Dear Colleagues,

We believe the most important thing we can do to improve the relationship between Intermountain and physicians is communicate, openly and honestly. With that in mind, please see the following Med Staff News update, which has important information for you and your practice.

Please let us know if you think this update is a worthwhile effort. If there is something you want more information about, let us know. If you have questions, comments or concerns, don’t hesitate to contact either of us.

Thank you for all that you do in support of Intermountain Healthcare and patients you serve.

Sincerely,

Brent Wallace, MD  Susan DuBois
Chief Medical Officer  Assistant Vice President
Intermountain Healthcare  Physician Relations and Medical Affairs
brent.wallace@imail.org  susan.dubois@imail.org
(801) 442-3866   (801) 442-2840

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The work Intermountain and Cerner teams are doing continues to go well. The project is challenging and will have broad impact for everyone at Intermountain Healthcare. The teams are aligned with clinical and business areas as we all put our best efforts toward improving the quality of care we provide patients, the business solutions we use to manage healthcare, and the tools and technologies we all use every day in our work. This is part of Intermountain’s commitment to create an extraordinary experience anchored by clinical and operational excellence.

**AFFILIATED PHYSICIAN STRATEGY**

The Affiliated Physician Strategy group is in the process of establishing a governance structure for defining and implementing several options to integrate the Intermountain-Cerner system with affiliated physician practices. The team is working with physician and region leaders, Legal and Compliance to develop approaches and strategies that are flexible and comply with STARK, antitrust privacy, anti-kickback and other provisions, laws and regulations governing these activities.

**CERNER SYSTEM SCOPE DECISIONS FINALIZED FOR MANY ANCILLARY INFORMATION SYSTEMS**

Over the last three months, Intermountain teams have completed scope evaluations for ancillary clinical and financial information systems in critical areas to determine if the respective Cerner tool will be used. The following systems are in scope to move to Cerner in the current project timelines:

- APACHE
- Behavioral Health
- Bone Marrow Transplant
- Coumadin Clinic
- GE RIS
- Homecare (in scope for a later phase of the project)
- Infrastructure and Hosting
- Medical Oncology/Infusion Services
- Mammography Reporting System
- NuCard2
- Pediatric Oncology
- Physical Therapy
- StorkBytes/Fetal Monitoring
- SureScripts
- Surgical Services and Anesthesia
- Telcor Lab Billing (in scope for a later phase of the project)

The following systems are out of scope for the current transition to Cerner but may be included in the future as Cerner develops the necessary functionality within the single integrated information system:

- Antimicrobial Stewardship/Infection Control
- EMR Order Interface
- Genetic Counseling
- Genetics Database
- Interface Engine
- Interface Trading Partner
- Organ Transplant
- Research/Clinical Trials
- Retail Pharmacy
- Systoc

The Model System Steering Committee is still evaluating 20+ systems to determine if they will be in- or out-of-scope for the current project plan.

**MODEL SYSTEM WORKFLOW VALIDATION SESSIONS**

The Model System Validation Sessions were conducted January 27-31. This was the first time clinical leaders had a comprehensive view of Intermountain’s current configuration of Cerner’s platform. The sessions started with a large gathering of clinical, business, and
I.S. leaders to view the system followed by three days of 160+ breakout sessions for deep dive analysis of the current configuration, functionality and workflows. The Cerner team will spend the next five weeks addressing gaps and corrections and making additions identified by leaders. The next Validation Sessions week will be March 10. This entire process will be repeated every six weeks.

During the Validation Sessions weeks, anyone can access the Intermountain-Cerner Solutions Gallery, which will provide hands-on access and 1:1 time with an expert for any given topic regarding the Intermountain configuration of the Cerner system. The Solutions Gallery is in the Zion Conference Room on the 5th floor at the South Office Building on the IMED campus. The next Solution Gallery access is March 11, 12, and 13 from 4:00 pm – 5:00 pm (additional times may be added).

MODEL SYSTEM STEERING COMMITTEE WORKGROUPS
The Model System Steering Committee is responsible for configuring and implementing the Cerner system to support Intermountain’s care process models and to meet Intermountain’s clinical, revenue cycle and operational information requirements. The committee is led by Craig Jacobsen and is comprised of clinical, business and technical leaders for the over 20 workgroups currently engaged in the Intermountain-Cerner project. Please feel free to reach out to these leaders with your questions and ideas.

<table>
<thead>
<tr>
<th>Project Team</th>
<th>Clinical or Business Lead</th>
<th>Technical Lead</th>
<th>Cerner Representative</th>
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<tr>
<td>Acute Care</td>
<td>Lisa Graydon; Chris Wood, MD</td>
<td>Diane Rindlisbacher</td>
<td>Katie Fitzpatrick</td>
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<td>Susan Brown; Physician Lead – TBD</td>
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<td>Adam Miklius</td>
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<td>Alexis Smith</td>
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<td>Wayne Watson; Todd Allen, MD</td>
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<td>Roxi Davitt</td>
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<td>Enterprise Data Warehouse</td>
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<td>Lee Pierce</td>
<td>Mike Nelson</td>
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<td>HIM</td>
<td>Mary Staub</td>
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<td>Homecare</td>
<td>Lisa Musgrave; Tim Veach</td>
<td>Dustin Shelton</td>
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<td>Imaging</td>
<td>Heidi Warner</td>
<td>Geoff Duke</td>
<td>Darren Reed</td>
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<td>Interfaces/Data Migration</td>
<td>Not Applicable</td>
<td>Tammy Madsen</td>
<td>Lynne Mixon</td>
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<td>Internal Audit</td>
<td>Jen Conley</td>
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<td>I.S. Infrastructure/Hosting</td>
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<td>Don Franklin</td>
<td>Brijesh Parikh</td>
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<td>I.S. Security</td>
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<td>Karl West</td>
<td>Brijesh Parikh</td>
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<td>Laboratory</td>
<td>Sterling Bennett, MD</td>
<td>Kelly Passey</td>
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<td>Medical Informatics</td>
<td>Kathryn Kuttler</td>
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<td>Jeff Johnson</td>
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<td>Steve Karren</td>
<td>Ankur Buch</td>
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<td>Practice Management</td>
<td>Chris Thornock</td>
<td>Tracy Rich-Greiner</td>
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<td>Primary Children’s Hospital</td>
<td>Alison Larson</td>
<td>Joe Hales</td>
<td>Tim Borgeson</td>
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<td>Quality Reporting, Ambulatory</td>
<td>Teresa Hall</td>
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<td>Robin Betts; Maureen Clancy</td>
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<td>Revenue Cycle Organization</td>
<td>Mike Jex</td>
<td>Shely Johnson</td>
<td>Pete Hubbard</td>
</tr>
</tbody>
</table>

If you have questions or comments about the Cerner project, please contact Mark Briesacher, MD at mark.briesacher@imail.org, or Craig Jacobsen, AVP, Information Systems, at craig.jacobsen@imail.org.
Shared Accountability Update

Teams across Intermountain continue to implement projects related to Intermountain’s Shared Accountability initiative—our approach to providing better care and improving health for patients and the people in our communities, while keeping costs sustainable. Shared Accountability includes everyone in improving care—physicians, patients, healthcare organizations, and payers.

Intermountain’s three key Shared Accountability strategies are redesigning care, engaging patients, and realigning financial incentives. Here is a summary of current activity:

The Health Education and Health Literacy Guidance Council has streamlined and improved patient education materials. Intermountain has purchased a library of patient education content from Krames Staywell, including web content, patient instruction sheets, videos, and animations. Teams are currently reviewing the content to be integrated into Intermountain’s websites, mobile apps, MyHealth portal, and Cerner applications. Intermountain has created a new patient education library site that can be accessed inside the Intermountain firewall by typing PEN in the URL bar.

A physician payment model pilot is operating in information-gathering mode. The pilot—which pays for care provided plus a performance-based payment for meeting quality, service, and total cost of care goals—launched last fall with a small subset of patients at 15 Intermountain Medical Group and affiliated clinics. It operates in test mode through June, as we learn from the experience and work with participating providers to consider needed adjustments. Tools developed for the model provide physicians with data to support care decisions. Clinicians can see current performance and feedback on service and quality goals; see overall population health metrics and patient risk scores; and track costs.

Care management services are being streamlined and extended to more patients. More than 700 Intermountain employees across the system have a role in case management, disease management, or care coordination functions. These efforts have often been fragmented between facilities and services. Intermountain is focusing this year on streamlining and coordinating these processes for both episodic case management, where services are provided for a specific episode of care or treatment, and longitudinal care management, where services are provided long-term. Care management coordination efforts will support physician practices with resources like health coaches to help patients comply with treatment plans.

In concert with these efforts, Intermountain recently opened a new Personalized Care Clinic, located in Intermountain Medical Center, to provide better care for patients with complex healthcare needs, often accompanied by social or economic factors that affect health. This is a specialized outpatient clinic that brings together a multidisciplinary team of physicians and other care clinicians to provide intensive, short-term to intermediate-term care services. This is an innovative approach that Intermountain is testing and
Continued on next page

Intermountain’s LiVe Well efforts continue to expand with wellness and prevention services in our LiVe Well Centers, hospitals, and clinics, as well as many services online and in the community. A healthy lifestyle care process model supports patients in the clinical setting.

Best practices are being developed more rapidly and applied more consistently. For more than a decade, physicians and clinicians through Intermountain’s Clinical Programs and Clinical Services teams have been developing evidence-based care process models. This year, these teams are using Intermountain’s vast data repositories to enhance development and consistent implementation of best practice standards. As we focus on best standards of care, we increase patient access to effective care, decrease the risk of unnecessary interventions, and improve clinical outcomes.

Intermountain continues to introduce its version of the patient-centered “medical home” concept, which we call Personalized Primary Care (with Intermountain Medical Group clinics) and Advanced Primary Care (with affiliated physician clinics). This program aims to provide better care coordination for patients with chronic and high-risk medical conditions. All Medical Group clinics will be participating in Personalized Primary Care this year. Participation among affiliated physician clinics should be complete in 2015.

Pilots of three Shared Decision-Making tools (EMMI Solutions, Health Dialog, and Archimedes IndiGO) are moving forward at select Medical Group clinics with plans for future expansion. These tools are designed to promote dialogue between patients and providers and to empower patients to make health decisions that are best aligned with their values.

If you have questions about Intermountain’s Shared Accountability initiative, please contact Brent Wallace, MD, at brent.wallace@imail.org.
Several recent events reported to the state involve retained objects and inaccurate counting procedures. One such case involved a 58 year old female seen in the ER after an auto accident. She was sent to surgery for repair of a gastric perforation and liver laceration and hospitalized for five days. The patient returned to the ER a week later with a complaint of fever and increased abdominal pain. A CT of her abdomen revealed five retained laparotomy sponges from the previous surgery. The patient was then taken to surgery for sponge recovery and abdominal cleanup. During the initial surgery, multiple staff assisted in the operating room with the room set-up. There were two surgeons, one resident, one anesthesiologist, four scrubs, five RNs, plus two orderlies. Upon arrival to the OR the patient was in stable/controlled, non-life threatening condition. Initial sponge and instrument counts occurred.

During the case, two personnel changes occurred. The initial scrub and the initial surgeon were both relieved and the two circulating nurses and one resident remained throughout the procedure. The initial surgeon used lap sponges to pack abdominal quadrants and was relieved by the on-coming trauma surgeon. Near the end of the case, the first closing count began. The relief surgeon was not aware the quadrant packs had been placed. The first closing count was conducted by the same scrub that did the initial count but not the same circulator. The final count was conducted by a relief scrub and the circulator from the initial count. During the closing count, the surgeon performed a gentle brief scan of the abdominal cavity so as not to cause bleeding. This was stopped before completion when the staff reported that the count was correct.

**Root Causes: multiple staff changes and incorrect counts**

If you have questions, please contact Jeanne Nelson at jeanne.nelson@imail.org.

**TOPICS FOR DISCUSSION**
- Could this happen to one of your patients?
- What kinds of communication gaps do you experience during procedures or surgery?
- What recommendations do you have to improve processes around these issues?
Do you need your Intermountain CME transcript? Go to www.intermountainhealthcare.org/mycme and log in with your Intermountain Healthcare master username and password. After logging in it will take you to a list of topics. On the top navigation bar click on the link, “VIEW COMPLETE TRANSCRIPT”. Select the date range you wish to print and then generate a PDF that can be saved or printed.

If you have questions, please contact SarahAnn Whitbeck at sarahann.whitbeck@imail.org.
Cardiovascular Clinical Program

The Cardiovascular Clinical Program team continues to have many exciting advances. Our Heart Failure Board Goal for 2014 includes:

1. More than 90% of inpatients with possible HF will have their HF identification and risk stratification report shared with the inpatient care providers.
2. All inpatients with HF will have a report sent to their hospital attending and PCP if their clinical data warrants consideration of ICD, CRT, LVAD or transplant.
3. Electronic discharge program will be used in more than 90% of HF patients at each facility.
4. Multidisciplinary, intensive risk stratified CPM will be developed and piloted at McKay-Dee Hospital.
5. All inpatients with a primary diagnosis of HF at medium or high risk for readmission will be provided with a scale and BP cuff (if they cannot afford their own) and a personalized self-management plan.
6. More than 50% of inpatients with a primary diagnosis of HF will have an advanced directive completed and entered in the EMR.
7. CPM will be developed for rapid treatment of patients presenting to the ED or hospital to resolve the acute problem in less than two nights.
8. Guidelines for appropriate use of palliative care and hospice will be developed and disseminated.
9. Clinical guidelines for outpatient management of HF will be developed and shared with Intermountain primary care and cardiologists.

In addition, we are partnering with the Primary Care Clinical Program to produce meaningful resources and pathways for optimal care of patients with hypertension. Details can be viewed [here](#).

If you have any questions, please contact Donald Lappe, MD, at donald.lappe@imail.org, or Colleen Roberts at colleen.roberts@imail.org.
Primary Care Clinical Program

First Quarter 2014

This year we will be highlighting new support for patients with high blood pressure at Intermountain. The High Blood Pressure Development Team has been busy creating a best practice model for our clinical teams. Additionally this team will be presenting at the Primary Care Clinical Program Clinical Learning Day (CLD) in UCR to share:

- Recommended HTN treatment algorithms for all patients including specialty populations
- Suggested clinic work flows
- Patient education tools
- Reports which have been created to:
  1. Assist clinical teams in the management of their HTN patients
  2. Support population health and guide Intermountain Shared Accountability initiatives

Also in support of the Choosing Wisely® campaign which was launched last year, the Clinical Program continues to develop this initiative bringing additional opportunities to light including the utilization of cervical cancer screening and HPV testing, d sea scan testing rates and antibiotic utilization. A Choosing Wisely® Dashboard has been created to evaluate the rate of imaging of patients with low back pain, number and types of labs ordered at well visit exams and antibiotic utilization. Clinical Program leadership will be orienting Medical Group leadership and clinical teams to all of the measures now available to review and to understand the differences in variation as well as compliance to CPMs.

A new Prediabetes CPM has been developed and will be shared at the CLD as well. Presently Intermountain’s diabetes prevention program has been implemented in 5 regions (22 clinics). Current plans include:

- Identifying patients with prediabetes better through changes in lab procedures
- Working across the organization to leverage and coordinate resources; standardize processes to optimize impact
- Developing reporting capabilities to monitor, measure and manage prediabetes

Mental Health Integration continues to diffuse throughout Intermountain with secondary clinics now implementing this Team-Based Care approach including collaboration with Pediatrics, Women & Newborn (e.g., maternal fetal medicine, OB/GYN), TOSH Spine Clinic, Diabetes Care Center, Personalized Care Center and Sleep Disorder Clinic. The Primary Care Clinical Program will be posting an MHI dashboard later this quarter to measure changes in PHQ9 and No Show Rates as well as an evaluation of emergency room and inpatient stays for patients within both primary care and secondary care.

If you have any questions, please contact Wayne Cannon, MD, at wayne.cannon@imail.org, or Sharon Hamilton at sharon.hamilton@imail.org.
Women and Newborn Clinical Program

In an effort to more accurately identify neonates at risk for early onset sepsis (EOS) due to chorioamnionitis, Intermountain has obtained permission to utilize the Early Onset Sepsis Risk Score developed by Kaiser Permanente. Our Intermountain data appears to be similar to the published data from Kaiser and Boston. Use of this score to guide treatment—instead of using only the criteria “Temperature of 38° C or greater not attributable to specific cause”—will allow a reduction of the number of babies treated due to maternal chorioamnionitis from about 7.5% of live births 34 weeks gestation and greater to about 2%. This is expected to significantly reduce Special Care Nursery and NICU admissions, reduce disruption in maternal-newborn bonding, and save costs while better targeting the population at risk for EOS.

This new EOS score more accurately estimates the probability of neonatal early onset infection on the basis of five maternal intrapartum risk factors:

- Gestational age
- Highest maternal temperature
- Length of duration of rupture of membranes
- GBS status
- Antibiotics given

More detailed information on the use of the EOS score can be found under the newborn topic here.

If you have any questions, please contact Teri Kiehn at teri.kiehn@imail.org.
Imaging Services Update

In 2011-2012, the combined CV Clinical Program and Imaging Services Board Goal included the development of a database and reporting tool to track cumulative radiation doses for common high dose imaging examinations (CT, cardiac catheterization, cardiac nuclear medicine, and angiography). This data is now available, enabling impact of interventions on radiation dose to be tracked.

As head CT is the most common CT procedure performed, Imaging Services has placed focus on reducing CT dose for head CT's system wide. In 2013, pediatric radiologists piloted a process to do observational studies to determine appropriate low-dose scanning protocols. The standard pediatric head CT protocols that emerged from this process were subsequently installed and implemented on all of the CT scanners across the system. Average pediatric head CT doses declined 5% from the first to the second half of the year. In 2014, this process is being extended as we establish and implement standardized imaging protocols for adult head CT. Imaging Services radiation stretch goal for 2014 is that 90% of all head CTs will be performed with a dose of <2 mSv.

If you have any questions, please contact Keith White, MD, at keith.white@imail.org.
TeleCritical Care Overview

Intermountain Healthcare is in the process of implementing TeleCritical Care (TCC), a new program designed to improve our critical patients’ access to care and support our bedside staff in ICUs and EDs throughout the system.

The backbone of TCC is Intermountain’s Teleservices Technology, a secure interactive audio and video system that will soon connect intensivists and critical care nurses at the TCC Support Center, located at the Supply Chain Center in Midvale, with every critical care patient in our hospitals. The TCC team will serve as a real-time clinical decision support resource, and assist and collaborate with bedside staff as needed 24 hours a day, 7 days a week.

Clinical Leadership has prioritized the TCC program, with a goal to implement on an accelerated timeline, from now through the end of 2014. For more information about TeleCritical Care, please visit www.intermountain.net/tcc or www.intermountainphysician.org/tcc.

PROPOSED IMPLEMENTATION TIMELINE*

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*To be approved. Subject to change.

If you have questions or need further information, please contact Marni Chandler at marni.chandler@imail.org.
SCOR Study Begins March 3

The SCORE study – (Antimicrobial) Stewardship in Community Hospitals Optimizing Outcomes and Resources – begins March 3, 2014 for all of Intermountain’s smaller community hospitals. Antimicrobial Stewardship is a structured mechanism to optimize the use of antimicrobials within our hospitals and clinics. The need for Antimicrobial Stewardship has never been greater than it is today. With rising rates of antibiotic resistance in Utah, rising rates of Clostridium difficile infection and the lack of new antibiotics in development; Antibiotic Stewardship is necessary to maintain our current antimicrobial supply and protect our patients from multidrug-resistant pathogens. How to effectively implement Antimicrobial Stewardship programs in small, community hospitals is uncertain. This study will evaluate three different Antimicrobial Stewardship strategies in an attempt to optimize clinical outcomes while maximizing our resources.

The SCORE study is a cluster, randomized clinical trial evaluating three different Antimicrobial Stewardship programs. The study sites include all Intermountain hospitals except Primary Children’s Hospital, Intermountain Medical Center, LDS Hospital, McKay-Dee Hospital, Utah Valley Regional Medical Center, Dixie Regional Medical Center and TOSH. Starting March 3rd, all hospitals in the study will incorporate antimicrobial best practices. These include:

- Writing an indication for every antimicrobial ordered
- Converting IV antimicrobial to oral when clinical parameters are met
- Taking an “antibiotic timeout” on every patient

In addition to these best practices, many of the study hospitals will now restrict certain antimicrobials (daptomycin, linezolid, ceftaroline, imipenem/meropenem, tigecycline, and anti-mold agents) to specific clinical situations. Approvals will need to be obtained via your local pharmacist and/or in conjunction with Infectious Diseases. Pharmacists will also assist clinicians in prompt antibiotic de-escalation in patients with positive microbiologic cultures.

For more information on the changes occurring in your hospital, contact your pharmacy director or Eddie Stenehjem, MD (Infectious Diseases, Principal Investigator) at (801) 50-SCORE or score@imail.org.
Resources for Treating Patients with Chronic Pain and Low Back Pain

Intermountain Pain Services has established a Chronic Pain Registry, and is currently developing a Low Back Pain Registry, to help providers manage their patients with both conditions. This information is available for providers by request only.

Since there are not specific quality standards required for chronic pain, and due to the sensitive nature of some of the information, patient distribution spreadsheets are available for providers interested in reviewing their patients for possible case management. Individual provider reports include a primary care providers list of chronic pain patients that meet criteria during the last rolling 12-month period. Patient demographic information, utilization data, opiate and benzodiazepines, and other outcome information are part of the report. If you would like a copy of your Chronic Pain Report, please contact Linda Caston, Pain Services Data Manager, at linda.caston@imail.org.

In addition to the registries, the Primary Care Clinical Program together with Pain Management Clinical Services developed the Chronic Pain Care Process Model (Non-Cancer) CPM and the Low Back Pain LBP CPM to help primary care providers and case managers improve care and monitor patient outcomes for this population.

If you have questions, please contact Linda Caston at linda.caston@imail.org.
Catheter Associated Urinary Tract Infections

Catheter associated urinary tract infections (CAUTIs) are the most common hospital acquired infections in most US hospitals, causing over 500,000 infections annually. Currently, our rates of CAUTI exceed those recommended by CMS. Consequently, Intermountain Healthcare is working to reduce CAUTI rates in all facilities as its patient safety Board Goal in 2014.

The quickest, safest way to reduce CAUTIs is to remove the catheter at the earliest possible moment. Several initiatives aimed at catheter removal, safe catheter insertion and maintenance are underway. These include:

**Daily electronic list of removable urinary catheters:** List all patients with Foleys. Clinician assesses for medical necessity and may request physician order for d/c.

**Nurse initiated urinary catheter removal:** Several facilities (Urban North and Urban South regions) are trialing an order set for automatic nurse removal of the catheter at the earliest possible moment, once the indication for its insertion is no longer met.

**Insertion education:** Requires “pass off” of aseptic insertion technique.

**Urine sampling:** Education on indications (“odor” not an indication). Use of urinary catheters for collection not recommended as many are unnecessarily left in increasing patient risk.

**How can you help?**

Physicians can improve our CAUTI rates by:

- Being aware of all lines and catheters on a daily basis for hospitalized patients
- Ordering removal of the urinary catheter on the earliest possible day of hospitalization
- Not inserting a catheter if not needed, or if only for sampling urine
- Ordering a UA with reflex to culture (instead of urine cultures only) for hospitalized patients with new fever

If you have questions, please contact Kristin Dascomb, MD, at kristin.dascomb@imail.org.
Technology Assessment ("M-Tech") News at SelectHealth

The M-Tech is SelectHealth’s formal process for reviewing emerging healthcare 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:

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<tr>
<th>Technology</th>
<th>Date Reviewed*</th>
<th>Committee Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amyvid PET Scans in Alzheimer’s Disease</td>
<td>12-17-13</td>
<td>Deny as investigational. Current evidence has failed to demonstrate the clinical utility of Amyvid PET scans in patients with dementia. See Medical Policy #546</td>
</tr>
<tr>
<td>Percutaneous Treatment of Mitral Valve Insufficiency (e.g., MitraClip)</td>
<td>12-28-13</td>
<td>Cover consistent with FDA approved indication. Current evidence has demonstrated the efficacy and safety of this procedure in patients with degenerative mitral regurgitation who have severe disease and are not candidates for standard surgical mitral valve surgery due to excessive surgical risk. See Medical Policy #464</td>
</tr>
<tr>
<td>Breast Tomosynthesis</td>
<td>1-28-14</td>
<td>Cover as for both screening and diagnostic indications. Published evidence supports the use of breast tomosynthesis as having greater sensitivity and specificity in identifying breast cancer thus reducing recall rates and further interventions or delay in treatment of clinically relevant breast cancer. See Medical Policy #415</td>
</tr>
<tr>
<td>Cone-beam CT in Dental Applications</td>
<td>1-28-14</td>
<td>Deny as investigational and not medically necessary. Current evidence regarding cone-beam CT scans is limited and has failed to demonstrate efficacy, safety or cost effectiveness over standard dental imaging techniques. See Medical Policy #549</td>
</tr>
<tr>
<td>Closed Loop Insulin Delivery systems</td>
<td>1-28-14</td>
<td>Cover in Type 1 diabetic patients over age 8 who would otherwise qualify for a continuous glucose monitor based upon current hypoglycemic parameters only. Current evidence suggests the potential for improved health outcomes in appropriately selected patients, in particular, a decrease in nocturnal hypoglycemic episodes, with this system. See Medical Policy #548</td>
</tr>
</tbody>
</table>

If you have any questions, please contact Ken Schaecher, MD, FACP, CPC, at ken.schaecher@selecthealth.org.
In accordance with Centers for Medicare & Medicaid (CMS) guidelines, members on SelectHealth Advantage plans cannot be held financially responsible for services that are ordered by a contracted provider and completed by a non-contracted provider, even if the services are generally not covered for Medicare beneficiaries. CMS considers services ordered by a contracted provider to be “plan directed care.” As such, if the contracted provider orders a service from a non-contracted provider, CMS expects that the service will be covered at the member’s in-network benefit level. The only exception to this is if the member signs a pre-service denial, in which case the provider can bill the patient.

Similarly, if a contracted provider completes a service that SelectHealth Advantage denies, the member cannot be held financially responsible. Again, CMS considers services provided by a contracted provider to be “plan directed care.” Therefore, if a contracted provider completes a service that is not covered on the plan, the member cannot be asked to pay for more than their usual cost-share. The only exception to this is if the member signs a pre-service denial, in which case the provider can bill the patient.

Our preauthorization list, found here, can be used as a reference for providers to know what is covered by the plan. Common services that might not be covered include genetic testing from non-contracted labs and referrals to out-of-network providers who provide specialized services. If services such as these are ordered from a non-contracted provider, the member cannot be held financially responsible, regardless of whether the ordering provider is contracted or not.

Contracted SelectHealth Advantage providers are responsible to ensure appropriate utilization of health services and appropriate network referrals. SelectHealth Advantage cannot be successful without the engagement of contracted providers to provide cost-effective care.

SelectHealth Advantage is closely partnered with Intermountain Healthcare, and the financial risk for SelectHealth Advantage is also aligned with Intermountain. Therefore, it is imperative that contracted providers use in-network providers for referrals, and that they know and understand what is covered and what is not covered for SelectHealth Advantage patients. This is particularly important if contracted providers order services that may be out of network. If you have questions about coverage, call Member Services at 855-442-9900 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

If you have questions, please contact Dot Verbrugge, MD, at dot.verbrugge@selecthealth.org.
New Care Process Models (CPM’s)

In 2013, SelectHealth led the development of a new care process model around management of atrial fibrillation and revised the Chronic Kidney Disease CPM to reflect updated guidelines from KDIGO.

The recent CPMs created by Intermountain Healthcare and SelectHealth are taking a more practical approach to assist physicians in clinical decisions. Typically, the first several pages of the CPM include an algorithm and the remaining portion of the CPM explains in detail the algorithm and highlights important clinical tools.

The atrial fibrillation CPM, developed with guidance from Intermountain cardiologists, includes the practical management of new onset atrial fibrillation, the importance of stroke prevention using the CHA2DS2-VASc risk score, assessing the role of primary care physicians for monitoring of antiarrhythmic medications and the role for warfarin and the novel anticoagulants. It can be accessed here.

The CKD CPM discusses all aspects of chronic kidney disease. The CPM incorporated the new international guidelines, KDIGO: Kidney Disease: Improving Global Outcomes. The CPM provides the new criteria for CKD, the importance of albumin assessment for staging and progression, prevention of renal failure with contrast agents and the reevaluation of bone disease treatment in CKD. It can be accessed here.

Future Clinical Learning Days will highlight the important aspects in these CPMs.

If you have any questions, please contact Ken Schaecher, MD, FACP, CPC, at ken.schaecher@selecthealth.org.
The Annual Wellness Visit (AWV) (G0438 and G0439), is a yearly preventive visit for members on a Medicare plan that includes a personalized prevention plan. There is no out-of-pocket cost for the patient receiving an AWV. We strongly encourage Primary Care Provider (PCPs) to complete an AWV for every SelectHealth Advantage member each year.

The scope of the AWV differs from a routine annual physical. The following components, among others, are required to be completed and documented:

- Health Wellness Assessment — a form that should be completed by your patient
- Full medical history
- Screening for depression
- Functional assessment — ability to perform ADLs
- Physical assessment — height, weight, and blood pressure
- A wellness plan, which includes these elements:
  1. Appropriate health screening tests
  2. Interventions list recommended for the patient’s unique conditions
  3. Health advice, including referrals for health education, if indicated

More details can be found on the CMS Quick Reference Guide here.

Effective January 1, 2014, preventive exams (CPT 99381-99397) are also covered for SelectHealth Advantage patients with no cost share to the patient. These exams require completion and documentation of the following:

- Age and gender appropriate history
- Examination
- Counseling/anticipatory guidance/risk factor reduction interventions
- Ordering of appropriate laboratory/diagnostic procedures

When all of the components of both the AWV and the preventive exam are completed and documented, SelectHealth Advantage will cover an AWV code and a preventive exam code at no cost share to the patient. If both codes are billed, documentation must include an evaluation and assessment of all chronic medical conditions, as well as notation of the current treatment plan for each condition.

If a patient’s condition warrants a medical problem being addressed more fully, and the preventive exam code is not appropriate to bill with the AWV code, the PCP can bill the appropriate E&M code along with the AWV. In this case, a co-pay will apply for the visit. However, a provider cannot receive payment for an AWV, a preventive exam, and an E&M on the same date of service.

If you have questions, please contact Dot Verbrugge, MD, at dot.verbrugge@selecthealth.org.
In late January the ICD-10 Provider Education committee began distributing instructions for accessing compliance training materials for providers in department meetings.

The compliance training materials were created by Precyse University. To gain access to this content, email the following information to ICD10@imail.org:

- Your full name
- Your credentials (MD, DO, FNP, etc.)
- Your specialty
- Your Intermountain user name (for validation only)

You will receive a response email with instructions for accessing the content. Some titles will be pre-populated in the system for you. All providers are encouraged to begin with the ICD-10 and the Physician content and then any titles pertinent to his or her specialty.

You can find more information about the ICD-10 Migration Project by typing ICD10 in the browser of any Intermountain owned computer or through the physician portal.

*The primary purpose of this program is to provide compliance training to those who are involved in the practice of medicine in Intermountain Healthcare’s service area.

If you have any questions, please contact Ken Marrott at ken.marrott@imail.org.
Patient Status Order and Physician Certification

Intermountain will soon be implementing an electronic Patient Status Order (PSO) form module in Help2, which will help us meet CMS inpatient payment requirements announced in October 2013.

This Help2 module is slated to be developed and piloted at McKay-Dee Hospital by April and will roll out rapidly across the system after testing. When available, the module will standardize the workflow process of initiating and completing a PSO form, enhance completion compliance, and reduce lost revenue due to invalid PSO forms or Physician certifications.

If you have questions, please contact Masood Safaee, MD, at masood.safaee@imail.org.
Get “FITT” and Strengthen Your Muscles

By: Liz Joy, MD, MPH

When we think of “exercise”, we typically think about aerobic exercise, such as brisk walking, jogging, swimming, etc. However, the Physical Activity Guidelines for Americans recommend that adults get not only a minimum of 150 minutes per week of moderate intensity aerobic activity, but also participate in muscle-strengthening activities that are moderate or high intensity, involving all major muscle groups on 2 or more days a week. There are many health and wellness benefits of muscle strengthening.

1. Weight maintenance – strength training, by increasing lean body mass can lead to a significant increase in metabolic rate (up to 15%).
2. Healthier state of mind – strength training works as well for some as anti-depressant medication. A strong body leads to a strong mind.
3. Improved balance and lower likelihood of falls – studies have demonstrated up to a 40% reduction in falls following a simple strength and balance intervention in older adults.
4. Bone strengthening – Bone responds to load by building more bone (Wolff’s law).
5. Arthritis relief – stronger muscles support and protect osteo-arthritis joints, thereby preventing further damage and reducing pain.
6. Improved blood glucose control – In those with diabetes, muscle-strengthening leads to improvements in blood sugar control.

The FITT principle (Frequency, Intensity, Time, Type), can be used to describe a muscle strengthening exercise prescription.

- **Frequency:** Ideally muscle-strengthening exercises are performed 2 times per week
- **Intensity:** Exercises that are moderate to vigorous intensity will lead to improvements in muscle strength, tone and mass. Typically, if you can lift a weight more than 12 times with relative ease, it is probably too light. If you are unable to lift it at least 6-8 times, it is probably too heavy
- **Time:** While there are no specific recommendations regarding time spent performing muscle-strengthening exercises, a total body workout can be performed by most adults in 30-60 minutes depending on fitness level and experience.
- **Type:** This is where it gets interesting. Opportunities to incorporate strength training have exploded! CrossFit is an example of this wave. Started in 2000, there are now an estimated 7000 CrossFit programs nationwide. The 7 Minute Workout is another example. A bit of a misnomer, in that it is ideally performed 3 times (so a 21 minute workout), it requires only a floor, a chair and a wall to achieve a total body strength-training workout. The 7 Minute Workout app is a free download to smart phones.

Whether you go to a gym, follow along with an exercise video, or use an app, there are many more options to incorporate strength training into your fitness regimen. The benefits of this type of exercise are significant, and become even more important as we age.

If you have any questions, please contact Liz Joy, MD, MPH, at liz.joy@imail.org.