Message from Brent and Susan

Dear Colleagues,

Welcome to the first monthly installment of Intermountain Med Staff News, a news brief for our credentialed practitioners. Our goal is to keep you informed and up to date, and to continually develop strong relationships with you and your staff.

To that end, this new monthly version features a shorter format, and a focus on making articles easier to read and highly relevant to your work. You will need to log in using your credentials to view these articles. If you are having trouble remembering your username and password, please contact Chris Robertson at 801.507.9174 or chris.robertson@imail.org.

Med Staff News is easy to navigate: Click on any title in the list below and you'll be taken directly to that article. Of course, you can also read the entire newsletter on the Physician Website.

We encourage you to reach out to the contacts noted at the end of each article, or to either of us, if you have questions, comments, or suggestions. Thank you for all that you do in support of Intermountain Healthcare and the patients and communities we serve.

Sincerely,

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Susan DuBois
Assistant Vice President, Physician Relations and Medical Affairs
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The best health outcomes occur when patients are engaged in their own care. To do this, patients need a clear and complete understanding of what to do, but many patients find healthcare instructions overwhelming. Not understanding puts patients at greater risk for medication errors, poorly managed conditions, and unnecessary emergency visits.

Health literacy techniques aim to prevent errors in patient self-care by ensuring clear and complete communication with healthcare providers. The error prevention techniques we practice daily with Zero Harm offer useful parallels: They are performed routinely, every day; in repeat-backs, both parties are asked to confirm the communication; and clarifying questions are encouraged.

Error prevention is important, both in our facilities and in patients' homes. Follow these tips to promote health literacy and prevent errors in your daily communication with patients:

Assume ALL patients are at risk for not understanding their health condition or how to manage it. A patient’s ability to understand can contract or expand based on current circumstances, so it’s best to always check for understanding of key points.

Use plain language. It’s easy to slip into medical jargon without realizing it. Keep a list of key terms used in your practice and patient friendly alternatives. Everyone benefits from clear, actionable information.

Ask your patients to tell you what they heard in their own words. This is called the teach-back method. An important part of teach-back is emphasizing to the patient this is not a quiz of their knowledge. It’s a test of how well you did teaching so you can try
Again where something wasn’t clear. For more tips on getting comfortable with teach-back, visit the Teach-back webpage.

Instead of “Do you have any questions?” ask “What questions do you have?” This indicates that asking questions is normal, not a sign of inadequacy.

If you have questions, please contact Jan Stucki at 801.442.3508 or Jan.Stucki@imail.org.

**Intermountain Systemwide Initiatives**

**Integrated Team-Based Care Study Results in improving Healthcare Quality, Use and Cost**

A major new study by Intermountain Healthcare researchers and published in the Journal of the American Medical Association (JAMA) shows that delivering integrated mental and physical healthcare in team-based primary care settings results in better clinical outcomes for patients, lower rates of healthcare utilization, and lower costs.

The study is published in the August 23/30 issue of the Journal of the American Medical Association. It was accompanied by an editorial in JAMA that heralded the benefits of integrated mental healthcare.

The 10-year study shows the benefits of care provided by team-based providers in an integrated delivery system. The study measured 113,452 adult patients who received care from 2003 through 2013 in 113 primary care practices at Intermountain, including 27 team-based medical practices and 75 traditional practices.

**Results**

A dramatically higher rate of patients in team-based practices were screened for depression — which allowed care providers to provide medical and behavioral interventions earlier — compared to patients in traditional practices. 46.1 percent of patients in team-based practices were diagnosed with active depression compared to 24.1 percent in traditional practices.

Editorial in JAMA reinforces the benefits of integrated mental health care: “Providing integrated mental health and primary care is the right thing to do for the sake of the patient...”

“This study has several important implications. Integrated (team-based care) is clearly superior to (traditional practice management) for patients with complex mental illness and chronic medical disease, consistent with the increasing recognition that this type of care is best applied to higher-risk patients with substantial disease burden,” says the editorial by Thomas Schwenk, MD, of the University of Nevada’s Reno School of Medicine. “It would be unethical from this point on to randomize this type of high-risk patient to usual care when integrated care has been shown in many studies...”
24.6 percent of patients in team-based practices adhered to diabetes care protocols, including regular blood glucose testing, compared to 19.5 percent in traditional practices — which demonstrated how well patients engaged with care teams in working together to manage their health.

48.4 percent of patients in team-based practices had a documented self-care plan to help them manage their health conditions, compared to 8.7 percent in traditional practices.

The study used high blood pressure as a control variable — meaning care management for that condition wasn’t yet changed in the team-based care model so that researchers could have a reference point. 85 percent of patients in the team-based care group had controlled high blood pressure, compared to 97.7 percent in traditional practices. As researchers predicted, high blood pressure management did not show the same large improvements as shown for the conditions that team-based care targeted, such as depression and diabetes. These results strengthen the link between team-based care and the better clinical results shown in other areas.

Patients in team-based medical practices also used fewer healthcare services and had lower total costs, according to the study. Data showed that per 100 person years:

The rate of emergency room visits was 18.1 for patients in team-based practices versus 23.5 visits for patients in traditional practices, which is a reduction of 23.0 percent.

The rate of hospital admissions was 9.5 for patients in team-based practices versus 10.6 in traditional practices, which is a reduction of 10.6 percent.

The number of primary care physician encounters was 232.8 for patients in team-based practices versus 250.4 for patients in traditional practices, which is a reduction of 7.0 percent.

Payments to providers were $3,400 for patients in team-based practices versus $3,515 for patients in traditional practices, which is a savings of 3.3 percent. The payments were less than the investment costs Intermountain incurred in creating the team-based practice model.

The senior author of the study is Brent James, MD, MStat, Intermountain’s Chief Quality Officer and Executive Director of the Intermountain Institute for Healthcare Delivery Research. Other members of the research team included Kimberly Brunisholz, PhD; Carter Dredge, MHA; Pascal Briot, MBA; Kyle Grazier, PhD; Adam Wilcox, PhD; and Lucy Savitz, PhD, MBA.
A recent Intermountain Healthcare study examined 1.7 million adult patient visits to 28 Intermountain InstaCare clinics over six years. The study, led by James Hart, MD, Intermountain InstaCare, and Mike Woodruff, MD, Director of Emergency Department Quality for Intermountain's Central Region, discovered distinct relationships between heart rate, systolic blood pressure, and the risk of adverse short-term outcomes after an urgent care visit. The risks were most pronounced in older age groups. Further, they found that
blood pressure ranges traditionally considered “normal” may not be a good fit for patients visiting an urgent care clinic. The original research paper can be viewed online in the Western Journal of Emergency Medicine.

“Since more patients are coming to the urgent care clinic for all kinds of complaints, our aim is to develop tools to ensure that patients get the right kind of care to match the severity of their illness,” says Dr. Hart. “To begin, we examined short-term outcomes that seemed to represent a worsening of the patient's condition after an InstaCare visit.” The researchers hypothesized that a patient's age and vital signs might help predict clinical deterioration.

“We were surprised to find that the blood pressures recorded at InstaCare visits were markedly higher than what would traditionally be considered “normal”, particularly for older patients,” says Dr. Woodruff. Further, it was relatively lower, not higher blood pressures that were associated with increasing risk of adverse short-term outcomes. This was surprising, given that most of outpatient medical literature is focused on the perils of high blood pressure, not low blood pressure, and certainly not “low normal.”

“Large datasets give us the ability to see patterns and identify trends that would otherwise be invisible,” says Dr. Hart. “For example, adult heart rate and blood pressure ranges for normal or critical values have not really changed in outpatient medicine for the last 100+ years. Nor have adult patients been grouped into categories other than ‘old’ or ‘not old.’” By using such a large dataset, the team was able to visualize patterns related to age, heart rate, and systolic blood pressure that have been elusive to date. Specifically, they found that advancing age, higher heart rate, and lower blood pressure were associated with short-term adverse outcomes.

Drs. Hart and Woodruff are working to operationalize this new understanding by educating providers and developing tools to help clinicians more accurately estimate patient risk at the point of care. “As healthcare technology matures, we have a vision of bringing intelligent analysis of patient-specific data to the right provider at the right time, to model risk and predict patient outcomes.”

To find out more about Intermountain Healthcare Research and the advancement of medical knowledge in many clinical areas visit intermountainresearch.org
Stanford Medicine and Intermountain Healthcare have announced the recipients of more than $500,000 in seed grants focused on transforming healthcare.

The seed grants, up to $75,000 each, were awarded to projects that will be jointly led by principal investigators from Intermountain and Stanford, and will take effect before the end of the year.

The seven selected projects focus on genomics, machine learning, biomarkers and epidemiology, biomarkers closer to basic science research, networks of care, infectious disease, and telemedicine. Although they're from diverse clinical areas, all the studies are designed to improve patient care. Following are the names of the grant recipients and their project titles:

- Whole-genome DNA sequencing of stage-3 colorectal cancer — Lincoln Nadauld, MD, PhD, Intermountain precision genomics; James Ford, MD, associate professor of oncology and of genetics at Stanford.

- Baseline assessment of hand hygiene practices and ICU microbiology — Bill Beninati, MD, Intermountain critical care medicine; Arnold Milstein, MD, MPH, professor of medicine at Stanford.

- Developing a precision-based approach for the diagnosis and prognosis of heart failure with preserved ejection fraction in the community — Kirk Knowlton, MD, Intermountain cardiovascular medicine; Francois Haddad, MD, clinical associate professor of cardiovascular medicine at Stanford.

- Translational approaches to the mechanisms of septic cardiomyopathy — Samuel Brown, MD, Intermountain critical care medicine; Euan Ashley, MRCP, DPhil, associate professor of cardiovascular medicine at Stanford.

- Implementation and evaluation of graduating from pediatric to adult care — Aimee Hersh, MD, department of pediatrics, University of
Utah and Intermountain’s Primary Children’s Hospital; Korey Hood, PhD, clinical professor of pediatrics at Stanford.

Impact of donor-derived BK virus infection and immune recovery in kidney transplant recipients — Diane Alonso, MD, Intermountain transplant services; Benjamin Pinsky, MD, PhD, assistant professor of pathology and of infectious diseases at Stanford.

Development and implementation of a digital health-care program for patients with atrial fibrillation — Jared Bunch, MD, Intermountain heart-rhythm services; Mintu Turakhia, MD, assistant professor of cardiovascular medicine at Stanford.

“The Intermountain-Stanford grant program is part of an exciting collaboration between Intermountain and Stanford that began almost two years ago and is focused on advancing clinical care best practices, education and training and clinical research in heart disease, cancer, and other conditions. The purpose of the grant award is to spearhead and accelerate research between the two organizations and support innovative projects in research, patient care, and medical education” says Laura Kaiser, Intermountain Healthcare’s Executive Vice President and Chief Operating Officer.

To find out more about Intermountain Healthcare Research and the advancement of medical knowledge in many clinical areas visit IntermountainResearch.org.

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COMPLIANCE UPDATE

Physician Time and Effort Log Application
By Ryan Williamson

A few years ago, Intermountain self-disclosed STARK Law violations related to improper financial relationships with physicians, resulting in a $25.5 million dollar settlement. Learning from this unfortunate event, we assessed and implemented many corrective actions, including the creation of a physician time and effort log application.

Within this application is a tool that removes the need for physicians to submit paper time and effort logs. This tool is available for physicians contracted in for administrative duties, medical directorships, and on-call services. Because there are some inherent risks with submitting paper logs (e.g. manual pay calculations, illegible handwriting, inaccurate submissions, etc.) that could potentially allow incorrect payments, the application helps mitigate these risks by having the necessary contract details loaded for each physician role and providing accurate payment requests based off of the contract details and submitted logs.

The application is currently available for individual physicians who have an active contract with Intermountain. Future enhancements are being investigated to accommodate physician group payments rather than an individual.

The application is web-based and can be accessed via a mobile device or computer, with the mobile version having a simplified interface. Training for the application is located on the desktop sign-in page of the application or from the link below where a quick-guide and two short training videos can be reviewed.

Training Documents and Videos

Desktop Application

Mobile Application

For assistance in accessing and setting up the application, please contact your Region/Division Compliance Officer, Compliance Administrator, or Operations Officer.
Introduction

Physicians and other LIPs authorized to order restraint, seclusion and physical holds must have a working knowledge of hospital policy regarding the use of restraint, seclusion and physical holds.

Philosophy of Use

Intermountain Healthcare's philosophy on the use of restraint, seclusion and physical holds highlights the following key points:

- Use only to protect the immediate safety of the patient, staff, or others.
- Use only as a last resort and when less restrictive alternative interventions have been ineffective.
- Should never be used as a means of coercion, discipline, convenience, or staff retaliation.
- The least restrictive form of restraint, seclusion or physical hold that protects the physical safety of the patient, staff, or others is to be used.
- Discontinue restraint, seclusion or physical hold at the earliest possible time, regardless of the scheduled expiration of the order.

Definitions

Restraint - There are two main subsets of restraints:
Non-Violent/Non-Self Destructive Restraints: an instrument or a means of restraint to prevent the infliction of harm to self or others, during a medical procedure or treatment (i.e. Restraints used when a patient is pulling at lines or catheters or disturbing dressings and wounds).

Violent/Self-Destructive Restraints: confinement or seclusion that is initiated because a patient is acting aggressively or threateningly. Violent restraint types include physical restraints i.e. Soft limb or physical holds and/or seclusion.

- **Seclusion** is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

- **Physical holds** are considered a method of restraint. Physical hold is defined as holding a patient against his or her will in a manner that restricts movement or access to his or her body is considered a restraint. Physical holds are considered a violent/ self-destructive restraint and require the same documentation as a violent/ self-destructive restraint. When initiated on a patient it must be ordered by an LIP, documented in the patient medical record and monitored according to policy.

## Non-Violent/Non-Self Destructive (NV/NSD) Restraint

### Medical Staff Role: Ordering

**Obtaining a Medical Order:**

- The LIP completes the NV/NSD order sticker.

- The NV/NSD order will cover one restraint episode, from initiation to discontinuation, no trial periods allowed.

- NV/NSD order sticker is available on the nursing units.
iCentra will have an electronic process for restraint ordering.

**Completion of the NV/NSD order/sticker:**

The completion of the order is important for compliance with The Joint Commission Standards and CMS guidelines.

Restraint indication, type, location and initiation date/time are required.

All required fields on the order must be completed.

**Medical Reasons for NV/NSD Restraint:**

- Dislodgement of lifesaving equipment.
- Picking at surgical/treatment site.
- Pulling at tubes and lines.

**Restraint Type:**

CMS guidelines require the physician to choose the type of restraint used. The type of restraints are listed on the NV/NSD order sticker.

- Soft limb upper/lower.
- Nylon limb upper/lower.
- Mittens.
- Immobilizers.
- Other per specialty area.

**PRN orders:**

Restraint orders cannot be ordered PRN.

**Violent-Self Destructive Restraint, Seclusion and Physical Holds**

**Medical Staff Role: Ordering and Assessment**

**Obtaining a Medical Order:**

An order for restraint, seclusion or physical hold must be obtained during the process or within a few minutes of initiation. During emergency application periods, a restraint, seclusion physical holds may be initiated without an order, but one must be obtained as soon as possible, no later than one hour. Orders may not be written as a PRN order.
Age | Max. Time Limit for Orders
---|------------------------
8 and younger | 1 hour
9-17 | 2 hours
18 and older | 4 hours

Renewing an Order:

The order may be renewed up to a total of 24 hours, but may not exceed the allowable age specific maximum time limits. An order should not be renewed if the intervention has been discontinued prior to the expiration of the order at which time a new order must be obtained.

Medical Residents:

If a medical student, resident, or fellow requires a co-signature, they are not considered “independent” and may not prescribe an order for restraint, seclusion or physical hold.

Face-to-Face Assessment:

A patient assessment, both physical and behavioral, must be completed by the LIP or appropriately trained RN within one-hour of the initiation of restraint, seclusion or physical hold. For residential and day treatment the physician or Advanced Practice Clinician (APC) completes the patient assessment within two-hours of the initiation of restraint, seclusion or physical hold. For residential and day treatment, when a verbal (telephone) order is given, the physician/APC completes the patient assessment within 24 hours if restraint/seclusion discontinued prior to the original verbal order expiration.

Required Physician/LIP Evaluation:
If an order for the continued use of restraint, seclusion or physical hold is required beyond 24 hours, the physician/LIP must evaluate the patient prior to giving a new order.

Amending the Treatment Plan:

The use of restraint, seclusion or physical hold requires an evaluation of the patient’s treatment plan. Any recommended changes require an update of the treatment plan.

The following resources / policies / protocols are available:

- Restraint Non-violent Non-self-destructive Pediatric Adult Protocol
- Restraint Seclusion Violent or Self Destructive Pediatric Adult Protocol
- Restraint Seclusion Policy
- Restraint Seclusion Violent or Self Destructive Order Time Frame

If you have questions, please contact Cindy Cook at cindy.cook@imail.org.

Intermountain Looks to Improve Identification and Treatment of Depression to Remission

By Beth Wright

Depression is a common condition affecting at least 8% of Americans ages 12 and older in any twelve month period. Patients may experience a single episode of depression or have multiple episodes of depression in a lifetime. Childbirth can precipitate a sudden onset of depression, and depression often occurs with other medical conditions such as heart failure, diabetes, asthma, chronic pain, and substance use disorders. Depression, along with co-existing medical conditions, adds to the overall patient disability and worsens the prognosis for all conditions.
In the recently completed Community Health Needs Assessment (CHNA) survey, depression has been identified as one of the four focus priorities and will likely make the other 3 conditions identified more difficult to manage in comorbidity. All of the Clinical Programs will be identifying one of these four conditions as a 2017 secondary goal. The BHCP looks forward to engaging with other Clinical Programs to address these conditions and the impact that depression has on co-occurring medical conditions.

Screenings and ongoing assessments are important interventions in the treatment of depression in the primary care setting. For early identification, the recommendation includes annual screening using the PHQ2 (Patient Health Questionnaire) for all patients ages 12 and older and follow up of positive screens using the PHQ9/A tool. Once identified and diagnosed, patients benefit from repeated PHQ9/A’s to help assess progress to remission. Treating depression to remission within 11-13 months has been established as a national quality standard and is clinical best practice.

The 2017 Behavioral Health goals will begin a multi-year initiative across the Intermountain system to improve the identification and treatment of depression to remission. We invite operational leaders and clinical providers to evaluate their local practices for gaps and needs in order to help meet the identified community health needs.

If you have any questions, please contact the Behavioral Health Clinical Program at BHCP@imail.org.
knee and total hip surgeons from across the Intermountain system have gathered via telepresence and WebEx to talk about everything related to total joint replacement surgery and how to improve care. Each meeting is scheduled for 50 minutes to allow the physicians to get to clinic or the OR on time. Dr. Nate Momberger leads the meetings and begins each one with an M&M case presentation by one of the surgeons, followed by a didactic presentation on a specific clinical topic, and concludes with a quick “other business” topic that requires some surgeon input. And every meeting ends on time, if not a little early.

To date, the group has covered topics such as the use of antibiotic bone cement, VTE risk stratification and prophylaxis protocols, and surgical approaches for total hip arthroplasty. Each topic has presented an opportunity to identify—with the help of data from the MSKCP total joint dashboard and occasional short surveys sent to the group in advance—variations in practice patterns. The assigned presenter of each topic summarizes the literature and makes recommendations regarding best practice that the group then discusses. Over time, the protocols the surgeons choose will become integrated within PowerPlans in iCentra to serve as real-time decision support. The MSKCP has groups working to help finalize protocols for four of the topics that have been discussed in the weekly meeting: 1) antibiotic bone cement; 2) VTE risk stratification and prophylaxis; 3) criteria for knee manipulations under anesthesia; and 4) post-operative opioid prescribing.

Meeting Success Factors:

- Don’t interrupt clinic or surgery
- Start and end on time
- Include only topics that are relevant to physicians and their subspecialty
- Provide reliable data
- Conclude with clear recommendations

While the prospect of a 6:30am meeting each week was not initially met with enthusiasm, the group has consistently had 20 to 30 surgeons in attendance from 11 hospitals in Utah and Idaho. The regular attendees perform over half of all total joint surgeries done at Intermountain facilities and have expressed that they find the meetings valuable. The MSKCP plans to initiate
additional weekly meetings for other orthopedic subspecialties and in 2017, meeting participation will drive a portion of physicians’ annual incentive payment.

If you have any questions, please contact Casey Leavitt, Operations Director, Musculoskeletal Clinical Program at casey.leavitt@imail.org.

Stroke TeleHealth Service Expands to Inpatients

This fall we are expanding Stroke TeleHealth services to all inpatients in acute care settings at Intermountain hospitals. The inpatient stroke protocol is similar to our ED stroke protocol with the physician response and communication via TeleHealth equipment; however the activation protocol differs slightly. If the acute care patient has an acute neurologic change (balance, eyes, face, arm, speech) the rapid response team (RRT) will be notified and assess the patient first before activating the Stroke TeleHealth service. The RRT will rule out non-stroke related causes of neurological symptoms such as hypoglycemia, seizure, or narcotic overdose. If those conditions are ruled out the staff will order a stat head CT. Once the stat head CT has been obtained, the RRT/physician can contact a neurologist via a TeleHealth cart. The neurologist will assist staff and attending physicians to determine next treatment options, including the need for IV Alteplase and/or transfer to another facility.
If you have any questions, please contact Kristy Veale at Kristy.veale@imail.org.

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Opioid Prescribing Guidelines and Care Process Model — Acute & Chronic Pain Management

By Linda Caston

Pain Management Clinical Services is anticipating the system-wide release of opioid prescribing guidelines for both acute and chronic pain management. These guidelines are evidence-based and support national and state developed opioid prescribing guidelines released this year. Development of these guidelines include input from various medical specialists, clinical disciplines, and the 2016 CDC guidelines for opioid prescribing. In 2017, the clinical service will work collaboratively with several clinical programs on their population specific goals for managing opioid misuse. If you have any questions, please contact Linda.Caston@imail.org.

Controlled Substance Medication Management Agreement:

The agreement has been updated this month to include additional patient identifiers to help with assuring that the document is placed in the appropriate medical record. Contact Linda.Caston@imail.org with questions.
Pain Clinic Pilot:

The pilot will serve as a model for phased implementation across the system for chronic and complex pain management in the North Region. In addition, it will serve as a consultative service for providers on pain management. Contact Bridget.Shears@imail.org or Joel.Porter@imail.org for additional information.

Living Well with Chronic Pain Self-Management Education Program:

Pain Management Clinical Services has partnered with Community Benefits to provide patients with education and self-management tools to assist with the management of chronic pain. The demand for the course has increased; during 2017, at least 15 classes will be held in Intermountain facilities or community health centers. For additional information, please contact Linda.Caston@imail.org.

Medicaid and Opiate prescribing change:

Effective October 1, 2016, Utah Medicaid will restrict the initial fill of short acting opiates to no more than a 7-day supply.

Intermountain Pain Assessment Tool (iPAT): A new system-wide pain assessment tool will be launched during January 2017. Intermountain researchers completed a 3-year validation of the new tool that was designed to help standardize adult pain assessments across the system. The tool was validated by hundreds of Intermountain staff and patients through face-to-face or phone interviews, email surveys and field testing in a variety of care areas. The validation process for use with pediatric patients will begin in 2017. Contact Bridget.Shears@imail.org for additional information.

Comfort Channel for patients with pain: Results are in! Patients find value in the Pain Comfort Channel, as reported via the HCAHPS survey, conducted at both Utah Valley and LDS Hospitals. The Comfort Channel is an evidence-based inpatient viewing channel designed to help patients relax and reduce pain medication needs through a process of distraction. The channel has been piloted at the two hospitals for the past year. There are three viewing components of the Comfort Channel; soothing music, visual imagery, and patient education on opioids, the benefits of movement in recovery, and guided meditation exercises.
The Respiratory Outpatient Clinics

By Carolyn Reynolds

Respiratory Outpatient Clinics (ROC) at various intermountain facilities treat pediatric patients (2 years and under) with bronchiolitis. These clinics provide a convenient resource for families with patients who have been treated by a physician, do not require admission to a hospital, and may need further symptom management during their viral course. ROCs have been successful in garnering patient and physician satisfaction, and being financially accountable. Click here for a complete list of ROCs with contact information.

The following clinic assessment process includes a respiratory therapist evaluation and interventions:

- Assess oxygen saturation using SpO2.
- Assess hydration status.
- Assess respiratory system using the bronchiolitis scoring tool.
- Perform nasopharyngeal suctioning.
- Administer albuterol trial only if the patient's condition meets the criteria set by the AAP clinical practice guideline. Albuterol is not routinely given.

Patients are instructed to return to the clinic if they display any of the following symptoms:

- Labored breathing (retractions, increased respiratory rate).
- Decreased drinking.
- Decreased urine output (instructions to parents include 6-8 wet diapers/24 hours).

To register a patient for a visit to a ROC:

Refer to the list of ROC locations and contact phone numbers (click here to download).
Share the list with families and ask them to call their preferred clinic.

Inform the family to call the clinic prior to coming in order to:

- Ask for verification that their insurance is accepted at the site.
- Receive clinic directions, what time to arrive, and estimated wait time.

Notify the family that a current, signed prescription from a physician or licensed independent practitioner must be brought to the clinic before the patient can be treated.

To obtain bronchiolitis order forms/prescriptions:

A print-on-demand form is available through the Physician’s Portal or click here to download.

Once the clinic name and number have been selected, the form will auto-populate. Please print the form, select the orderable items, and authenticate the order (name, date, and signature). The parent/caregiver should be instructed to bring the completed, authenticated order form with them to the ROC. Orders remain active for 7 days.

Note: Order forms may change from season to season. Please use the most current version.

Frequently Asked Questions:

Q. What is the approximate patient turnaround time?
A. The turnaround time is approximately 20-60 minutes from the time the patient arrives. It is recommended that families call the clinic 30 minutes prior to arriving for workflow purposes.

Q. Can respiratory therapists perform viral testing via flocked swabs in a ROC?
A. Routine virologic testing is not recommended. The value of identifying a specific viral etiology causing bronchiolitis has not been demonstrated (Clinical Practice Guideline: The Diagnosis, Management, and Prevention of Bronchiolitis PEDIATRICS Vol. 134, No. 5 November 1, 2014). Viral testing will not be done in the ROCs.

Q. Can pediatric patients with asthma or croup be cared for in a ROC?
A. No, the Pediatric Guidance Council does not feel these subsets of patients should be cared for in a ROC. Refer to the
For additional information about clinical practice guidelines please refer to the study “Clinical practice guideline: The diagnosis, management, and prevention of bronchiolitis”.

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**WOMEN & NEWBORNS**

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**Neonatal Resuscitation Program Update**

**7th Edition Effective October 1, 2016**

Summary of Key Issues and Major Changes with the Neonatal Resuscitation Program (NRP), 7th edition. Corporate recommendations from Intermountain Healthcare are indicated by an asterisk *.

Initial Steps of Newborn care should be completed in “The Golden Minute”. Neonatal cardiac arrest is predominantly asphyxial, so initiation of ventilation remains the focus of initial resuscitation.

Non-vigorous newborns with meconium-stained fluid do not require routine intubation and tracheal suctioning. However, if an infant is born through meconium-stained amniotic fluid and presents with poor muscle tone and inadequate breathing efforts, the infant should be placed under a radiant and PPV initiated. Intubate and suction only if the airway is obstructed.

Temperature should be recorded as a predictor of outcomes and as a quality indicator.

Resuscitation of preterm newborns of less than 35 weeks gestation should be initiated with low oxygen (21% to *30%) and the oxygen should be titrated to achieve preductal oxygen saturation approximating the range achieved in healthy term infants.

When positive pressure ventilation is initiated consider using an electronic cardiac monitor for accurate assessment of heart rate. Assessment of heart rate remains critical during the first minute of resuscitation and the use of a 3-lead ECG may provide a more accurate heart rate because providers may not assess heart rate
accurately by auscultation or palpation. Pulse oximetry may underestimate heart rate. Use of the ECG does not replace the need for pulse oximetry to evaluate the newborn’s oxygenation.

Intubation is strongly recommended prior to beginning chest compressions. If intubation is not successful * (no more than 4 attempts) or not feasible, a laryngeal mask airway (LMA) may be used. LMA’s may be used in all newborns 34 weeks or greater. If unable to intubate or place LMA continue effective bag and mask ventilation.

Intubation depth will now be determined by measuring the nasal tragus length plus 1 cm. Nasal tragus depth is validated in both full-term and preterm newborns. The NTL is determined by measuring from the baby’s nasal septum to the ear tragus. Gestational age is also an accurate predictor of the correct insertion depth. Please see page 135 in the new NRP manual for complete chart.

Chest compressions are administered with the 2-thumb technique. Once the endotracheal tube or LMA is secured the compressor administers chest compressions from the head of the newborn and the person delivering ventilation moves to the side.

Current evidence suggests that cord clamping should be delayed for a least 30-60 seconds for most vigorous term and preterm newborns and does not recommend cord milking. * However, based on recent evidence published after the NRP 7th edition materials were finalized, the Intermountain Healthcare NICU Development Team recommends Cord Milking for the following indications:

- Preterm Newborns < 30 Weeks PMA
- If greater than 30 weeks PMA, cord milking may be done at provider discretion
- Abruption, other acute blood loss

If you have any questions, please contact Jean Millar, Operations Director, W&N Clinical Program at jean.millar@imail.org.
Preventive Lab Services Change

Effective January 1, 2017, for SelectHealth commercial plan members, the lab services listed below will no longer be covered as preventive but will be covered under medical benefits when billed with covered diagnosis codes:

- Urinalysis (CPT codes - 81000, 81001, 81002, 81003, 81005)
- Thyroid-Stimulating Hormone (TSH) in individuals older than age one (CPT – 84443)
- Comprehensive Metabolic Panel (CPT – 80053)
- Basic Metabolic Panel (CPT – 80048)
- General Health Panel (CPT – 80050)

When making policy decisions, SelectHealth evaluates coverage based on many factors, including evidence-based guidelines provided by public health agencies and the positions of leading national professional organizations. The coverage of these lab tests as preventive, or screening labs, is not supported by Intermountain Healthcare® Primary Clinical Programs, Intermountain Population Health Management, the American College of Physicians, nor the American Academy of Family Physicians.

If you have questions about this policy change, please contact your Provider Relations representative. For questions about a specific member's benefits, call Member Services at 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.