Message from Brent and Susan

Dear Colleagues,

Welcome to this month’s edition of Intermountain Med Staff News, a news brief for Intermountain credentialed practitioners. Our goal, particularly with all the changes taking place in the healthcare environment, is to keep you informed. Our new monthly version features a shorter format and a focus on articles that are highly relevant to your work.

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 in PDF format on Intermountain’s Physician Portal.

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.

If you have an article to submit or an idea for a story, please share it with us.

We value our relationship with you. Thank you for all that you do in support of Intermountain Healthcare and the patients and communities we serve.

Sincerely,

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INTERMOUNTAIN BOARD GOALS

Intermountain Board Goals
The primary objective of Antibiotic Stewardship is to improve the infectious diseases management (including antibiotic prescribing) of patients to improve clinical outcomes, minimize antibiotic resistance, and decrease adverse events and unintended consequences (e.g. C. difficile infection). As of January 1st, 2017, hospitals must have antibiotic stewardship programs for Joint Commission accreditation.

**Key points**
Why we need to focus on antibiotic prescribing:

Reduce antimicrobial resistance: Antibiotic-resistant infections cause more than 2 million illnesses and 23,000 deaths each year, costing the U.S. healthcare system over $20 billion each year. Antibiotic use is a major driver of antibiotic resistance.

Improve patient outcomes: Antibiotic-resistant infections result in increased morbidity and mortality, and increased hospital length of stay. Appropriate management of infectious diseases improves outcomes.

Reduce C. difficile rates: C. difficile causes approximately 453,000 infections and 29,000 deaths each year. Effective antibiotic stewardship programs can reduce C. difficile infections.

Reduce antibiotic adverse events: Antibiotics are responsible for more than 140,000 emergency department visits each year.

What can you do to improve use?

Write an indication for all antibiotics (even better, provide a duration).

Reassess all antibiotics orders in 48 hours and adjust as needed.

Obtain the most appropriate cultures prior to initiating antibiotics.

Follow infection control measures with every patients—remove vascular and urinary catheters ASAP!

Have pharmacy manage Vancomycin.

Don’t check a urinalysis or urine culture unless clinically indicated (i.e. the patient has symptoms of a urinary tract infection).

Treat infections, not positive cultures. Not all positive cultures require antibiotics.

Call Infectious Diseases or your Antibiotic Stewardship Pharmacist if you have any questions!

Authors:
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Division of Clinical Epidemiology and Infectious Diseases
Intermountain Medical Center

Applies to:
Physicians, licensed independent practitioners, medical students and residents, physician assistants, nurse practitioners providing services in Intermountain Healthcare facilities and clinics.
Legacy of Life Dinner and Gala Honors Dr. Kent Jones

The 27th Annual Legacy of Life Dinner and Gala was held on Thursday, March 30, at the Little America Hotel. Hundreds stood to give Dr. Kent Jones a rousing ovation as he was presented with the Scientific Achievement Award from the Intermountain Research and Medical Foundation. The annual Legacy of Life award and banquet "recognizes eminent leaders with Utah ties for their contributions to the well-being of mankind." Along with Dr. Kent Jones, Pamela J. Atkinson, and Stephanie Horne Clark were also honored. More than $140,000 was raised from the event, which will be used to advance cardiovascular and pulmonary health worldwide.

Medical colleagues, business leaders, and family members honored Jones in a video presentation, describing him as a loyal friend, supportive father, and renowned pioneer in the field of heart surgery. Dr. Donald Lappé said Jones' work with other foremost surgeons has led to "miraculous" results for numerous patients over the past few decades. "Some of these (patients) ... have come into (the hospital) in a wheelchair or on oxygen ... and the next day they walk out of the hospital fully recovered and are able to go on to a normal life," Lappé said. "He wants to save lives and make a difference, and he's done that for a long time now," says Cappey Jones regarding the clear impact her husband has had on heart patients over the years.
Dr. Kent Jones said he feels like the luckiest man alive because of the fulfilling career he's been able to lead. "If I could cut this (award) up and give it to any people in this audience that's what I'd do, because there's so many people with Intermountain Healthcare that have contributed to the legacy and life of our patients. ... To be able to practice a specialty that I love for the past 40 years, it doesn't get much better than that," he said.

Jones is also a Clinical Professor of Surgery at the University of Utah. He completed the second heart transplant ever in the Intermountain West in 1985 — the first ever at LDS Hospital. He previously served as Chairman of the Division of Cardiovascular Surgery for Intermountain Healthcare and also served as Chairman of the Division of Cardiovascular and Thoracic Surgery for Intermountain Healthcare, LDS Hospital and Intermountain Medical Center. Dr. Kent Jones is also a past President of the Crimson Club board of directors at the University of Utah.

Outpatient Isolation Guideline

Earlier this year, Intermountain published a system outpatient isolation guideline for all hospital outpatient settings and the Medical Group clinics. Areas that are affected include but are not limited to: Wound Care, Respiratory Care, Rehabilitation Units, Emergency Rooms, Infusion Services, and other units where patients receive outpatient care.

All patients will be treated according to standard precautions which means if there is contact to open skin or wounds, staff will wear gowns and gloves. If there are droplets from coughing patients, the patient will be asked to wear a mask and staff will wear appropriate attire (mask, gown, gloves).
Following the CDC Guidelines for outpatient settings, patients who are symptomatic with a communicable disease will be isolated according to their symptoms and/or known diagnosis.

Isolation precautions fall into the following categories.

1. **Contact Precautions.** Applies to patients with the presence of incontinence of stool, draining wounds, copious secretions, pressure ulcers, ostomy, and/or tubes with draining fluids. PPE - Gloves should be worn when touching the patient, patient's immediate environment, or belongings. Gowns should be worn if substantial and prolonged contact is anticipated. Includes vancomycin-resistant Enterococcus (VRE), methicillin-resistant Staphylococcus aureus (MRSA), and Clostridium difficile.

2. **Droplet Precautions.** Applies to patients known or suspected to be infected with a pathogen that can be transmitted by droplet route; these include but are not limited to respiratory viruses (e.g. influenza, parainfluenza, adenovirus, respiratory syncytial virus, and bordetella pertussis). PPE - Facemask should be worn over nose and mouth. If substantial spraying of fluids is anticipated, glove and gowns should be worn as well as goggles or a face shield. Controversy exists over the potential distance that large respiratory droplets may travel, but recommendations have not changed from the use of surgical masks within 3-feet of the patient.

3. **Airborne Precautions.** Applies to patients known or suspected to be infected with a pathogen that can be transmitted by airborne route including but not limited to: TB, measles, and chickenpox (until lesion crusted). PPE - Place a mask over the patient as soon as the patient enters the facility with instructions to keep it on at all times. If the patient cannot tolerate a mask, they should cover their mouth with tissue and be escorted immediately to an exam room far away from the entrance. In this case, staff should wear an N-95 if available. If substantial spraying of fluids is anticipated, wear gloves, gown, and goggles or face shield.

Training of staff has started in the Medical Group clinics and is forthcoming in the hospital-based outpatient units.
We have a strong foundation of amazing caregivers who come to work each day thinking about doing a great job in caring for our patients and customers. Alignment with this approach of patients first, of *Helping people live the healthiest lives possible*, is what makes us strong and well-prepared to re-imagine what our future will be. I’m optimistic about our future because we have the people and leaders to move us forward.

Intermountain Healthcare is embarking on a new set of strategies that are focused on the fundamentals of Extraordinary Care — safety, quality, patient experience, access, and stewardship, all within the context of engaged caregivers. You’ll hear about new strategies, tactics, and key performance indicators (measures of how we are doing) for each fundamental, many of which will require us to think about how we care for patients differently. Being skeptical about them is normal, and in fact a healthy step for exactly what I’m asking of everyone. I have two requests:

From my perspective, we’re in a great position, and it is time to be courageous.

Mark Briesacher, MD, Senior VP & Chief Physician Executive, and President, Intermountain Medical Group talks about our strengths and opportunities

For questions, contact:

Joan Golden
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First, work as a team, and think about how you can make the tactics and strategies work for your patients (always patients first) in your clinics and departments. You know your practices, your patients, and your communities, and you know how to solve for the dilemmas we face today in healthcare.

Second, be courageous and innovative about improving how we care for our patients.

Let’s talk about one fundamental of care that’s a must for the Intermountain Medical Group to improve on: Access for our patients to the extraordinary care each of you provides. This calls for being customer-centric — providing care where, when, and how people desire to receive it. Our Medical Group Board discussed our strategies and tactics last week and I want to share with you where we’re headed:

The first tactic is to get to regular business hours. Every clinic and department will be available by phone and for face-to-face visits continuously from 8 a.m. to 5 p.m. Monday through Friday. This can be accomplished by opening on time, and staggering breaks so we can offer appointments throughout the day while still allowing caregivers to take breaks.

The second tactic is that each clinic and department will create a plan to have expanded hours, determining how their team needs to evolve to provide appointments before 8 a.m., after 5 p.m., on the weekend, or some combination of these. For most caregivers this is not a matter of working harder; rather it’s about a patients-first mindset, challenging past models, and thinking about ways to work smart and efficiently. I’ve already heard about great ideas from many clinics on how they’re staggering start times a few days each week, or planning on adding advanced practice clinicians to create more appointment slots throughout the day and early evening. I’m most impressed by the commitment from physicians and advanced practice clinicians to share the expanded hours of access and make it work for everyone.

The third tactic is to go digital. Each clinic and department should begin thinking about and preparing to implement

Proof of our commitment and courage
Recently, Intermountain Healthcare received the Hearst Health Prize for our ground-breaking work in Mental Health Integration, and this reminds me of what a small group of committed and courageous caregivers can accomplish. Being part of one of the first clinics that implemented Mental Health Integration, I recall being skeptical about the idea, especially because it would change how I’d practice. I was going to meet with the psychologist or psychiatrist at the end of their visit with my patient, and I was going to learn to manage these complex medications? Well, with people like Brenda Reiss-Brennan, PhD, Wayne Cannon, MD, George Durham, MD, Rich Ferre, MD, and Linda Leckman, MD, providing leadership and encouragement (note the courage part of encouragement), myself and many others came to appreciate how this model helps our patients, and helps us be better clinicians. Mental Health Integration is now a national model of excellence. I personally can’t imagine taking care of kids and families without it.
online patient appointment scheduling and scheduled video visits. We’re learning a lot about how best to use these new technologies to free up your clinic team to help more with patients at the clinic rather than spending time on the phone scheduling appointments. Giving our customers more control and the ability to do their own self-service, much like many other businesses and medical groups, can greatly increase loyalty and satisfaction.

In the coming weeks I’ll share more about our strategies for the other fundamentals of extraordinary care: safety, quality, patient experience, stewardship, and engaged caregivers. Remember, we’re in a great place to shape healthcare for the future, keeping patients first and becoming the best medical group in the country. I know all of you will take on this challenge and be courageous on behalf of your patients. They deserve it, and I am so thankful for what each of you does to honor and respect the trust and confidence our patients place in us each day.

INTERMOUNTAIN SYSTEMWIDE INITIATIVES

Non-Renewal of Intermountain’s System License for VisualDx

Intermountain has a responsibility to review all expenditures, to ensure that they are used for items essential to our mission. The price of all our e-resources continues to increase year after year. As we reviewed the use and cost of VisualDx, we found that just over 100 people use it. For comparison, more than 5500 people use UpToDate each month. We can only sustain those resources that have a cost-proportional-to-use, or are at least strategic to our future success.

What has Changed?
The VisualDx system license has expired.
When did this Occur?
The license expired at the end of March, 2017.

We recognize that VisualDx has some interesting features and was useful for those 100+ who used it. However, even among its users, surveys showed that VisualDx was not their number-one e-resource. We have a responsibility to provide the best care possible, at the lowest sustainable cost. While VisualDx was a nice-to-have component, it was not found to have wide usage, it was quite costly, and it did not fit in the planned strategic direction for Intermountain. For these reasons, our contract with VisualDx was not renewed. We apologize for the impact this decision may have on current users.

Contact Daniel Ricks at Daniel.Ricks@imail.org

INTERMOUNTAIN SYSTEMWIDE INITIATIVES

The Opioid Epidemic Is Growing and We Each Share In the Cause and In the Solution

If today is an average day, in the state of Utah, one person will die of an opioid overdose. Utah has the seventh highest opioid death rate in the nation. The rare reporting of these events in the media conceals the reality that a death from opioid overdose usually represents the end of a preventable and painful path that leaves scars on family, friends and communities.
Opioids are dangerous and, for far too long, we have consumed them and prescribed them without fully realizing the inherent risks. Old and young alike can become opioid dependent with as few as seven doses prescribed for an acute condition or surgical procedure. The number of deaths caused by opioids is easy to measure, but what is more difficult to quantify are the social, emotional, and economic costs of the opioid epidemic for our state and the nation.

There are troubling facts that help us understand the real scope of this problem. Opioid addiction is seen in 16% of the US population, or approximately 40 million people, which is almost twice as many as the 27 million with heart disease, the 26 million with diabetes, or the 19 million Americans with cancer. It is no wonder that each of us are only one person removed from someone directly affected by the opioid epidemic. While we struggle to enact solutions, our family members, friends and neighbors continue to develop dependence, addiction, and some die.

As providers we need to ask ourselves the question, “Where do these people get the opioids that caused their death?” We know that 55% came from friends or family members for free, 17% from a prescriber, and 11% were purchased from friend or family member. A total of 83% of opioids used resulting in death essentially came from left over opioids legally prescribed by medical providers. We can and should prescribe fewer opioids for every condition.

In the state of Utah, we are seeing alarming and inappropriate increases in prescribing rates of opioid pain medication. In the year 2000, the per capita use of opioids in the state of Utah was 48 mg per person, and this increased 378% by the year 2010 to 230 mg per person. Accidents, surgery, and other medical conditions that might merit opioid prescribing did not increase 378% during this same period of time. Currently, 7,000 opioid prescriptions are filled each day in Utah. In our state, 42% of pregnant Medicaid recipients receive an opioid prescription compared to the national benchmark of 23%. As our prescribing habits have changed to prescribing far more opioids than we previously prescribed, so has the need for substance use disorder treatment. In 2001, the state of Utah had 130 licensed substance use disorder treatment sites. Today, there are over 500 sites, and the estimated cost to the state of Utah from opioid abuse alone is over $237 million per year.
The scope of the problem is alarming, the impact touches each of us, and we need to take action. In 2015, Intermountain Healthcare helped create the Opioid Community Collaborative (OCC) to attack this problem from a 360-degree approach including: raising awareness; limiting the supply through provider education and the promotion of safe use, storage, and disposal; identifying and managing those at risk through the provision of naloxone and offering chronic pain management courses; and providing evidence-based treatment. All of our pharmacies have blue “take back” boxes to give easy access for disposal of left over opioids and other medications. Intermountain Healthcare is acting to reverse this disquieting trend, and we are asking for your support in your individual practices and patient encounters.

The provider education arm of the OCC is gathering prescribing data to share with practitioners. This data shows significant variation in prescribing habits among specialists treating the same conditions. Our measured and published experience shows that we can prescribe less than half of what we currently prescribe and still adequately treat acute conditions. Surgical Services, Musculoskeletal, Neurosciences, Intensive Medicine, Primary Care, and our Women & Newborns programs are gathering consumption data for specific procedures to guide clinicians in appropriate use and to avoid over prescribing.

In April, Intermountain Healthcare published several articles to help guide us in the appropriate use of opioids: a) guideline for opioid tapering, b) guideline for acute pain opioid prescribing, and c) care process model for opioid prescribing in chronic pain conditions. To help further educate our physicians, patients and the community about the risks and precautions of opioid therapy for chronic pain, the Pain Management Clinical Services, in partnership with Community Benefit program, recently published a video titled “Opioids for Chronic Pain Management.” This video is now available and is published on both our internal and public-facing pain management websites.

https://m.intermountain.net/pain/Pages/Home.aspx

intermountainhealthcare.org/painmanagement
Intermountain Health Care is devoting employee resources, leadership, and financial support to make a difference in this complex problem. However, this is not a problem that any one institution or individual can solve. Each one of us has a responsibility to help reverse this epidemic. This is not a new mysterious virus which will require intense epidemiological research and years of vaccine development. There are simple steps we can take immediately. As patients, we can simply opt out of taking opioids and demand alternatives. As providers we can immediately cut in half, or more, the number of opioid tablets we prescribe. As nurses we can educate patients about potential pitfalls of opioid use and encourage patients to use non opioid alternatives. Pain medications for acute and chronic use can be secured at home so that others cannot have access to them for diversion. We can refuse to share prescription pain medication with others. We can recognize the early signs of dependency and addiction and help patients, family, and friends get the treatment and assistance they need. We can dispose of unused opioids as soon as acute conditions can be managed with non-opioid medication.

At Intermountain Healthcare, we will continue to gather and share provider and specialty specific opioid prescribing data across the system to show that we can dramatically reduce over prescribing and limit the availability of excess opioids in the community. We will all gain a greater perspective on the problem within our system, and during this year, we will see how changing our practices’ patterns can reverse the trend so that on an average day in Utah another patient won’t become dependent from an excess prescription of an opioid, won’t need substance use disorder treatment, and won’t die from a prescription opioid overdose.

For questions, please contact Dr. Jay Bishoff, Director, Intermountain Urological Institute and Co-Director Provider Education Committee of the Opioid Community Collaborative
CME Activities Update

The Newborn Pediatric Critical Care Conference will be May 5 from 7:30 a.m. – 4:30 p.m. at the Utah Valley Convention Center in downtown Provo, Utah. The purpose of the activity is to provide educational updates for medical staff with interest in, or working with, pediatric and newborn patients, especially in critical care situations. Registered nurses, APRNs, physicians, respiratory therapists caring for pediatric and newborn (including intensive care patients) are invited to participate. The registration fee is $40 to attend in person and $25 to participate in the internet live option via WebEx. Visit www.intermountainphysician.org/npccc to sign up and learn more.

The 25th Annual Heart and Vascular Outreach Symposium is April 28 from 8 a.m. – 3 p.m. at McKay-Dee Hospital in Ogden, Utah. This symposium will cover management of atrial fibrillation and anticoagulation for primary care physicians, pre-operative evaluation for non-cardiac surgery, unusual vascular presentations for young and healthy adults, clearing up 10 ways cardiologists create confusion through their tests, and surgical treatments for atrial fibrillation. Those invited to attend include primary care physicians, cardiologists, cardiothoracic surgeons, hospitalists, APCs, registered nurses, and other care providers who care for patients with cardiovascular disease. Most of the attendees practice in the Intermountain Region (including, but not limited to Utah, Wyoming, Nevada, Montana, and Idaho). Residents may attend for free, however, registration is required. For all other professionals, the registration fee is $55. Visit www.intermountainphysician.org/heartsymposium to register and learn more.
The 10th Annual Huntsman-Intermountain Cancer Care Program Conference will be held on Wednesday, June 28, 2017, from 5:30 – 8:00 p.m. at the LDS Hospital Auditorium in Salt Lake City, Utah. The purpose of this meeting is to promote clinical collaboration amongst members and leaders of the HICCP program and provide healthcare information that attendees can utilize to improve care for cancer patients. Huntsman-Intermountain Cancer Care Program physicians, leaders, nurses, technical staff and associates are invited to attend. There is no cost to sign up, however registration is required. Visit www.intermountainphysician.org/cme/hiccp for more information.

The 4th Annual Excellence in Trauma Care Conference will be September 28-29 at the Grand Summit Hotel in Park City. The purpose of this conference is to provide an annual, multi-day conference for MDs and APCs practicing in Trauma and Acute Care focused on fundamental training in caring for patients who are traumatically injured and or critically ill. This conference will provide: Intense up-to-date training, evidence-based lectures, hands-on procedural training and breakout sessions focusing on clinical skill, research and administrative areas. Learn more and register at www.intermountaincme.org/TraumaCareConf.

Save the Date: The Intensive Medical Clinical Program Conference will be on September 20 at Thanksgiving Point in Lehi, Utah.

Opioid Update

The Opioid Community Collaborative project is working to create a set of dashboards as part of the Intermountain Provider Education process.
It is anticipated that the creation and rollout of the dashboards will begin in the second phase and will encompass part of the third. Intensive Medicine, Neurosciences, Surgical Services, Musculoskeletal, Women and Newborn, and Primary Care are the six Clinical Programs that will have an opioid dashboard. Individual physicians will have the ability to compare their opioid prescribing behaviors against averages of other physicians in the same specialty within their region and across Intermountain.

Each program is looking at diagnoses or procedures relevant to that specialty. For instance, Neurosciences is looking at the diagnoses of headache and back pain while Primary Care is looking at back pain, cough/bronchitis, fractures and headache.

For questions, please contact Intermountain Healthcare Continuing Medical Education at 801-442-3930 or cme@imail.org.

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**RESEARCH UPDATE**

**Intermountain Healthcare, as Part of the I-PASS Study Group, Receives the John M. Eisenberg Award for Innovation in Patient Safety and Quality**
Intermountain’s patients are safer today thanks to the knowledge gained from participating in the national I-PASS Study Group — a study that improved patient handoffs. Recently recognized for this achievement, Intermountain received the 2016 John M. Eisenberg Award for Innovation in Patient Safety and Quality, one of the nation’s most notable patient safety awards.

The Eisenberg Award is presented annually by The Joint Commission and the National Quality Forum. Lead researcher, Raj Srivastava, MD, MPH, Intermountain Healthcare’s AVP of Research, along with six other members of the national I-PASS Executive Council, accepted the award April 4, 2017 at the forum’s annual conference in Washington, D.C.

Primary Children’s Hospital, the Shock-Trauma ICU at Intermountain Medical Center, and the University of Utah’s School of Medicine who collaborated with institutions across the country, were honored for their work to develop, test and implement I-PASS, which is a package of interventions designed to standardize communications during patient handoffs. I-PASS is an acronym for each step of the handoff process: Illness severity, Patient summary, Action list, Situational awareness and contingency planning, and Synthesis by receiver.

**How I-PASS was developed.** Primary Children’s Hospital and its partner physicians at the University of Utah’s School of Medicine were among the original nine members of the pediatric I-PASS Study Group, which began data gathering in 2011. The I-PASS Study Group now includes more than 150 individuals in more than 50 children’s and adult hospitals nationwide. In 2015, the I-PASS handoff tool was implemented in the Shock-Trauma ICU at Intermountain Medical Center.

**What are the results of I-PASS?** Initial results from a multi-center study of pediatric hospitals were published in the *New England Journal of Medicine* in November 2014. An estimated 80 percent of the most serious medical errors can be linked to communication failures, particularly during patient handoffs. The study says adverse events affect an estimated 3.7 percent of hospitalized patients — and 14 percent lead to death, yet 69 percent of the events are preventable.
More recently, I-PASS has been expanded to include additional hospitals, ICUs as well as hospital wards, and adult as well as pediatric services. “Standardized handoffs using the I-PASS methodology at Intermountain Medical Center has resulted in improved patient safety without a major effect on efficiency,” says Dr. Scott Stevens, director of the transitional year residency program and vice-chair of the Department of Medicine at Intermountain Medical Center. “Since it was first implemented in our Shock-Trauma ICU, it resulted in a 23 percent reduction in medical errors, a 30 percent reduction in preventable adverse events, and a 21 percent reduction in near-misses — while increasing the time per handoff only minimally, from 2.4 minutes to 2.5 minutes.”

Next Steps. Primary Children’s Hospital and the University of Utah’s School of Medicine are among seven pediatric sites nationwide participating in a study using the I-PASS model in family-centered rounding - a practice in which doctors’ daily patient rounds are done in the presence of patients and their families. This enables open discussion of a child’s diagnosis, treatment, and care plan, and allows families and nurses to ask questions and provide input as part of that process.

Intermountain Medical Center will implement its communication methodology between hospital and office physicians at the time of patient discharge, and has joined the I-PASS collaboration in a grant application to implement this new phase of I-PASS.

Please contact Raj Srivastava at Raj.Srivastava@imail.org with any questions.
iCentra is live at Alta View and Riverton Hospitals

On February 25, hospitals and clinics in the first phase of Intermountain Healthcare’s Central Region went live on iCentra. Alta View Hospital, Riverton Hospital, and Rose Canyon, Southridge, West Jordan, Draper, Sandy, Tooele, Bountiful, and Memorial Medical Group clinics are now using iCentra. Additionally, 271 affiliated physician clinics in the region have implemented iCentra.

Onsite support teams were available to assist caregivers during the transition and remained in the facilities for weeks as physicians and caregivers learned to be proficient on iCentra. Intermountain teams rounded on all 271 affiliated physician clinics to assist in the resolution of issues and provide additional support and training as needed.

The term “go live” refers to the window of time when we formally cut over to the new system through about 2-4 weeks after implementation. During this window, the focus is on maintaining stability in the surrounding environment while using a system to which caregivers are not yet fully accustomed. The more difficult stage – adoption – comes after that, when the focus shifts to helping people become proficient.

Intermountain is committed to a successful transition. We recognize this will be challenging, requiring extra time to complete work within the system during the first few weeks – even months.
During this time, it is important to remember that iCentra is about people: Our patients and our colleagues who care for them. It is a tool to help us achieve Intermountain’s mission of helping people live the healthiest lives possible® and allows us to fulfill our healing commitments. Over time, Intermountain caregivers and our affiliated providers will be able to more easily access and share patient information, contributing to enhanced collaboration and improved outcomes. Additionally, iCentra includes decision aids and patient education, providing a more consistent experience across Intermountain facilities. Our My Health offering will give patients access to their own medical information, enabling them to take a more proactive role in their own healthcare.

The next group to implement iCentra will be Central Region 2 (CR2), which includes LDS Hospital and TOSH, and Medical Group clinics including Salt Lake Clinic, Cottonwood Medical Clinic, as well as other sites in the North Salt Lake and South Salt Lake/South Davis regions. The go live date is May 6, 2017.

Please e-mail iCentra@imail.org with any questions.

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**INFECTIONOUS DISEASES**

**Testing for CDIFF to ensure effective treatment**
*Clostridium difficile* is the most common infectious cause of antibiotic associated diarrhea. As the name implies, diagnosing this infection can be difficult as historically, this organism was a challenge to detect in the laboratory. The most common tests used previously centered around rapid detection of the disease causing toxins A and/or B, however this test suffered from poor sensitivity and falsely negative tests were common. Detection of *C. difficile* antigen (GDH) is rapid and much more sensitive than non-molecular toxin tests, however a positive result does not confirm that the detected organism is producing toxin and falsely positive tests due to the presence of non-toxin producing strains was problematic. Innovations in diagnostic testing over the past several years have improved our ability to rapidly detect *C. difficile* in diarrheal stools with nucleic acid amplification tests (NAAT) that detect genes for toxins A and B. A limitation to NAAT testing is that it detects toxin DNA but does not always confirm that toxin is being produced. A positive NAAT can indicate colonization, the presence of non-viable organism or a falsely positive test.

Intermountain Healthcare laboratories have been using more sensitive diagnostic strategies over the past several years. Testing with CDIFF (GDH antigen and Toxin A/B detection with reflex to NAAT as needed) or more infrequently, NAAT alone has improved the percent of organisms detected. Unfortunately, with improved testing comes the clinical responsibility to be more precise about whom we choose to test in order to achieve the appropriate balance. Over diagnosing *C. difficile* when disease is not truly present can lead to inappropriate antibiotic treatment, disruption of a patient's gastrointestinal microbial community and increased risk for *C. difficile* infection. Underdiagnosing *C. difficile* can lead to delayed therapy, contamination of the hospital environment and transmission to other patients.

In order to help achieve the proper diagnostic balance, the Hospital-Onset Diarrhea Diagnostic Flowchart was developed to guide the decision-making process on when to order a diagnostic test for *C. difficile* in patients who develop diarrhea ≥72 hours after hospitalization. This document is meant to encourage the habit of confirming the presence of diarrhea (defined as the presence of 3 or more unformed stools in a 24 hour period) AND evaluating for alternative causes of diarrhea (e.g. laxative use) before ordering a *C. difficile* test.

[Download the Hospital-Onset Diarrhea Diagnostic Flowchart](#)

Please contact Bert Lopansri at bert.lopansri@imail.org with any questions.
Finally, there is no such thing as a perfect lab test. A positive *C. difficile* test does not always require antibiotic treatment and discontinuing the precipitating antibiotic may lead to cure. Conversely, a negative test does not always exclude infection and a different diagnostic strategy (e.g. *C. difficile* cell cytotoxicity assay) may be helpful. *C. difficile* test results (positive or negative) must always be interpreted in context with the patient's clinical condition and with an understanding of the pre-test probability for disease.

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**Intermountain’s Oncology Clinical Program has partnered with a leading cancer registry services company to improve our cancer data collection and reporting requirements**

CHAMPS Oncology is pleased to announce its new strategic partnership with the Oncology Clinical Program at Intermountain Healthcare.

CHAMPS Oncology is pleased to announce its new strategic partnership with the Oncology Clinical Program at Intermountain Healthcare. Through this newly established partnership, CHAMPS Oncology will ensure the successful operation of Intermountain Healthcare's cancer registry; guarantee quality data; provide educational interventions; set and maintain the framework for accreditation, as well as produce advanced cancer analytics for their cancer care leadership team.

"The CHAMPS Oncology team is honored to have been selected by Intermountain Healthcare," said Toni Hare, RHIT, CTR, Vice President, CHAMPS Oncology. "We are eager to begin building this strategic partnership, working together to implement a comprehensive registry system solution and insight2oncology®, as well as positioning Intermountain Healthcare's cancer program for a successful future."
CHAMPS Oncology understands the comprehensive needs of each region in the system and has designed a customized cancer registry system solution for Intermountain Healthcare that will ultimately improve patient care by delivering and transforming high-quality cancer data into actionable information.

"Given the increasing challenges to fulfill case abstraction requirements, enhance cancer registrar onboarding, training and continuing education, coupled with expected increases in cancer incidence rates, we are pleased to initiate a new business relationship with CHAMPS Oncology," said Brad Bott, MBA, CCRP, director, Oncology Clinical Program, Intermountain Healthcare. "Through the RFP process, contract negotiations and HR transition, the CHAMPS Oncology team has been superb to work with. We are very much looking forward to working together with CHAMPS Oncology to elevate our cancer registry activities to the highest level, while providing us with the timely and high-quality data we need to achieve our mission."

CHAMPS Oncology's team of highly skilled cancer information specialists and experienced certified tumor registrars will deliver a customized solution developed specifically for Intermountain Healthcare that includes:

- Cancer Registry Operations & Management (casefinding, abstracting, follow-up, cancer committee support)
- Data Quality & Education
- Cancer Program Consulting & Support
- CHAMPS insight2oncology® Advanced Analytics

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PEDiATRIC SPECIALTIES

https://m.intermountain.net/newsroom/Site%20Pages/Edition.aspx
Several new documents updated and published by the Pediatric Specialties Clinical Program

The Pediatric Specialties Clinical Program has updated and published several documents for you to use. Below is a short description of each update and a link to the document for you to review and determine if the information is needed for your practice.

**Modified Westley Scoring tool for CROUP:** This validated tool will be used in the Emergency setting as well as the inpatient setting for determining level of treatment needed for a patient with croup.

**Acknowledgement of Consent for Sedation:** This is a new form that an LIP who is performing a sedation will use to gain consent for the sedation. This form only needs to be used if the LIP who is sedating the patient is different than the provider performing the procedure.

**Pediatric Type 1 Diabetes and Pediatric Type 2 Diabetes:** After much debate and review my experts the Pediatric Diabetes care process model has been updated. The new documents have been split into care process models for Type 1 diabetes and Type 2 diabetes. In addition 4 flashcards have been created to make it easy to implement the new guidelines into practice. The flashcards can be accessed through the Physician app in the Best Practice Flashcards. The care process models can be accessed from the Physician app in the reference library under clinical programs then Pediatrics. For your review now links to the documents are below:

- [Diabetes: Pediatric Type 1 CPM](#)
- [Diabetes: Pediatric Type 2 CPM](#)
- [Diabetes: Evaluation and Screening flash card – Pediatric](#)
- [Diabetes: DKA Management flash card – Pediatric](#)
- [Diabetes: Insulin Adjustments flash card – Pediatric](#)
- [Diabetes: Sick Day Guidelines flash card – Pediatric](#)
Pediatric

For questions, please contact Carolyn Reynolds at Carolyn.Reynolds@imail.org or 801-442-3567.

WOMEN & NEWBORNS

Postpartum Screening for Gestational Diabetes Patients

Women with gestational diabetes are at an increased risk for developing type 2 diabetes. National guidelines and best practice recommend that they be screened at 6-12 weeks postpartum using 2 hour GTT, fasting glucose or Hgb A1C. A new alert has been added to iCentra to remind the provider to order the follow up testing at the time of OB discharge. The orders are contained within the alert and will be saved in the system for 14 weeks. The rule will check if a patient is pregnant and for gestational diabetes before firing the alert.

If you have any questions, please contact Kristi Nelson at Kristi.Nelson@imail.org.
Screening Tool Coming for all hysterectomy cases for Abnormal Uterine Bleeding (AUB)

Dr. Marc Harrison has asked Intermountain providers to compare their performance to national standards. One comparable national benchmark for hysterectomy rates in women is 1.36 per 1000 members. The Intermountain rate is nearly double the national average, at approximately 2.27 per 1000 members. Data further indicates that 40% of women with Abnormal Uterine Bleeding as an indication for hysterectomy did not receive a treatment or management that might avoid the need for a hysterectomy in the two years prior to the procedure. It is a goal for 2017 to do further assessment around the rates of hysterectomy for AUB.

Expect to see a few new questions asked when scheduling a surgical case for hysterectomy with a diagnosis of Abnormal Uterine Bleeding (AUB). These questions will include previous medical management options. In addition, the AUB CPM is in the process of being updated and should be available soon.

The GYN Development team recommends that you have the paper copy of this form available in your office and quickly mark the appropriate treatments attempted before the surgery is scheduled. This information will be asked during the scheduling process in iCentra.

Download the AUB Checklist for hysterectomy Scheduling.pdf

If you have any questions, please contact Kristi Nelson at Kristi.Nelson@imail.org.
Technology Assessment ("M-Tech") News at SelectHealth

M-Tech is SelectHealth's formal process for reviewing emerging health care technologies (procedures, devices, tests and "biologics") for the purpose of establishing coverage benefits. Existing technologies are, at times, also examined through this process. Following is a list of recent technologies reviewed and Committee recommendations:

Renal Autotransplantation, Reviewed January 17, 2017*

Committee Decision: Denied as unproven. The current state of the evidence is insufficient to reach conclusions regarding the efficacy or safety of this procedure for any indication. See Medical Policy #606.

Transcatheter Aortic Valve Replacement (TAVR) for Intermediate Risk, Reviewed January 17, 2017*

Committee Decision: Coverage Expanded to Include Intermediate Surgical Risk Patients. Current evidence suggests equal efficacy and similar safety of the TAVR procedure compared to the SAVR for patients with intermediate surgical risk. See Medical Policy #444

Gastric Electrical Stimulation for Gastroparesis,

If you have questions regarding coverage of these or any other technologies or procedures or if you would like SelectHealth to consider coverage for an emerging technology, please email us at mtech@selecthealth.org or call 801-442-7585.

All SelectHealth medical policies and technology assessments can be viewed on our website. Go to www.selecthealth.org, click on the "Provider" tab (upper right corner), enter your log in information, and then click on "Policies and Procedures" (left side of page) to be directed to the website.
Reviewed March 14, 2017*

**Committee Decision: Covered in Limited Situations.** Current evidence supports some level of efficacy of this gastric electrical stimulation in a select population though the relatively high rate of complications is concerning. Given the potential for significant cost savings in a population who are high resource utilizers, we recommend coverage of gastric electrical stimulation for treatment of gastroparesis when certain criteria are met. See Medical Policy #585

Inspire System as a Therapy to Treat Sleep Apnea,
Reviewed March 14, 2017*

**Committee Decision: Denied as unproven.** Current evidence is of low level and limited in volume. It suggests clinical benefit and limited safety concerns but given the number of members studied and the low level of evidence [GRADE 2B] this therapy is considered to be unproven. See Medical Policy #608

Pancreatic Transplant Alone, Reviewed March 14, 2017*

**Committee Decision: Covered in Limited Situations.** Current evidence is robust and demonstrates favorable outcomes for appropriately selected patients. In addition, given the high survivorship of pancreatic transplant, the potential cost offsets are significant and occur within a reasonable time frame to suggest the procedure is also cost effective. See Medical Policy #161

*Date Reviewed does not necessarily reflect the date of implementation of coverage policy.

Other technologies currently under active assessment by the M-Tech Committee is scheduled include the following. As the reviews are completed, notices will be sent to stakeholders accordingly to inform them as to SelectHealth’s coverage determinations:

Bariatric Surgery
Cartilage Implant for Osteoarthritis (Cartiva®)
Colon Cancer Recurrence Testing
ConfirmMDx Prostate Cancer Test
Corneal Crosslinking for Keratoconus
Decipher Prostate Cancer Classifier
DeNovoNT Natural Tissue Graft
iStent for Glaucoma
Magnetic Resonance-guided Focused Ultrasound (MRgFUS) for Bone Cancer
Magnetic Resonance-guided Focused Ultrasound (MRgFUS) for Prostate Cancer
Magnetic Resonance-guided Focused Ultrasound (MRgFUS) for Uterine Fibroids
Prolaris for Prostate Cancer
Pharmacogenomic Testing for Psychiatric Medication Management
Savi Scout® by Cianna
SIRT for Liver Cancer
Sublingual Immunotherapy
Transcranial Magnetic Stimulation for Mental Health Disorders
VBLOC for Weight loss
New Policies

No new policies.

Revised Policies

Policy #480: Genetic Testing: M-100 KRAS-Variant/Test for Ovarian Cancer Prediction (a.k.a. Genetic Testing: Preovar® for Ovarian Cancer Prediction) (Revised 02/24/2017)

Policy content and title changed to reflect change in test name.

Policy #475: Psychiatric Residential Treatment Centers (Revised 02/27/2017)

Added supporting information regarding the importance of RTC proximity to patient’s home.

Policy #567: Blephroplasty, Brow Ptosis Repair and Reconstructive Eyelid Surgery (Revised 02/27/2017)

Term “red reflex of pupils” replaced with “corneal light reflex.”

Policy #126: Heart Transplant: Children (Under Age 18) (Revised 02/16/2017)

Correction made Under Absolute Contraindications, #4, C, subsection 2. We changed: WBC less than 5,000 mm³ or “less than” 25,000 mm³ to “greater than” 25,000 mm³.

Policy #500: Infertility Evaluation and Treatment (Revised 02/16/2017)

Commercial Plan:
17-hydroxyprogesterone added under commercial plan policy, laboratory tests covered as part of the infertility benefit in the evaluation of infertility, Female. Changed the acronym for Dehydroepiandrosterone.
sulfate to (DHEAS) instead of (DHEA).
Page 5 under (DHEAS): -17-hydroxyprogesterone “or”
dehydroepiandrosterone the “or” changed to “and”.
Page 13, added “and” in between 1 year of
unprotected intercourse (and) 1 year of conventional
treatment.
Page 16, Corrected Punctuation error under Ovulation
Monitoring Studies: added a period after at 12
months. And capitalized “Whereas”.
Page 17, under Electroejaculation: “on suspected”
deleted in the first sentence.

Policy #129: **Hyperbaric Oxygen Therapy** (Revised
02/16/2017)

**Commercial Plan:**
Typo under **Chronic diabetic wounds**, changed and
"connection" of vascular abnormalities to "correction".

Policy #387: **Genetic Testing: FGFR1 for Lobular Breast
Carcinoma** (Revised 02/16/2017)

**Added the word “Breast” to the title for clarification.**

**Archived**

No archived policies.

Please contact Ken Schaecher at
ken.schaecher@selecthealth.org with any questions.