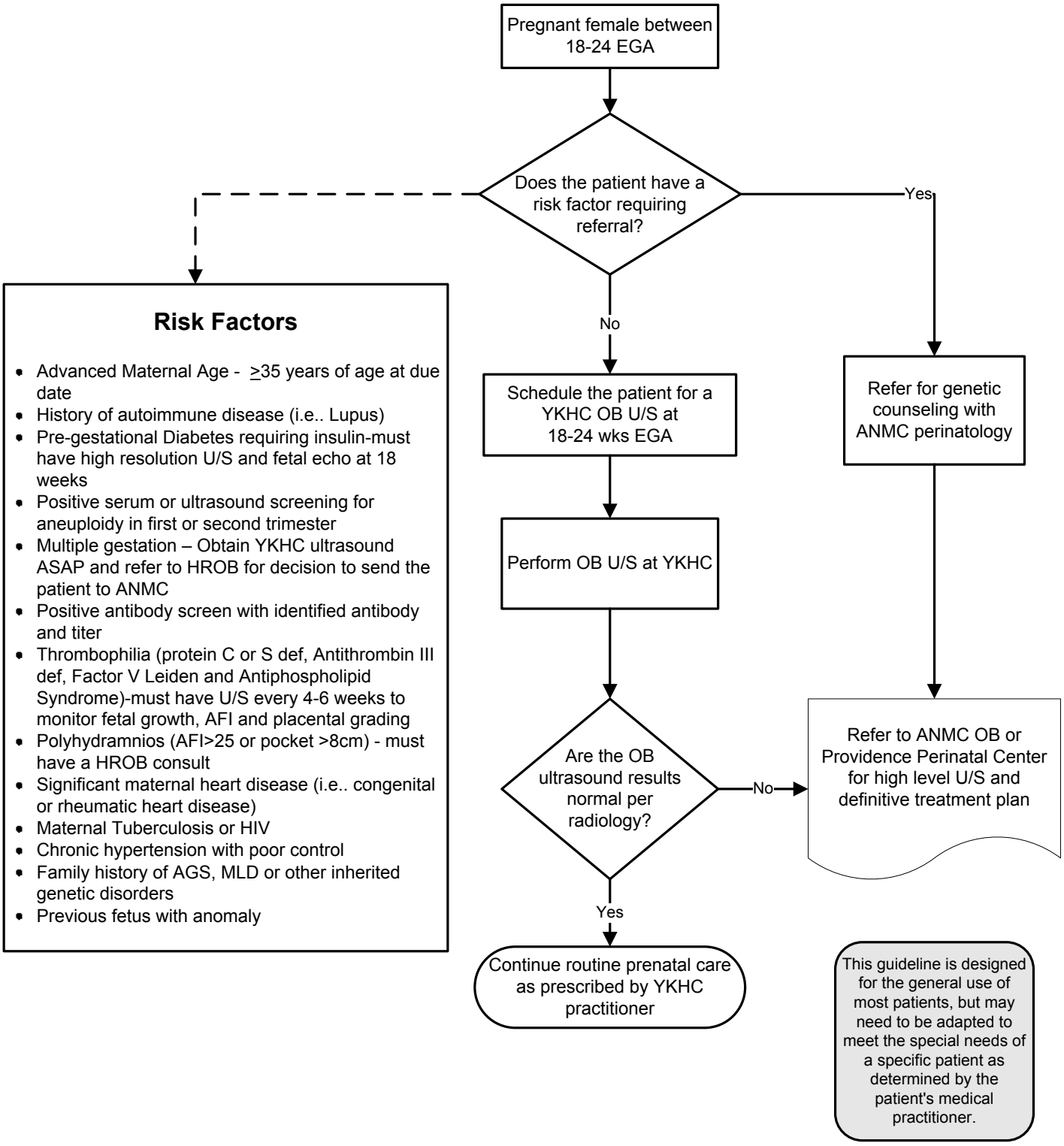
rev. 10-09-17

OB Protocols

YUKON-KUSKOKWIM HEALTH CORPORATION

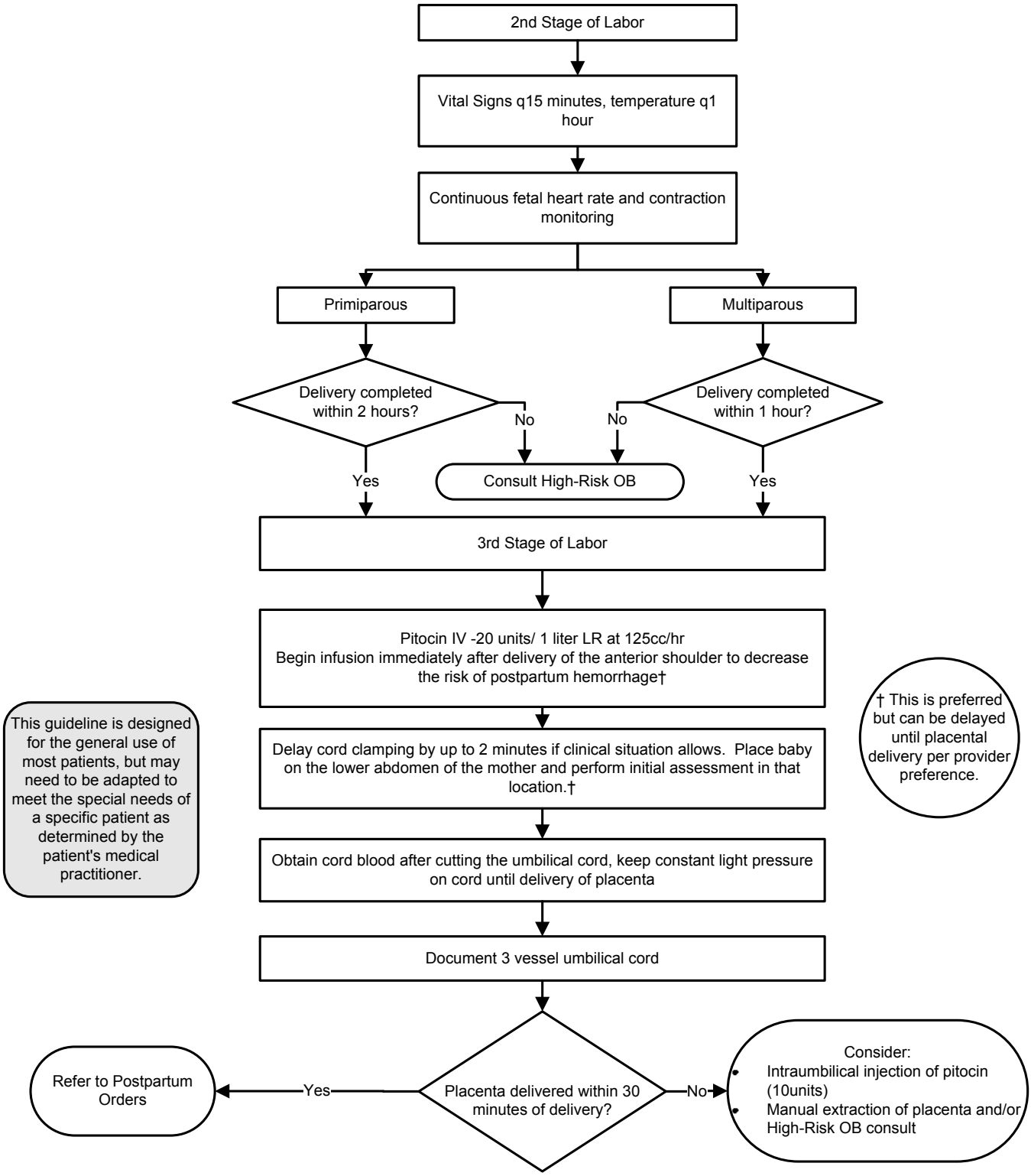
OB Ultrasound Referral – High Risk

MSEC approved 06/22/11



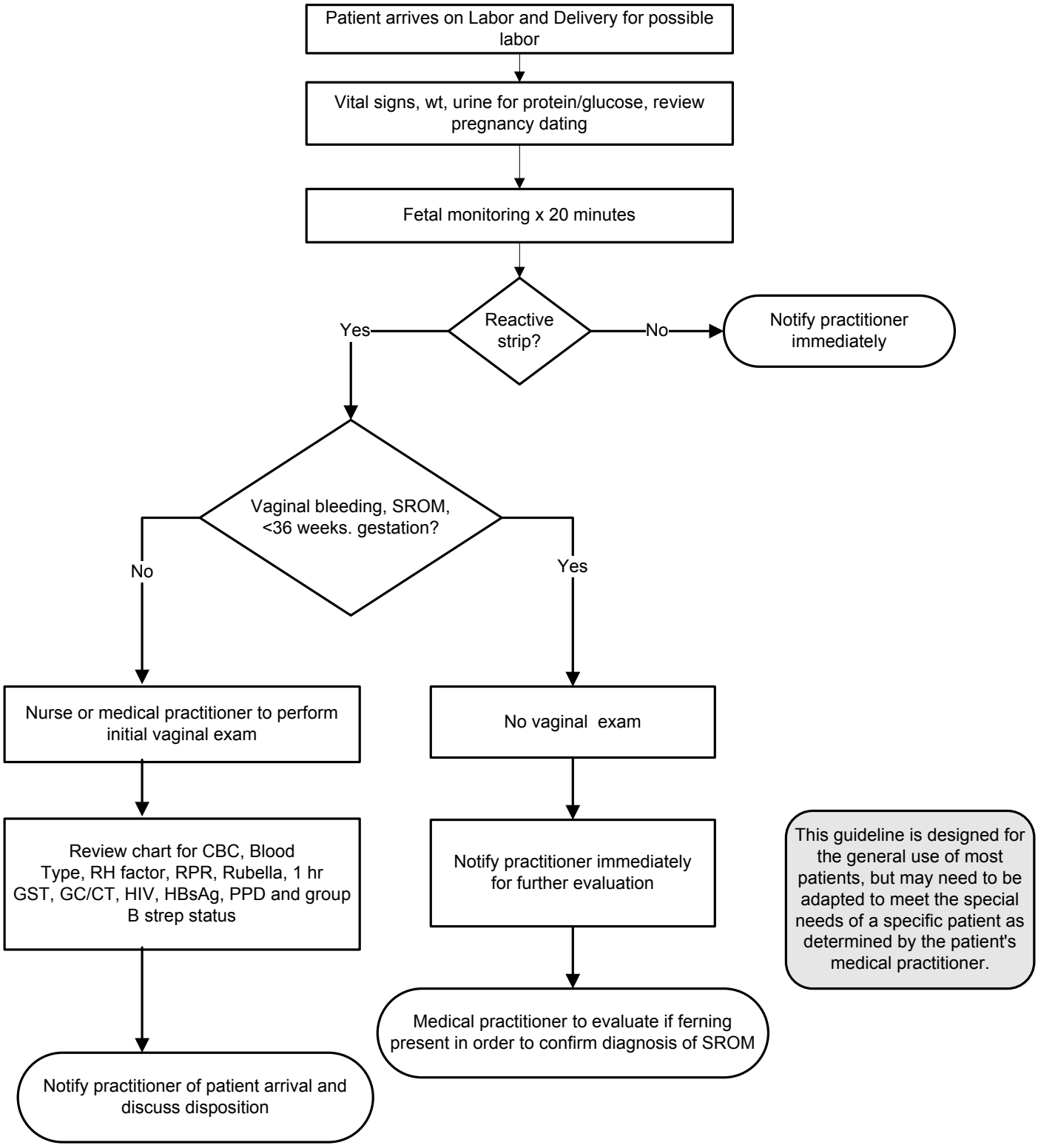
2nd and 3rd Stage of Labor

MSEC approved 06/22/11



Antepartum Patient

MSEC approved 06/22/11



Vaginal Birth After Cesarean (VBAC) - p.1

12/10/2013

Unit Structure:
The obstetrics unit of the Yukon Delta Regional Hospital has the capability to perform emergency cesarean sections as part of normal obstetric care during the intrapartum period. The operating room staff, obstetric nurses, North wing physician staff and the high-risk obstetricians (HROB) on call can respond to emergency situations as needed during before or after labor. A family practice perform vaginal births is in the hospital 24 hours a day. Obstetrical nursing is staffed to an appropriate level based on AWHONNN standards. An operating room team including certified nurse anesthetist, scrub nurse and circulating nurse is on-call 24 hours a day. An HROB physician is on-call 24 hours a day to provide obstetrical consultation and surgical services as needed.

Definitions:
- **Labor**: Regular and painful uterine contractions that cause cervical change.
- **Active Labor**: The cervix is 6 cm dilated and there are regular and painful uterine contractions.
- **Adequate Labor**: Contractions every 3 minutes with a 50 torr rise above baseline (internal monitor) or contractions every 3 minutes lasting at least 45 seconds that palpate strong (external monitor).
- **Provider capable of performing a cesarean section**: The HROB physician on-call.
- **Admission**: Occurs when labor has been diagnosed, or when decision is made to deliver the patient. Observation to determine if the patient is in labor is not considered admission.
- **Anesthesia**: Refers to a CRNA who is privileged by the hospital.
- **OR Team**: One person competent to scrub for a cesarean section and one person competent to circulate during a cesarean section. These may be OR technicians, LNA, CNA, LPN, or RN.

Risk Assessment:
- Each patient will Be evaluated for risk factors associated with decreased VBAC success and uterine rupture. This will be done at least 3 times during the patient's prenatal course:
  - » During an HROB conference soon after the patient's first prenatal visit.
  - » By the HROB on-call at 36 weeks after the patient's Be-in-Bethel (BIB) visit.
  - » By the HROB upon admission in labor.
- The association of factors related to an increased risk of uterine rupture has not been able to be translated into the reliable prediction of uterine rupture (1, 2). Patients without risk factors may experience uterine rupture.
- There is limited data on outcomes for women with multiple risk factors present. Some studies suggest that even when multiple risk factors are present, VBAC success rates are often at least 50% or higher (3). All patients should receive counseling about the assumed relative risk for VBAC success and uterine rupture. Management plans for these outcomes should be reviewed with the patient.

Low Risk Patient: Risk for uterine rupture approximately 0.3-0.7%.
- 1 or 2 prior low transverse cesarean section(s)
- Spontaneous onset labor
- No need for augmentation
- No repetitive FHR abnormalities
- Patients with a prior successful VBAC are especially low risk. However, their risk status escalates the same as other low risk patients.

Medium Risk Patient: Risk for uterine rupture is likely greater than 0.7%.
- Induction of labor
- Oxytocin augmentation
- < 18 months between prior cesarean section and current delivery.
- 3 or more prior low transverse cesarean sections.

High Risk Patient: Patients who have intra-partum signs or symptoms that may be associated with uterine rupture or failure of vaginal delivery (4).
- Recurrent clinically significant deceleration (variable, late or prolonged fetal heart rate decelerations) not responsive to clinical intervention
- Significant bleeding of uterine origin
- New onset of intense uterine pain
- 2 hours without cervical change in the active phase despite adequate labor

Prenatal Management:
- Records of prior delivery reviewed, including type of uterine incision and method of closure. Evaluate history of previous uterine surgery. Patients will only be approved for VBAC at YDRH if they have a documented transverse lower uterine segment scar that was closed in two layers.
- Appropriate patient education brochure given to patient and reviewed with patient.
- Appropriate VBAC consent reviewed during prenatal care and signed. This will be documented after the 1st prenatal visit, at the BIB visit and upon admission in labor.
- Informed consent should include a discussion of the following.

  - » A description of the process of risk assessment.
  - » The ability of the institution to care for the patient, based on her risk level.
  - » The process of transfer of care, should it become necessary based on risk factors.
  - » Institutional management plans for uterine rupture.
- Anesthesia consultation/evaluation per institution guidelines.
- If the primary OB provider cannot perform a cesarean section, consultation with provider privileged to perform a cesarean section.

Basic Intra-partum Care Recommendations for all VBAC Patients:
- Review with the patient the risks/benefits of proceeding with VBAC on admission. Determine if the patient's risk level has changed, or patient choice has changed. This review should be documented in the medical record.
- Estimated fetal weight will be documented by the HROB or north wing physician.
- Lab/Blood Bank Preparation
  - » CBC and Type and Screen.
- Anesthesia personnel notified of admission.
- Pediatric personnel notified of admission.
- OR Team notified of admission and plan in place if cesarean delivery needed.
  - » Does not mean an OR is kept open for patients at low risk.
- In Active Labor (6 cm dilated).
  - » Continuous Electronic Fetal Monitoring.
  - » Place 18 gauge IV.
  - » HROB on-call notified.
- All patients attempting VBAC should have their labor progress monitored carefully to ensure adequate progress. Arrest of labor is associated with decreased VBAC success and uterine rupture.

Intra-partum Management:
The laboring patient will be monitored and cared for based on obstetric policy for all laboring patients with the exceptions noted above.

Low Risk Patient:
- No additional interventions other than those listed above.
- The HROB may be at home within 1.5 miles of the hospital.
- Cesarean delivery provider may have other acute patient care responsibilities.

Medium Risk Patient:
- We recommend that these patients have a cesarean section. In some cases, when delivery is imminent, labor may be allowed to continue with careful counseling.
- The HROB on-call must come to the hospital. Cesarean delivery provider may have other acute patient care responsibilities.
- An open and staffed operating room is available or there is a plan in place if immediate delivery is required. This may be a room where there is adequate lighting, instruments, and general anesthesia can be administered if needed.
- An anesthesia provider is present in the hospital during the active phase of labor.

High Risk Patient:
- We recommend that these patients have an immediate cesarean section.

Caveats:
- Misoprostil WILL NOT be used in these patients.
- Patients with two prior cesarean sections will NOT be approved for VBAC at the YDRH.
- Patients with a single layer closure of the uterus will NOT be approved for VBAC at the YDRH.
- Patients who present for delivery at YDRH in labor with a previous cesarean and no plan of management will be evaluated by the HROB on-call. A risk assessment will be done and the patient will be counseled. If the risk cannot be adequately assessed, the patient will be offered a repeat cesarean section.

Proposed Performance Measure:
The percentage of patients for whom there is documented risk status at the time of admission, and documented change in risk status during labor, should that occur.

Complication Rates Associated With VBAC and Planned Cesarean Birth (Includes preterm and term births). (22)

Complication	VBAC Attempt	Planned Cesarean Birth
Uterine Rupture	468/100,000	26/100,000
Maternal Death	4/100,000	13/100,000
Hysterectomy	No significant difference	No significant difference
Blood Transfusion	No significant difference	No significant difference
Maternal Infection	No significant difference	No significant difference
Infant Infection	Insufficient information	Insufficient information
Infant Bag and Mask Ventilation Required	5,400/100,000	2,500/100,000
Transient Tachypnea of the Newborn (TTN)	3,600/100,000	4,200/100,000
Infant with Brain Injury (HIE)	Insufficient information	Insufficient information
Infant death in pregnancy or within 7 of birth (Perinatal Death Rate)	130/100,000	50/100,000
Infant death within 30 days of birth (Neonatal Death Rate)	110/100,000	60/100,000

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Studies were evaluated for quality according to the method outlined by the U.S. Preventative Services Task Force

I Evidence obtained from at least one properly designed randomized controlled trial.

II–1 Evidence obtained from well–designed controlled trials without randomization.

II–2 Evidence obtained from well–designed cohort or case–control analytic studies, preferably from more than one center or research group.

II–3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

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Clinical Guidelines • October 2017

Prenatal Care Guidelines

Rev Date: 6/20/17

BASICS

- Review the chart EVERY visit for incomplete lab or other required testing.
- Review the problem list EVERY visit for needed testing or intervention items.
- Patient should see a Bethel provider or CHA/P monthly from first visit to 32 weeks.
- Patient should see a Bethel Provider or CHA/P every 2 weeks after 32 weeks and then weekly at 36 weeks.
- If there is any question of EDC, see guideline or refer to HROB meeting for decision.

First Prenatal

NURSING/CASE MANAGER

- Order First Trimester Transvaginal OB Ultrasound (>6weeks) for dating
- Patient to initiate paperwork
  - Residential Information sheet
  - Pregnancy Verification Sheet—use LMP if no EDC from ultrasound
  - Quad screen consent form
  - FAS & Drug assessment screening questionnaire
  - 36wk BIB/Medevac Policy
- Review TB screening status –Patient MUST HAVE a negative Quantiferon or PPD prior to 36 weeks to stay at Prematernal Home. Place PPD if needed.
- Send patient for labs: Urinalysis with reflex, Blood type and screen, HbsAg, CBC, Rubella titer, RPR, HIV testing, HgA1C, 25-OH Vitamin D.
- Set up room for pelvic to do PAP (only do a PAP if it is due), Wet Prep, GC/CT (with verbal consent)
- Routine patient handouts: WIC handout

PROVIDER

- Prenatal H&P and Prenatal Education
- Chart review
- Offer Flu vaccine October through the end of the flu season
- Discuss and sign BIB/Medevac Policy contract
- Update the Problem List and include EDC and gravida/para in one problem
- Refer to HROB meeting if needed
- Ask about S/S of IHCP, if positive, add Bile acids and LFTs to lab draw

PATIENT

- Go to the Medicaid office to file for Medicaid
- Go to the WIC office to file for WIC

15–21 Weeks

- Quad screen to be drawn, if desired, must be drawn between 15 and 21 weeks gestation
- Review TB status

20 Weeks

- Ultrasound to screen for anomalies, US OB anatomy and cervical length
  - only one is needed no matter where it is done
  - Aim for 20 weeks
  - If anatomy incomplete, order a US OB follow-up for the next visit to complete the anatomy exam

24–28 Weeks

NURSING

- Labs: GST, CBC, 25-OH Vitamin D
- Tdap, after 24 weeks
- GST-50g (1/2 bottle or 5 oz)
  - If result >140mg/dl schedule 3 hour GTT ASAP.
  - If the result > 179, no GTT, refer directly to diabetes education
- Attempt to keep the patient until the results of the GST are back.
- Review TB status. Send to lab for Quantiferon if failed to have PPD read.

PROVIDER

- After 28 weeks ask about preeclampsia symptoms
- After 24 weeks ask about PTL symptoms and IHCP symptoms?
  - Back pain
  - Sudden increase in vaginal discharge
  - Pelvic Pressure
  - Cramps/contractions
- Educate patient on fetal movement count

36-week/ BIB date

- Labs: CBC, RPR, Pelvic exam with GBS culture, GC/CT, wet mount if concerns.
- Review TB status. Send to lab for Quantiferon if status unknown.
- Schedule appointments to be seen each week by Bethel provider through 41 weeks
- Complete Pre-maternal Home/Medical clearance paper
- Ask about any symptoms of:
  - Rupture of membranes
  - Preeclampsia
  - labor
  - itching

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CLINICAL GUIDELINES 2017

rev. 10-09-17

Outpatient Guidelines

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Skin and Soft Tissue Infection, p.1

MSEC approved 07/12/17

Skin and Soft Tissue infection identified

DO NOT use guideline for the following :
- Diabetic ulcer
-Vascular ulcer
- Necrotizing fasciitis
- Human or animal bite cellulitis
- Thrombophlebitis
- Erythema nodosum
- DVT
- Toxic shock syndrome
- Herpes zoster
- Fish finger
-Bacteremia
-Periorbital or orbital cellulitis
-IV drug use
-perineal/vulvar/perianal infections

If considering an above diagnosis, management must be individualized, and this guideline may not apply.

Abscess present?

Yes → Cutaneous abscess → Perform incision and drainage with local anesthesia. Culture wound and break up loculations. Place fixed Penrose drain if possible. Hot packs/soaks q2-4 hours and rest/elevation if on extremity

No → Purulent drainage or exudate?

Yes → Purulent cellulitis

No → Non-purulent cellulitis → See Page 2

Cellulitis >10 cm or >1% BSA in child (size of child's palm)

No, antibiotics not indicated → Outpatient management with daily follow up until continuous improvement is demonstrated

Yes → Consider empiric oral antibiotic therapy

Empiric oral Antibiotic Therapy
Adults
Septra DS 1-2 tabs PO q12hours (do not give to pregnant women)
Children:
Septra 4-6 mg/kg PO q 12 hours (based on TMP component)
Adults with sulfa allergy:
Doxycycline 100 mg PO q12 hours
Children with sulfa allergy:
>/=8 years: Doxycycline 2 mg/kg PO q12 hours x 10 days (max 100 mg/dose)
<8 years: Clindamycin 10-13 mg/kg PO q8 hours
Pregnant or breastfeeding women:
Clindamycin 450 mg PO TID
***Antibiotic duration 5-7 days**
***Septra and doxycycline do NOT cover strep pyogenes**

Does patient meet all criteria for outpatient management (see Box 2)?

yes → Outpatient management with daily follow up until continuous improvement is demonstrated

Vancomycin:
Strongly consider inpatient admission if vancomycin is considered
Remember, no outpatient vancomycin may be prescribed to patients <18 years old.

No →
- Admission with IV antibiotics. (See Box 3.)
- Recommend blood cultures, CBC, basic metabolic panel.
- Elevation and heating pad.
- Consider IV fluids.
- Address pain control.
- Consider imaging.
- If patient meets criteria for sepsis, follow sepsis guideline

BOX 2: Criteria for Outpatient Management:
- Afebrile and non-toxic
- Ambulatory and able to commute to hospital for outpatient treatment
- Able to care for self
- Tolerating PO fluids
- Pain controlled with oral pain meds
- Doesn't require hospitalization for elevation of extremity

BOX 3: Empiric Antibiotic Options
1. Vancomycin:
   • For adults: load with 30 mg/kg IV, then dose 15 mg/kg q8 or q12 hours.
   • For patients <18 years: 20 mg/kg IV q6 hours. If patient is obese, consider dosing based on ideal body weight.
2. Linezolid 600 mg IV/PO q12 hours. Restricted to known MRSA resistance or vancomycin allergy.
3. In children with rapidly progressing cellulitis/abscess or associated systemic symptoms (fever, listlessness, lethargy, etc.) consider covering Haemophilus influenzae type A/B with ceftriaxone 75 mg/kg IV/IM q24 hours in addition to above.

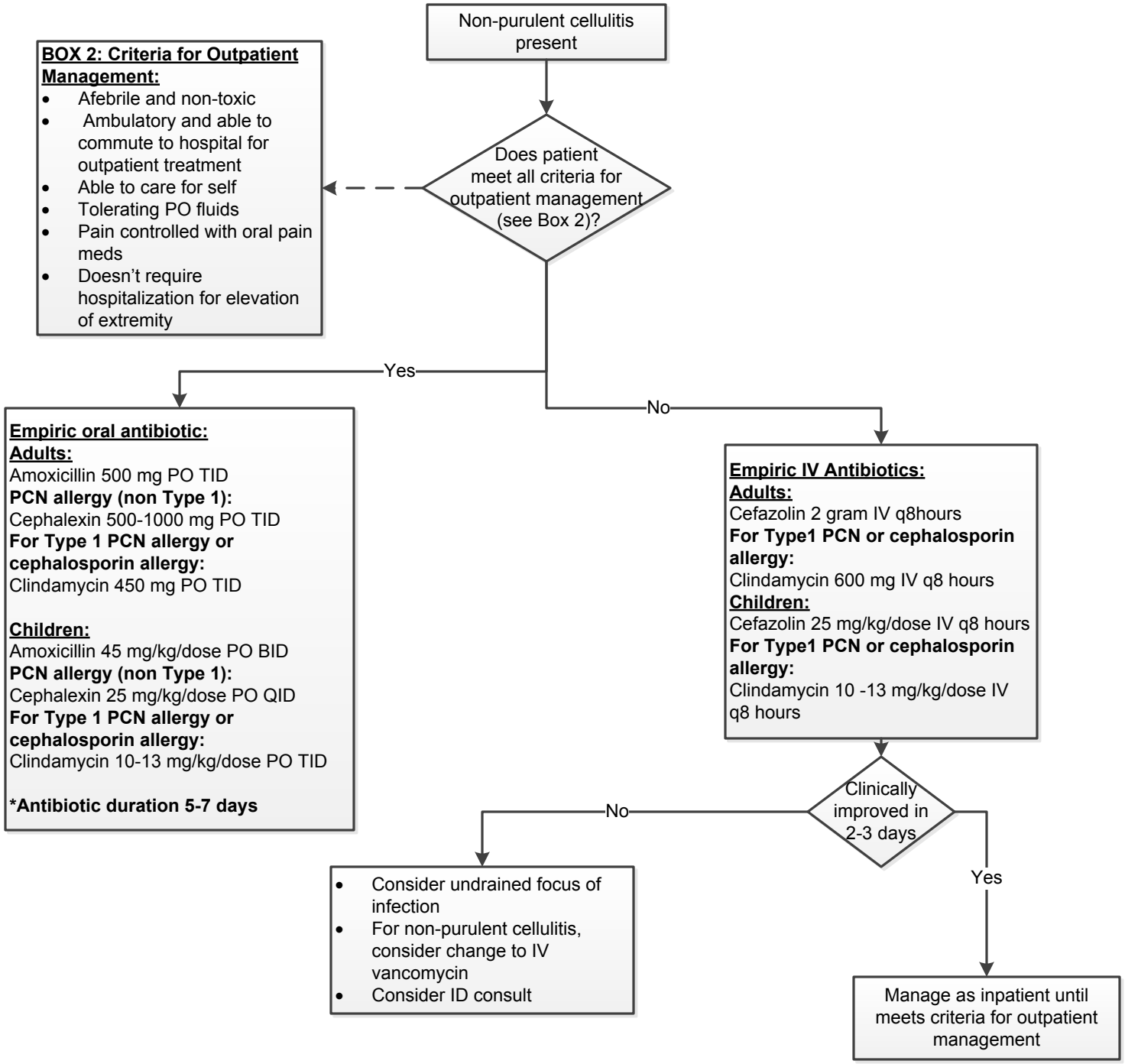
Patient improving?

Yes → Manage as inpatient until meets criteria for outpatient management

No →
- Review culture and sensitivities
- Consider imaging.
- Consider repeat incision and drainage

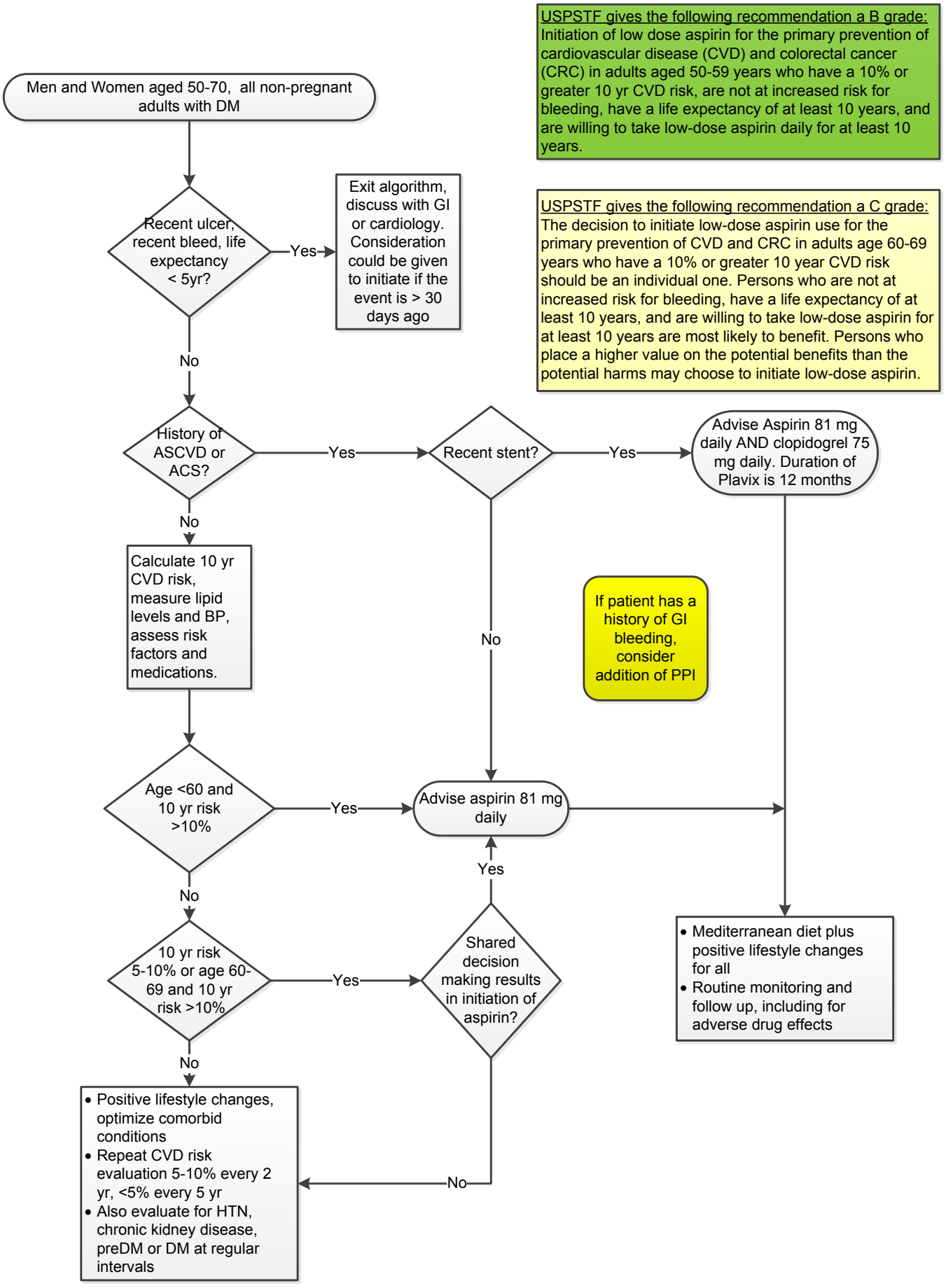
Skin and Soft Tissue Infection, p.2

MSEC approved 07-12-17



Aspirin

MSEC approved 07-12-17



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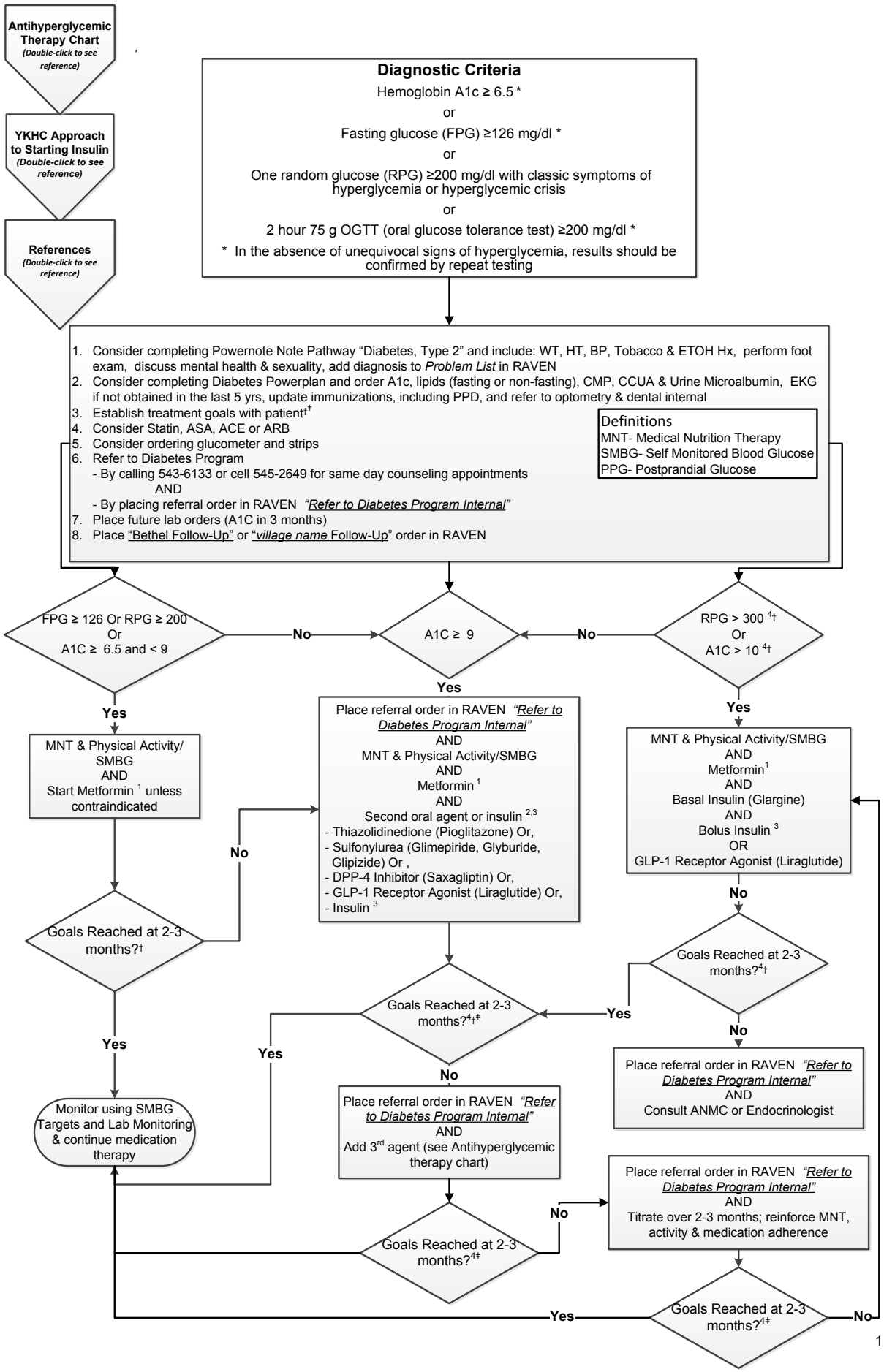
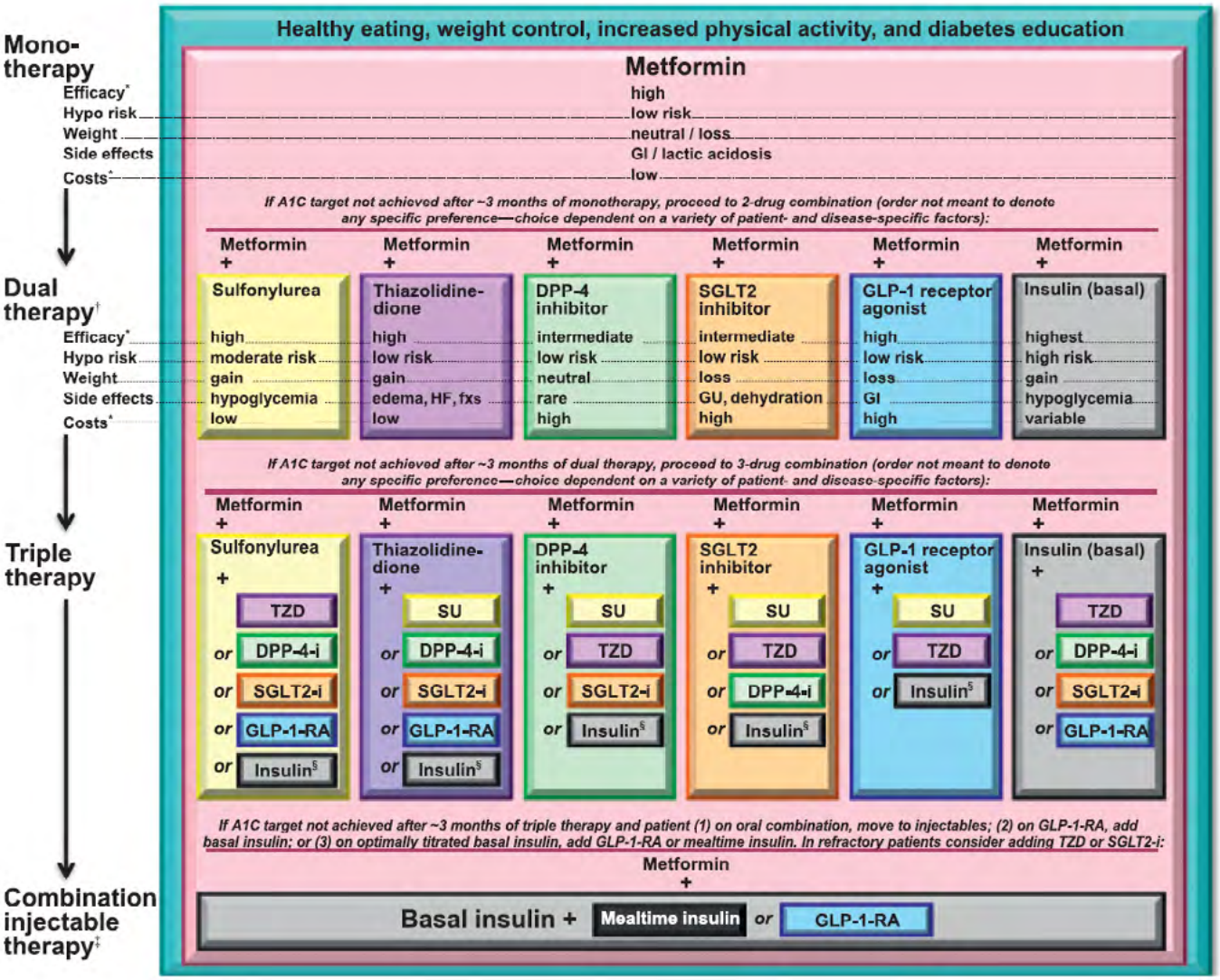
Clinical Guidelines • October 2017

Type 2 Diabetes

MSEC approved March, 2015





References

1. ADA 2014 Guidelines; Metformin: Preferred initial therapy (if tolerated and not contraindicated)
2. ADA 2014 Guidelines; Add second oral agent, GLP-1 receptor agonist, or insulin If non-insulin monotherapy at maximum tolerated dose does not achieve or maintain A1c target over 3 mos.
3. ADA 2014 Guidelines; Consider insulin therapy with or without other agents at outset in newly diagnosed patients with markedly symptomatic and/or elevated BG levels or A1C
4. ADA 2015 Standards of Care; Summary of glycemic recommendations for nonpregnant adults with diabetes

† More or less stringent glycemic controls may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy co-morbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations. (See Glycemic Targets Chart on the Document Library)

‡ Postprandial glucose may be targeted if A1c goals are not met despite reaching preprandial glucose goals.

Type 2 Diabetes

MSEC approved March, 2015

Basal Insulin

(usually with metformin +/- other noninsulin agent)

 # injections | **Complexity**

1 | **Low**

- **Start**: Insulin glargine 10 U/day or 0.1-0.2 U/kg/day.
- **Adjust:** 10-15% or 2-4 U once-twice weekly to reach FBG target.
- **For hypo:** Determine and address cause; ↓dose by 4 U or 10-20%.

If not controlled after FBG target is reached (or if dose >0.5 U/kg/day), treat PPG excursions with mealtime insulin. (Consider initial GLP-1-RA (exenatide) trial.)

2 | **Mod**

Add 1 rapid insulin (insulin aspart; regular insulin) **injection before largest meal**

- **Start:** 4 U, 0.1 U/kg, or 10% basal dose. If A1C <8%, consider ↓ basal by same amount.
- **Adjust:** ↑ dose by 1-2 U or 10-15% once-twice weekly until SMGB target reached.
- **For hypo:** Determine and address cause; ↓ corresponding dose by 2-4 U or 10-20%.

Change to premixed insulin (insulin protamine aspart/insulin aspart or NPH insulin) **twice daily**

- **Start:** Divide current basal dose into 2/3 AM, 1/3 PM or ½ AM, ½ PM.
- **Adjust:** ↑ dose by 1-2 U or 10-15% once-twice weekly until SMBG target reached.
- **For hypo:** Determine and address cause; ↓ corresponding dose by 2-4 U or 10-20%.

3+ | **High**

If not controlled, consider basal-bolus.

Add ≥ 2 rapid insulin injections before meals ("basal-bolus")

If not controlled, consider basal-bolus.

- **Start:** 4 U, or 0.1 U/kg, or 10% basal dose/meal. If A1C <8%, consider ↓ basal by same amount.
- **Adjust:** ↑ dose by 1-2 U or 10-15% once-twice weekly until SMBG target reached.
- **For hypo:** Determine and address cause; ↓ corresponding dose by 2-4 U or 10-20%.

Flexibility — More flexible — Less flexible

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Congestive Heart Failure, p.1

MSEC approved 07-12-17

Major risk factors:
- Hypertension
- Prior MI
- Diabetes
- Valvular heart disease
- Obesity

Minor Risk Factors:
- Alcohol abuse
- Cigarette smoking
- Dyslipidemia
- Renal insufficiency
- Sleep-disordered breathing
- Low physical activity
- Lower socioeconomic status
- Depression
- Increased dietary salt intake

Concern for Congestive Heart Failure

Are risk factors present?

No

Yes

BOX 1

Initiate education for Health Seeking Behaviors:
- No smoking, limit alcohol, avoid illicit drug use
- Eat a low saturated fat diet, rich in fruits and vegetables
- Educate regarding risk factors
- Keep BMI < 25
- Encourage physical activity 120-180 min/week
- Limit sugar sweetened beverages

Monitor for signs/symptoms:
- Shortness of breath
- Activity intolerance
- Orthopnea
- Frothy sputum
- Peripheral edema
- Sudden weight gain >2-3 lb
- Nocturia
- Altered mental status
- Hypoxemia
- Chest pain

Consider urgent/ emergent evaluation in ED if last three symptoms are present

Are positive findings present?

Yes

No

Follow plan of care for diagnosis/ management of CHF

BOX 2

Plan of care for CHF patients
- Encourage patient to collaborate with provider to treat known risk factors
- Evaluate patient at regular intervals for signs/ symptoms of heart failure
- Teach patient to report weight gain >2-3 lbs and changes in heart rhythm
- Instruct patient to comply with LV function testing
- Encourage medication compliance, especially with ACEI/ARB
- Patient education from Box 1

Seek to exclude CHF as diagnosis/cause of symptoms:
- ECG (acute ischemic findings, new LBBB)
- BNP

Transfer to ED if signs/symptoms of acute coronary syndrome are present

Both normal?

Yes

No

CHF unlikely cause of symptoms, consider CXR, CT chest, venous doppler, etc

- CXR,CBC, CMP, thyroid function testing, Hg A1C, Lipids, spirometry, microalbumin
- Refer for echocardiogram
- Lifestyle management with Box 1 and 2

See Page 2 for Heart Failure Management

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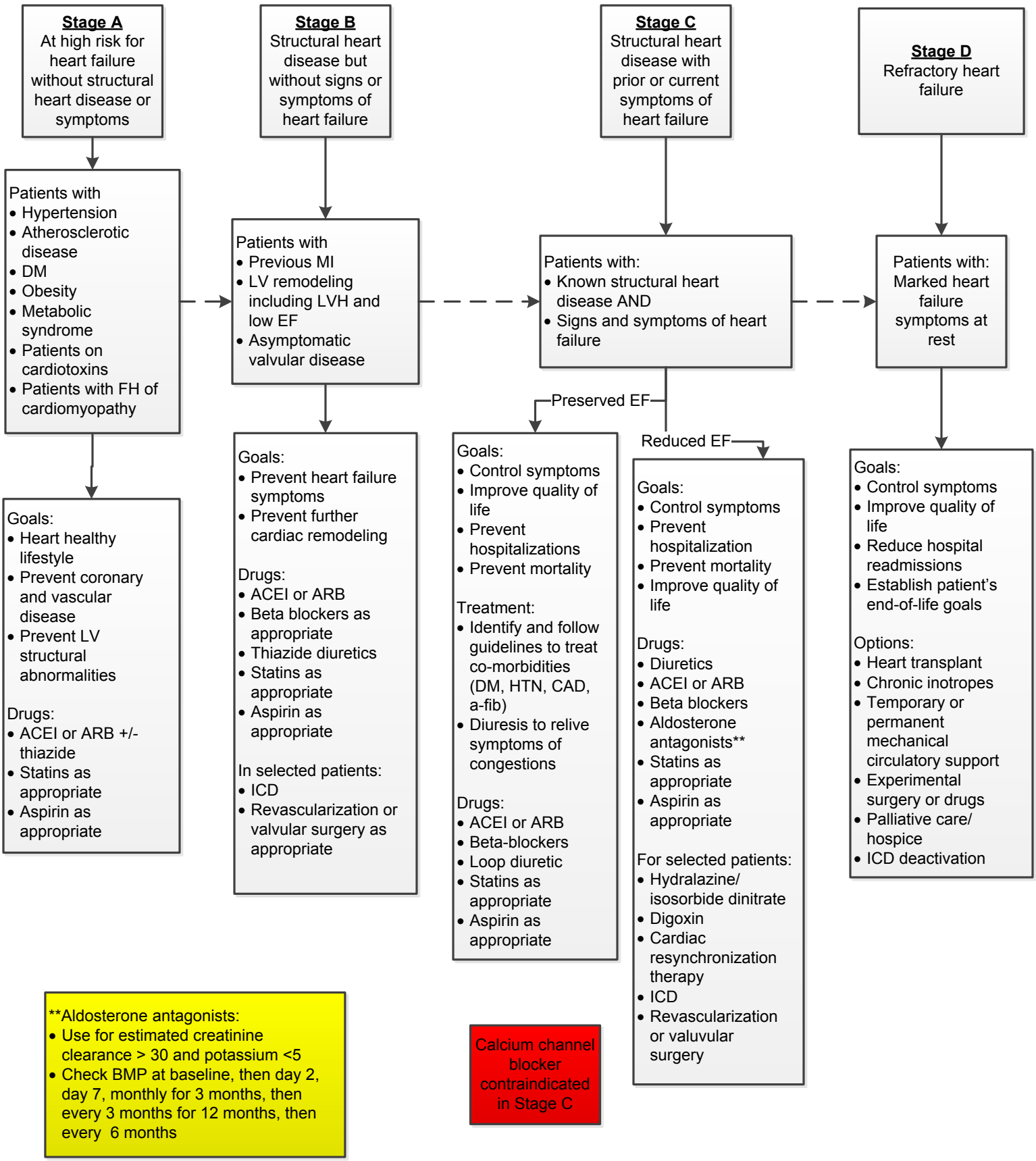
Clinical Guidelines • October 2017

Congestive Heart Failure, p.2

MSEC approved 07-12-17



Dyspepsia – H. Pylori

MSEC approved 9/21/17

Background Information:
- 75% of the AN/AI population is colonized with H. Pylori (range 61-84%)
- Screening or testing for H. Pylori for routine evaluation of dyspepsia or other GI symptoms is not clinically useful or supported by evidence for high prevalence populations
- For routine clinical practice, there **is insufficient evidence-based data** to support community-wide eradication as a mechanism for gastric cancer prevention
- Current literature **DO NOT** support a test and treat method

-Testing/Treatment strategy →

Dyspepsia

Weight loss/ fecal blood?

Yes

No

Empiric Treatment with H2 Blocker or PPI

Improvement ?

No

Yes

Perform Upper Endoscopy

Follow up for recurrence of clinical symptoms

Pediatrics:
- Goal is to determine underlying cause of symptoms, not solely the presence of H. Pylori infection
- Diagnostic testing is NOT recommended with functional abdominal pain
- Consider formal consult with Gastroenterology

Pregnancy and Lactation:
- Delay treatment until after pregnancy
- DO NOT use in Pregnancy: bismuth and tetracycline
- DO NOT use in lactation: bismuth, metronidazole, levofloxacin

H. Pylori identified by histology and/or CLO test from EGD
AND
Endoscopy reveals the following:
- Duodenal ulcers
- Gastric ulcer
- MALT lymphoma
- Intestinal metaplasia

Treat for H. Pylori with antibiotics

****All treatment is for 14 days****
Preferred Treatment:
Metronidazole 500 mg PO QID
Amoxicillin 1000 mg PO BID
Omeprazole 20 mg PO BID
Bismuth subsalicylate 524 mg PO QID

PCN allergic (anaphylactic):
Metronidazole 500 mg PO QID
Doxycycline 100 mg PO BID
Omeprazole 20 mg PO BID
Bismuth subsalicylate 524 mg PO QID

Recurrence/Failure:
Metronidazole 500 mg PO QID
Doxycycline 100 mg PO BID
Omeprazole 20 mg PO BID
Bismuth subsalicylate 524 mg PO QID
OR
Amoxicillin 1000 mg PO BID
Levofloxacin 500 mg PO daily (FDA Black Box)
Omeprazole 20 mg PO BID

Other causes of dyspepsia that antibiotics will NOT help, EVEN IF H. Pylori is detected:
- GERD
- Irritable Bowel Syndrome
- Mild/moderate gastritis
- Excessive/chronic NSAID use
- Heavy alcohol use
- Poor gastric mobility

Symptomatic relief Medications:
Adults:
Ranitidine 150 mg PO BID
Omeprazole 20 mg PO BID

Children:
Ranitidine 5-10 mg/kg PO divided BID

Eradication Testing:
- UBT for *Test of Cure* is necessary to determine need for retreatment
- 10-35% of individuals will fail treatment
- Serologic testing is not recommended due to prolonged antibody persistence beyond date of cure and false positive results
- Must be off PPI for >/= 2 weeks prior to UBT

Hypertension

MSEC approved 06/17

Age >/= 18 years, non-pregnant with hypertension.
Implement lifestyle modifications
Set BP goal, initiate BP lowering medication based on algorithm

Initial monitoring:
-EKG
-Hg A1C
-TSH
-CMP
-Pregnancy
-microalbumin

Initial Drugs of Choice for Hypertension
- ACE Inhibitor (ACEI)
- Angiotensin receptor blocker (ARB)
- Thiazide diuretic
- Calcium channel blocker (CCB)
- Beta blocker NOT first line except in pregnancy or women who may become pregnant

General Population
No Diabetes or CKD

Diabetes or CKD present

Age >/= 60 years → BP goal <150/90

Age <60 years → BP goal <140/90

All ages Diabetes present No CKD → BP goal <140/90

All ages and races CKD present with or without diabetes → BP goal < 140/90 → Initiate ACEI or ARB, alone or combo with another class

Consider compelling indications

Nonblack → Initiate thiazide, ACEI, ARB, or CCB, alone or in combination

Black → Initiate thiazide or CCB, alone or in combination

Strategy	Description
A	Start one drug, titrate to maximum dose, and then add a second drug
B	Start one drug, then add a second drug before achieving max dose of first
C	Begin 2 drugs at same time, as separate pills or combination pill. Initial combination therapy is recommended is BP is > 20/20 mm Hg above goal

At blood pressure goal?

Yes → Check BMP or CMP in 2 weeks except for CCB

No → Reinforce lifestyle and adherence
Titrate medications to maximum doses or consider adding another medication (ACEI, ARB, CCB, Thiazide)

At blood pressure goal?

Yes → Lifestyle Changes

No → Reinforce lifestyle and adherence
Add a medication class not already selected (i.e. beta blocker, aldosterone antagonist, others and titrate above medications to max

Lifestyle Changes:
-Smoking cessation
-Control blood glucose and lipids
-Diet
  -DASH diet recommended
  -moderate alcohol consumption
  -reduce sodium intake to no more than 2400 mg/day
  -limit alcohol to 2 drinks/day for men and 1 drink perday for women
-Physical activity
  -moderate-to-vigorous activity for 120-180 min/week

At blood pressure goal?

Yes → Continue treatment and monitoring.
- Annual CMP, A1C, lipids
- Microalbumin every 1-3 years

No → Reinforce lifestyle and adherence
Titrate meds to max doses, add another med and/or refer to hypertension specilaist

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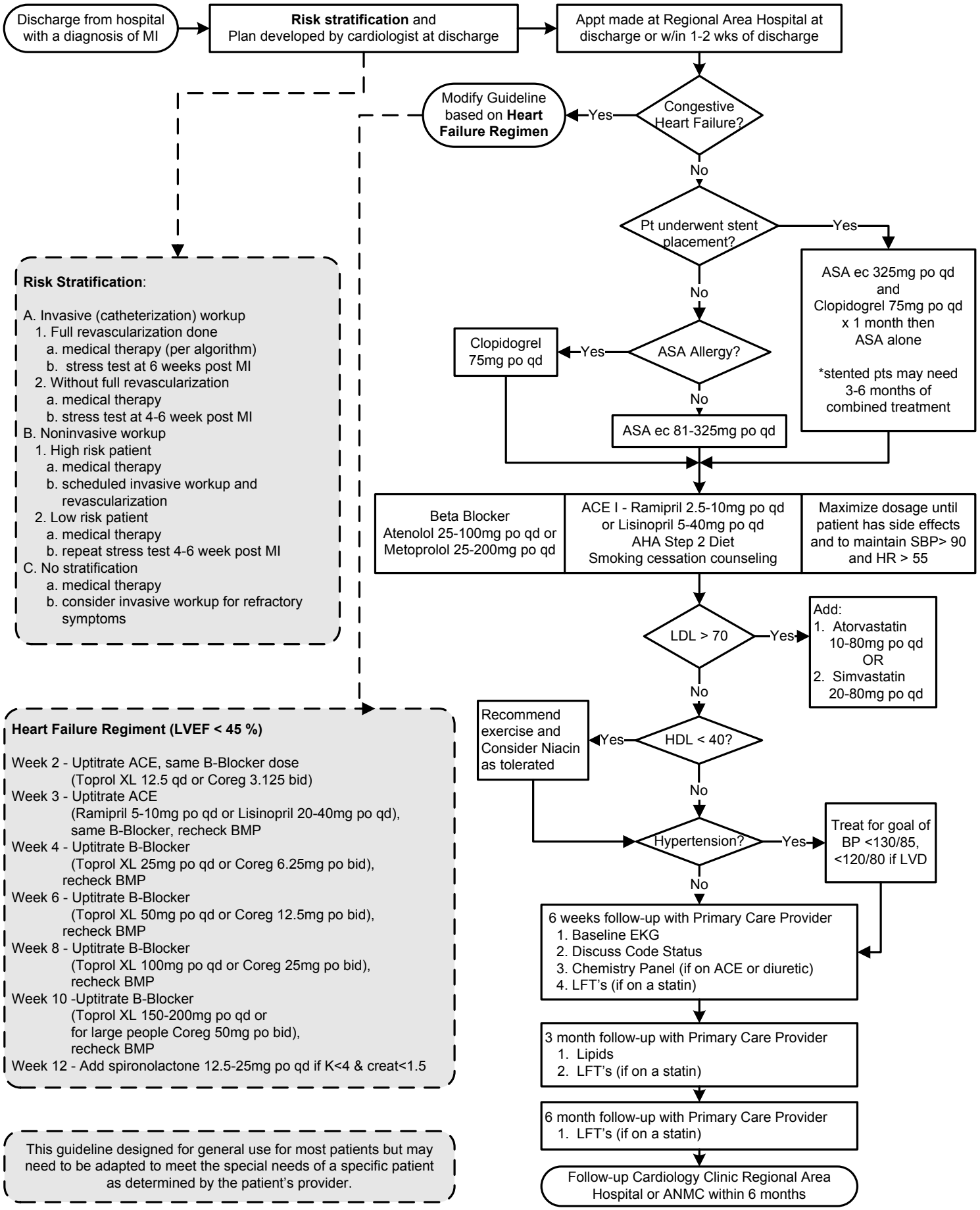
Myocardial Infarction (AMI) – Post Discharge Care

MSEC approved 06/22/11



Risk Stratification:

A. Invasive (catheterization) workup
  1. Full revascularization done
    a. medical therapy (per algorithm)
    b. stress test at 6 weeks post MI
  2. Without full revascularization
    a. medical therapy
    b. stress test at 4-6 week post MI
B. Noninvasive workup
  1. High risk patient
    a. medical therapy
    b. scheduled invasive workup and revascularization
  2. Low risk patient
    a. medical therapy
    b. repeat stress test 4-6 week post MI
C. No stratification
    a. medical therapy
    b. consider invasive workup for refractory symptoms

Heart Failure Regiment (LVEF < 45 %)

Week 2 - Uptitrate ACE, same B-Blocker dose
(Toprol XL 12.5 qd or Coreg 3.125 bid)
Week 3 - Uptitrate ACE
(Ramipril 5-10mg po qd or Lisinopril 20-40mg po qd), same B-Blocker, recheck BMP
Week 4 - Uptitrate B-Blocker
(Toprol XL 25mg po qd or Coreg 6.25mg po bid), recheck BMP
Week 6 - Uptitrate B-Blocker
(Toprol XL 50mg po qd or Coreg 12.5mg po bid), recheck BMP
Week 8 - Uptitrate B-Blocker
(Toprol XL 100mg po qd or Coreg 25mg po bid), recheck BMP
Week 10 -Uptitrate B-Blocker
(Toprol XL 150-200mg po qd or for large people Coreg 50mg po bid), recheck BMP
Week 12 - Add spironolactone 12.5-25mg po qd if K<4 & creat<1.5

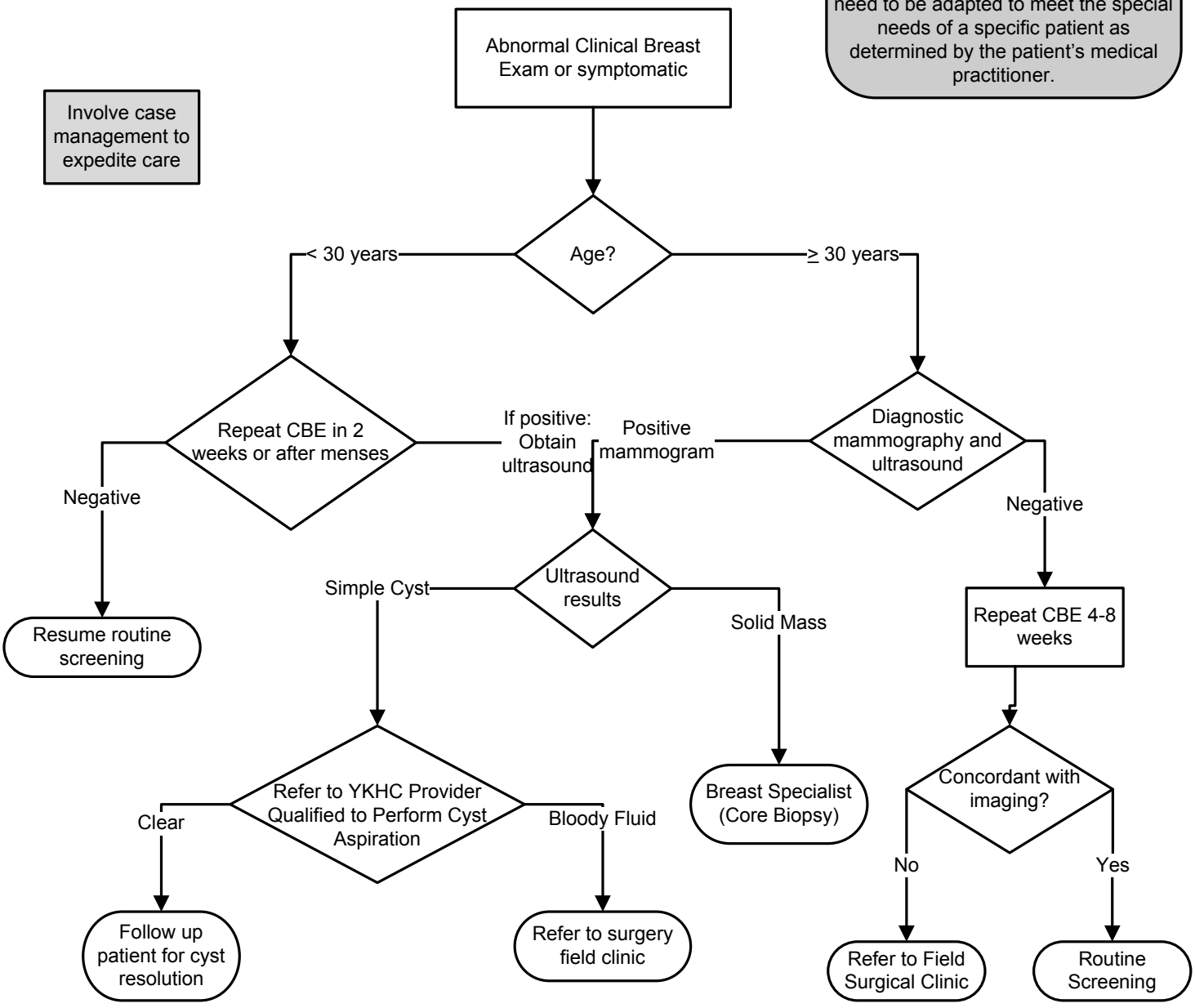
This guideline designed for general use for most patients but may need to be adapted to meet the special needs of a specific patient as determined by the patient's provider.

Breast Cancer Screening

MSEC approved 06/22/11

Clinical Breast Exam Screening Recommendations:
1. Breast self-examination: at provider's discretion
2. Clinical breast examination: at provider's discretion
3. Mammography: start age 45
screen every 2 years
end screening at age 70, based on health status

This guideline is designed for the general use of most patients, but may need to be adapted to meet the special needs of a specific patient as determined by the patient's medical practitioner.



IV Iron

MSEC approved 06/22/11

This Policy is adapted from ANMC policy, Internal Medicine Clinic Iron Deficiency Anemia Orders Approved 6/18/08

A provider identifies a patient with Iron deficiency anemia who can benefit from IV Iron therapy

Calculate Iron Deficit (ID)
ID=3.3(Hemoglobin deficit x blood volume)
ID = 3.3((14 - Hg) x ((weight in Kg x 65 ml/Kg)/100))
Example: Pt with Hg of 7 and weight 100 Kg.
ID = 3.3((14-7)x(100 x 65)/100))
ID = 1501 mg

Divide the ID to give as 300 – 500mg doses

Provider completes an IV Iron PCC for each planned dose as an outpatient or writes the appropriate orders if the patient is admitted.

Nursing staff complete the infusion and schedule any follow up doses

Can the patient remain in Bethel?

YES → Give doses weekly until ID corrected.

NO → Give doses daily until ID corrected.

Clinical Guidelines • October 2017

YUKON-KUSKOKWIM HEALTH CORPORATION

Latent Tuberculosis Bacterial Infection (LTBI)

MSEC Approved 4/19/12

High Risk for TB
1. Exposure to a Active TB pt
2. HIV+
3. Immunosupressed
4. Prednisone dependent on 15 mg a day or more.
5. Suspicious CXR
6. Under 6 months of age

+ PPD

At least 10 mm of induration **OR** > 5 mm induration (not redness) for patients who are High Risk for TB – See box on Left.

Needs to be read at 48-72 hours after placement for a true negative.
If positive – the induration will remain up to 7 days and it can be read until then.

Public Health Nursing Contact Information

(PHN) – Public Health Nurses
Phone – 543-2110
Fax – 543-0435

ALL DOT- (Directly Observed Therapy) WILL BE SET UP BY PHNs

Schedule 40 min Clinic appt.
Notify Public Health Clinic – fax them PEF or PCC

Can have patient do a 3 Sputums for AFB Smear /Culture in village or Bethel while waiting for appt date.

Examine patient and perform symptom review: Cough > 3 weeks, sputum, weight loss, sweats, fever, cough not resolving on antibiotics, fatigue

Get CXR/ LFTs, HIV on all patients. Consider STI screening - RPR/GC/CT.
Order 3 AFB Smear/AFB Cx to be done – 1st in the office now, other two at home 1st AM samples if not already done.

If concerned about False + PPD, consider getting QFT-gold.

CXR normal? Symptom review normal?

No → Consider Active TB. **See Tuberculosis Guideline**

Yes → Adult or child?

Older child or Adult → 1. Hold on LTBI meds while obtaining sputum samples
2.Ensure follow-up if medication deferred.
3. Have discussion with PHNs.
4. Send PCCs and med order to PHN

1. If negative smears – can start a LTBI treatment regimen – see box. If hx of INH resistance in the village – consider Rifampin treatment.
2. Public Health completes monthly symptom and medication side effects screens.
3. Consider following LFTs if alcohol use is an issue.
4. Await AFB Cultures..

If culture is positve – stop LTBI therapy and start 4 drug Active TB therapy.. Consult YKHC TB Officer.
See Tuberculosis guideline.

Infant or child unable to do sputum (<6years) → Treat as LTBI
1. See regimens and select with PHN discussion.
2. Use pills and a crusher- mixing it in pudding or applesauce.
3. See Q 3 months for follow up. Can check LFTs but not needed.
4. Send PCC/Med Rec to PHNs.

LTBI Treatment Meds
1. Isoniazid 300 mg Qday for 9 months – Adult, Peds 20 mg/kg max 300mg
2. Isoniazid 900 mg 2x a week for 9 months – Peds – 30 mg/kg max 900mg. –**ONLY DOT**
3. For 12 and up – Isoniazid wt based/Rifapentine wt. based Q week x 12 weeks. Not for pregnant, nursing, HIV+ on retrovirals, or LTBI with presumed INH or Rifampin resistance. **ONLY DOT**
4. If INH resistant – Rifampin QDay 10 mg/kg- 4 months adult. Peds- 10-20 mg/kg Qday- 6 months.

Adult or child?

Older child or adult → **Obtain sputums for AFB Smear/Culture x 3 if not already done.** → Start 4 drug therapy for active TB – **See Tuberculosis Guideline**.

Infant or child unable to do sputum (<6years) → Admit child for 3 days of AM Gastric Aspirates – see protocol. Then start 4 drugs TB therapy.

YUKON-KUSKOKWIM HEALTH CORPORATION

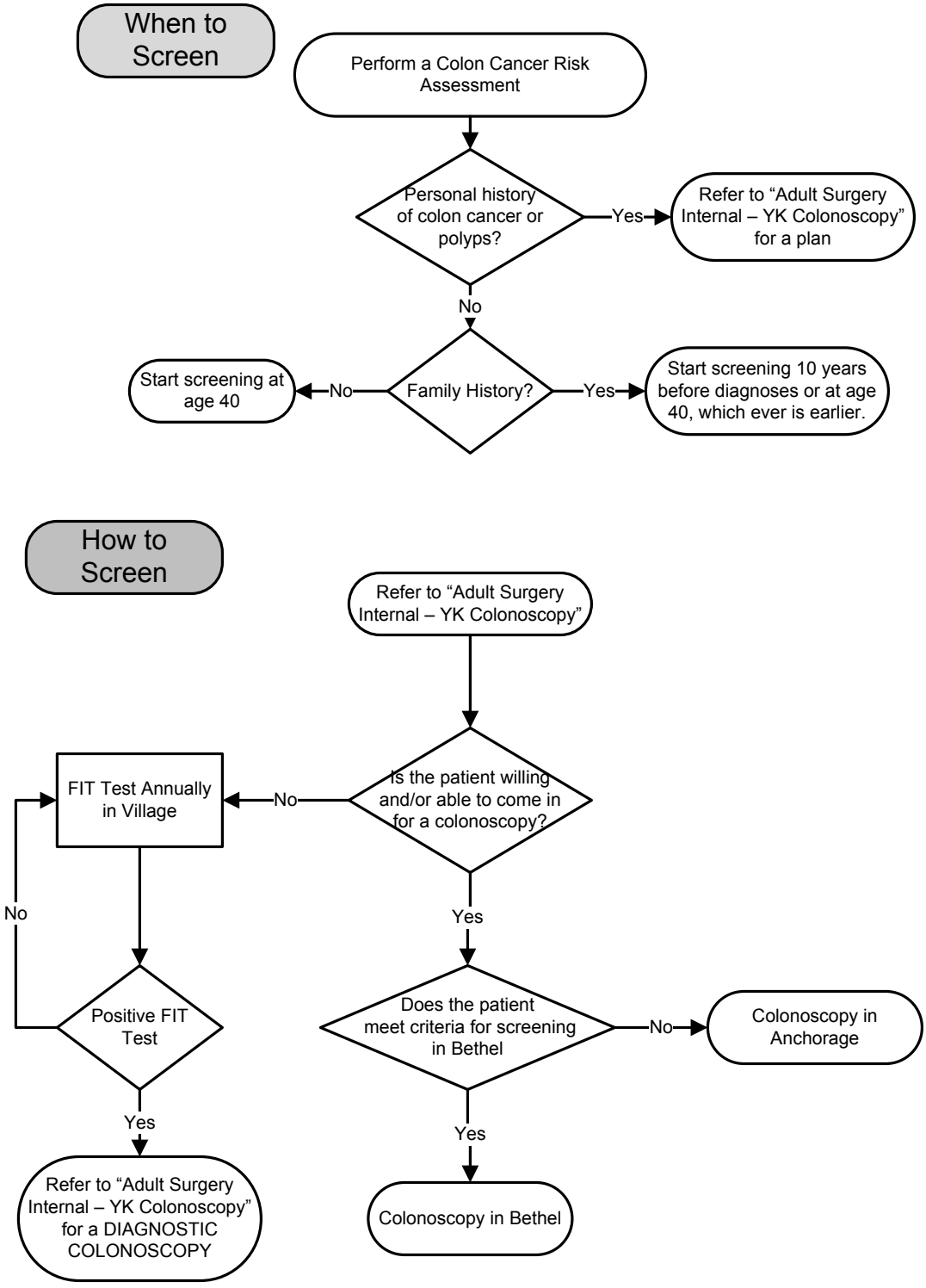
CLINICAL GUIDELINES 2017

rev. 10-09-17

Outpatient Protocols

Colon Cancer Screening

MSEC Approved 12/14/16



Contraception – Quick Start

3/25/13

This guideline is designed to establish a standard for starting contraception in all cases.

Was the first day of the LMP <5 days ago?

YES

Initiate Contraception today

- Urge condom use to protect against HIV and other STIs
- Provide at least 3-month supply of pills, rings, or patches.
- Patient should return for pregnancy test:
  - In 2 weeks after starting Depo Provera
  - If no period at the end of the first pill, patch or ring cycle.

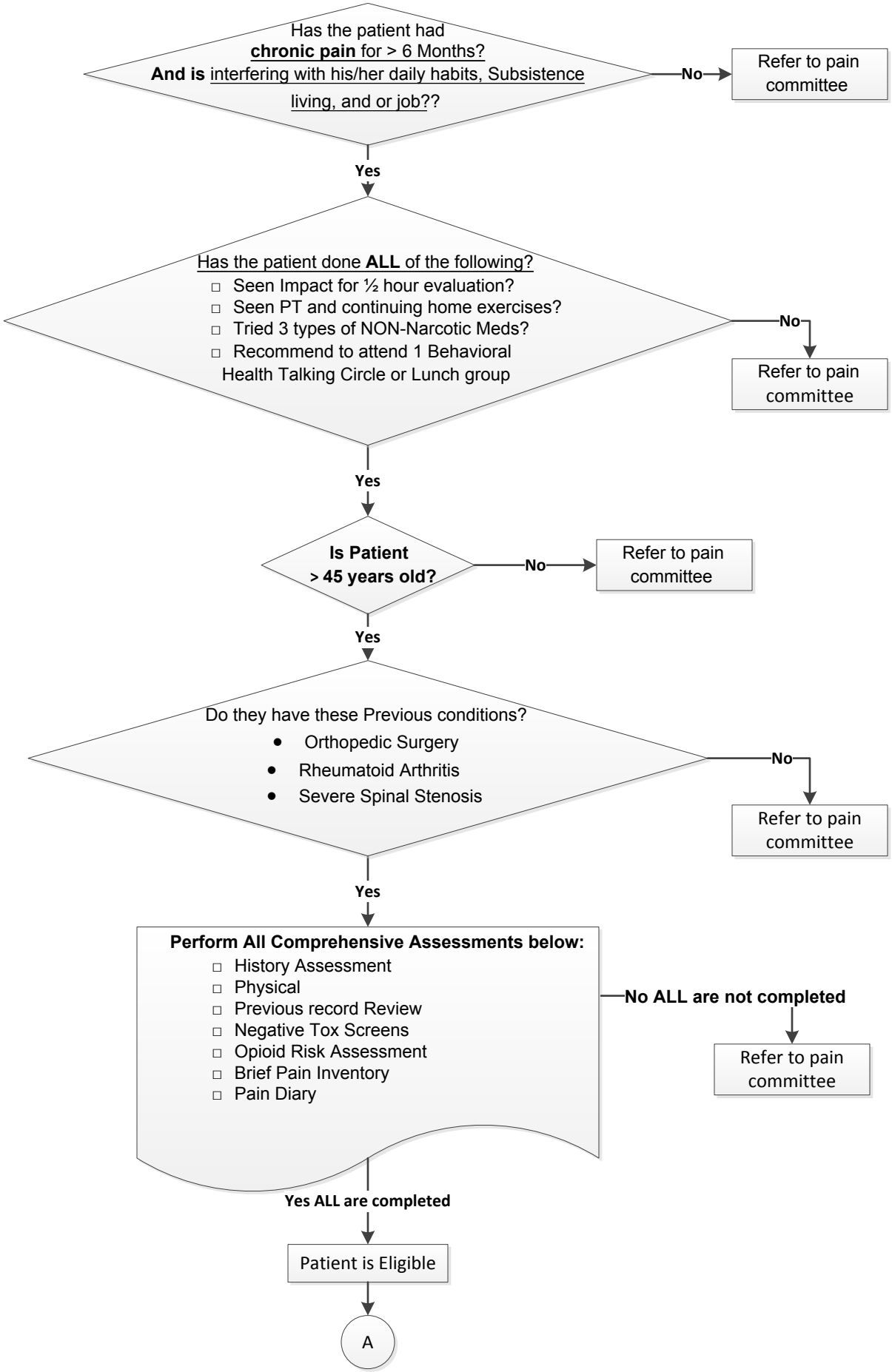
No

Do a urine pregnancy test.
If result is negative:

- Initiate contraception today.
- Advise condom use for one week, as back-up.
- Provide Emergency Contraception if patient has had unprotected sex in the past 5 days.
- Repeat pregnancy test in 2 weeks

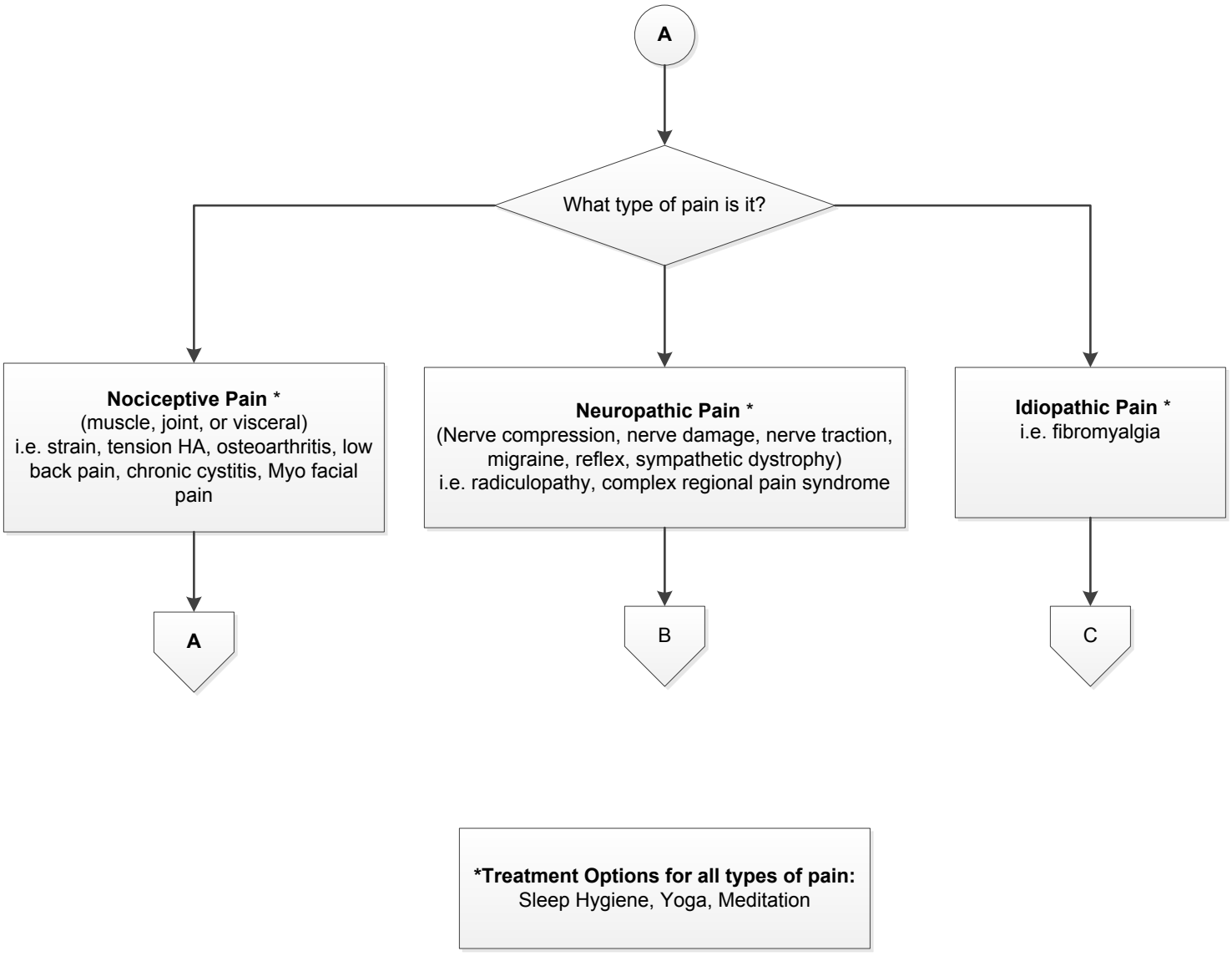
Chronic Pain – Narcotic Treatment Eligibility

MSEC Approved 1/ 21/15



Chronic Pain – Non Narcotics Treatment p.1

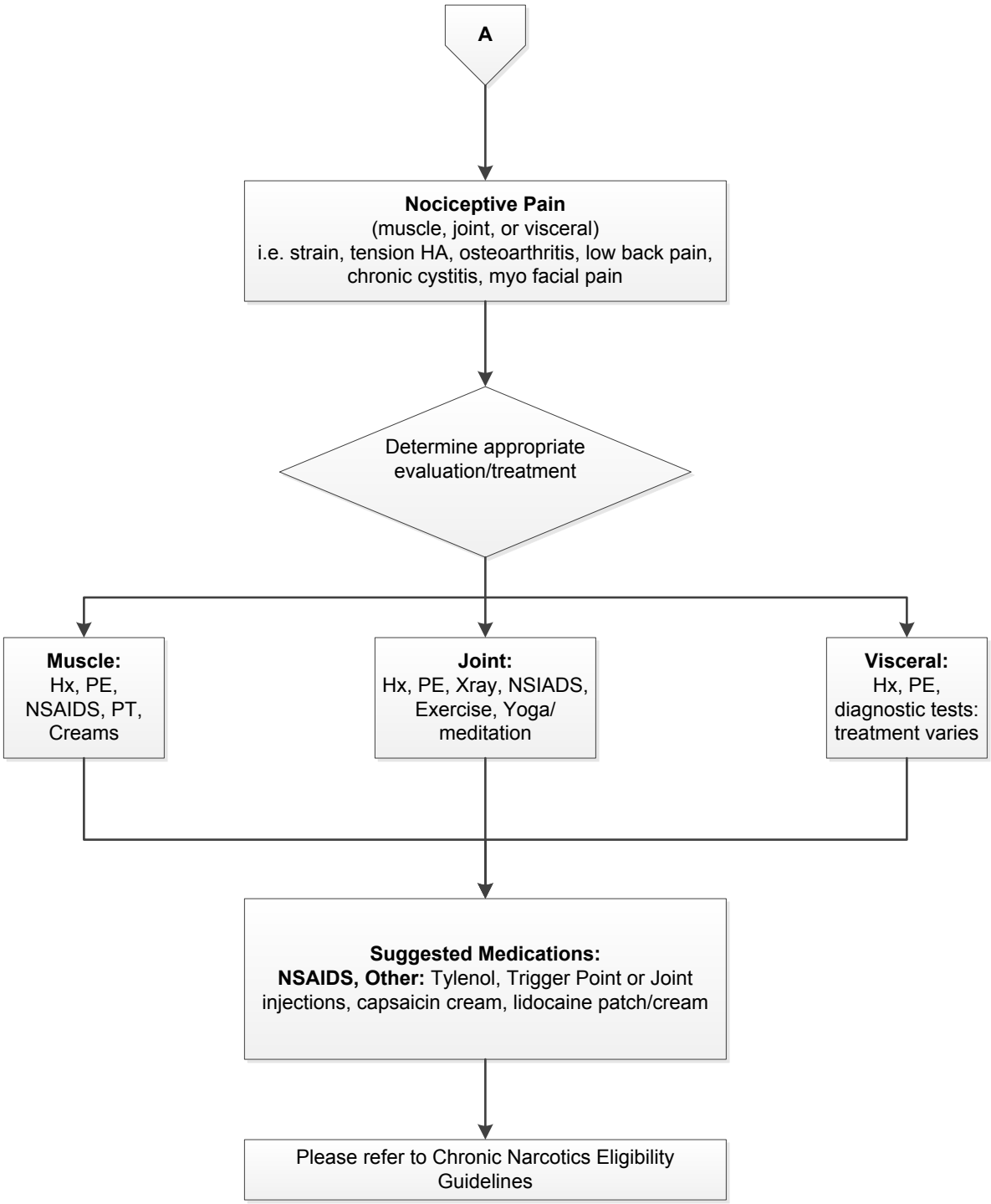
MSEC Approved 1/ 21/15



***Treatment Options for all types of pain:**
Sleep Hygiene, Yoga, Meditation

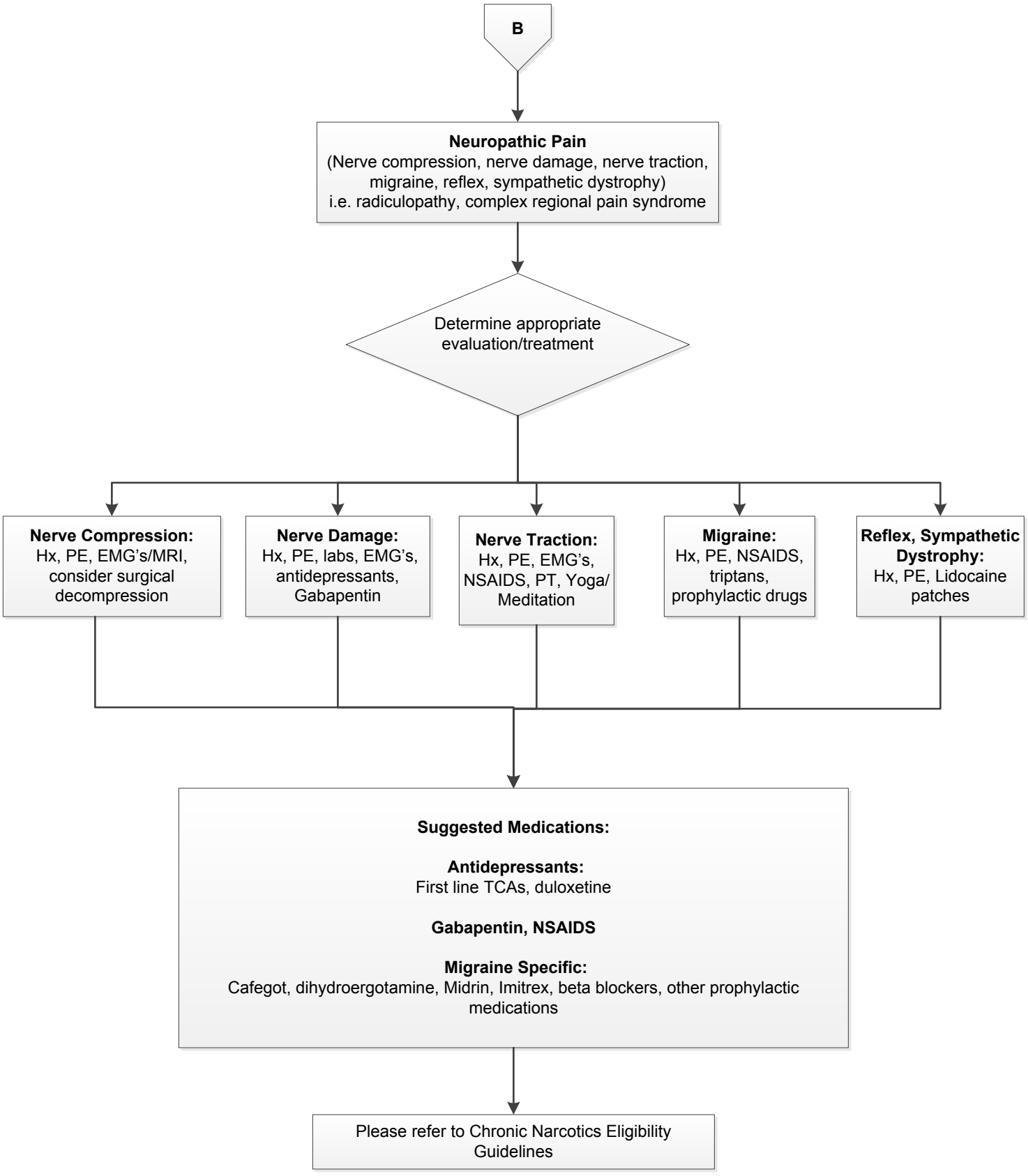
Chronic Pain – Non Narcotics Treatment p.2

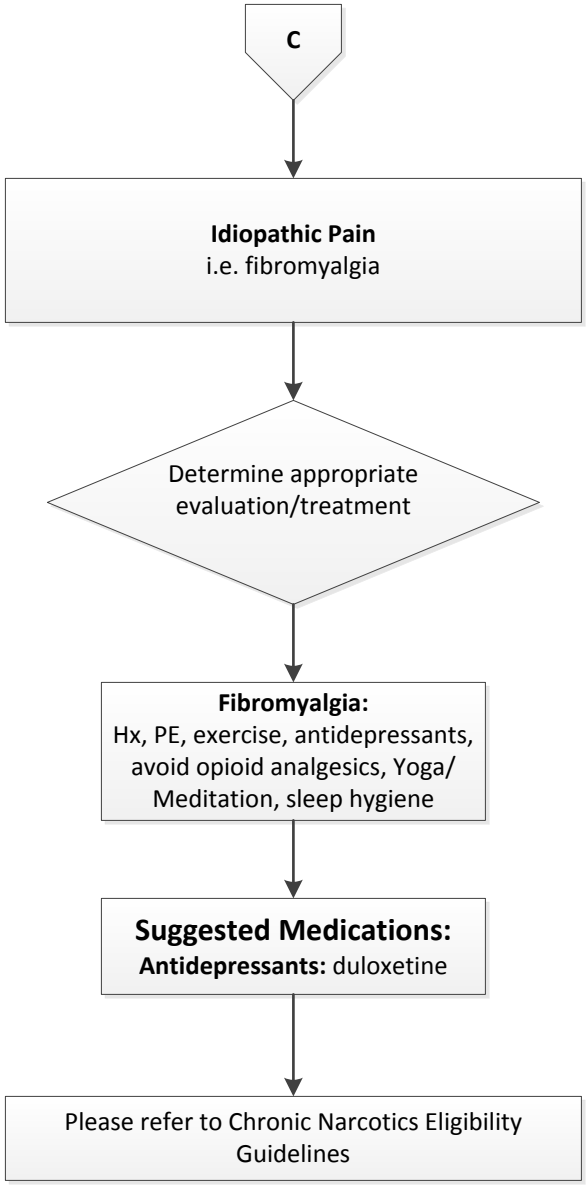
MSEC Approved 1/ 21/15



Chronic Pain – Non Narcotics Treatment p.3

MSEC Approved 1/ 21/15




C
Idiopathic Pain
i.e. fibromyalgia
Determine appropriate evaluation/treatment
Fibromyalgia:
Hx, PE, exercise, antidepressants, avoid opioid analgesics, Yoga/ Meditation, sleep hygiene
Suggested Medications:
Antidepressants: duloxetine
Please refer to Chronic Narcotics Eligibility Guidelines

Chronic Pain – Reassessment & Follow-Up

MSEC Approved 1/ 21/15

Follow up and reevaluation: Assess for:
1. functionality
2. adverse effects
3. achievement of goals
4. analgesia
5. behaviors of concern: see flow sheet

Were goal's achieved?

Yes → Reassess q 6 months, review agreement, revisit goals, taper as indicated

No 1st time → Reevaluate diagnosis, goals, tx

No 2nd time → Reevaluate diagnosis, goals, tx

No 3rd time → **Assess goal failure:**
1. Opioid non-responsive pain
2. Incorrect diagnosis
3. Psychiatric illness
4. Unrealistic goal setting
5. secondary gain (e.g. litigation)
6. Diversion and/ or abuse
7. Consider Behavioral Health Consult

For terminal cancer patients (with life expectancy less than or equal to 6 months) who have previously demonstrated good compliance with Chronic Medication agreement, documentation of titration for pain control as appropriate is acceptable without requiring new agreement. Continue to monitor for achievement of goals/ behaviors of concern

This guideline is designed for the general use of most patients, but may need to be adapted to meet special needs of a specific patient as determined by the patient's medical practitioner

Behaviors of concern?

Yes → **Patient showing behaviors of concern?**
1. ETOH abuse
2. poly drug abuse
3. Cocaine abuse (+tox screen)
4. Forgery
5. Stealing. Buying from the street
6. Negative tox screen for prescribed opioid/benzodiazepine
7. Hospitalization related to substance abuse
8. Drug overdose
9. Injection oral medications
10. Visit to ED with intoxication
11. Specific opioid/benzodiazepine (by name) request
12. Multiple unsanctioned opioid/benzodiazepine dose escalations
13. Recurring loss/stolen opioid/benzodiazepine prescriptions

- Refer to committee for review via pain committee order
- Consider stopping outpatient opiates while under review
- Monitor
- Compliance Tools (e.g. pill audits/UDS)
- Review at pain review
- Evaluate strikes
- 3 strikes cancel contract
- Reassess with patient's request letter
- If significant efforts of treatment consider restart agreement

No 1st time → Consider Toxicology screen → Change treatment/ agreement

No 2nd time → Consider Toxicology screen → Change treatment/ agreement

No 3rd time → Consider Toxicology screen → Consider referral to pain specialist, behavioral health, addiction therapy → Refer to Pain Committee via order

Coming Soon

Pre-Anesthesia Testing, p.1

2015

AGE	Hb/Hct	Coags	Lytes	Bun/Cr	Gluc	LFT's	EKG	CXR
0 - 59	No routine testing needed in this age group.							
> 60							X	
75 - 99	X		X	X	X		X	

DISEASE	Hb/Hct	Coags	Lytes	Bun/Cr	Gluc	LFT's	EKG	CXR	T&S
Hypertension			X				X		
Card - Mod	X		X	X			X		
Card - Severe	X		X	X			X	X	
Pulm - Mild									
Pulm - Severe	X						X	X	
Smoke > 20yr	X								
Malignancy	X								
Lymphoma								X	
Heptic	X	X	X			X			
Renal	X	X	X	X					
Bleeding	X(cbc)	X							
Diabetes			X	X	X		X		
Expected Blood Loss	X								X

MEDICATION	Hb/Hct	Coags	Lytes	Bun/Cr	Gluc	LFT's	EKG	CXR
Diuretic			X	X				
BP Meds			X	X			X	
Cardiac Meds			X	X			X	
Steroids			X		X			
Anticoagulants	X	X						

Other

Urine HCG: Needed within 48 hours of surgery in women of childbearing age (13–50).

Drug Levels: Level drawn on all patients on Digoxin and Dilantin.

CXR: Recent change in sputum quality or color, pneumonia in past 3 months, chronic home O2 use, planned intrathoracic surgery, or if exam reveals rales, rhonchi, or wheezes

Surgical Risk Screening Protocol Orders

1. Patients who are not to be scheduled at YKHC:

   a. Patients with BMI > 45 (Up to BMI of 45 is acceptable if no significant, unstable CV, respiratory, or endocrine Pathology is present)

      • English BMI Formula = (Weight in pounds / (Height in inches) x (Height in inches)) x 703

      • Metric BMI Formula = (Weight in Kilograms / (Height in Meters) x (Height in Meters))

   b. Obstructive Sleep Apnea Perioperative Risk Score of 5 or 6.

2. Preventive antibiotic therapy will be administered within one hour prior to skin incision per protocol pre-operatively, based on procedure type and patients allergies, unless otherwise ordered by physician.

3. DVT/VTE prevention methods will be implemented using SCIP Mechanical Prophylaxis Protocol unless contraindicated or otherwise documented in orders by physician.

Diabetes Management

1. Discontinue all oral agents the evening prior to surgery, except Metformin which can be taken the evening prior to surgery but not to day of surgery.

2. Discontinue insulin after midnight for AM surgeries.

3. Take 1/2 usual dose of insulin the AM of surgery if surgery is scheduled to start at noon or later.

4. Take 100% of Lantus insulin up to time of surgery.

5. Consume apple or cranberry juice up till 2 hours prior to arrival to surgery if insulin was used.

6. For insulin pumps, set to basal rate and continue throughout pre-operative period.

7. Arrival to Holding Area, Glucose will be obtained. Results treated by anesthesia.

continued on next page.

NPO Guidelines:

The pre-operative nurse will instruct all patients to be NPO after midnight and to follow the surgeon's instructions if they differ from these.

The surgeon who gives different instructions will be responsible for thorough patient instruction of anything other that these guidelines.

1. All patients are equal with regard to NPO guidelines (i.e. gastric emptying time, obesity)

2. Clear liquids may be consumed up to 2 hours prior to scheduled arrival time.

3. Clear liquids are water, black coffee, and beverages not cloudy and can be seen through. Sugar and artificial sweeteners are acceptable. All broths are NOT acceptable.

4. Patient may brush their teeth, but should not swallow tooth paste.

5. Gum and candy of any type are not allowed.

6. All patients will be allowed to eat a full, regular diet (solid) up to 8 hours prior to surgery. Patient going to the OR at 0730 who were NPO after midnight are considered to meet this standard.

7. Infants up to 24 months of age will be allowed breast milk up to 4 hours prior to the arrival to the hospital. Infant formula will be considered a solid.

Table 4. Estimated Energy Requirements for Various Activities, Based on Duke Activity Status Index*		
1 MET	**Can you...**	
		take care of yourself?
		eat, dress, or use the toilet?"
		walk indoors around the house?
		walk 1 or 2 blocks on level ground at 2-3 mph (3.2 - 4.8 KPH)?
<4 METs	**Can you...**	
		do light work around the house, such as dusting or washing dishes?
≥4 METs	**Can you...**	
		climb a flight of stairs or walk up a hill?
		walk on level ground at 4 mph (6.4 kph)?
		run a short distance?
		do heavy work around the house, such as scrubbing floors or lifting or moving furniture?
		participate in moderate recreational activities, such as golf, bowling, dancing, doubles tennis, or throwing a baseball or football?
≥10 METs	**Can you...**	
		participate in strenuous sports, such as swimming, singles tennis, football, basketball, or skiing?
* MET = metabolic equivalent.		
Adapted from J AM Coll Cardiol, with permission from Elsevier.		