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
The work on iCentra continues to move forward. Physicians, nurses, business staff, Information Systems and Cerner employees are working diligently to make this a successful collaboration that provides immediate tangible benefits to our clinical, financial and business operations. While there are aspects of the project that are challenging and require additional attention, everyone is striving to make this a successful project for Intermountain Healthcare and the patients who entrust their care to us.

“DISCOVER ICENTRA” VIDEOS
A series of videos are available on intermountain.net and the physician portal to help build general familiarity with the iCentra system. These videos are organized by venue and role and provide a general overview of the documentation and business workflow. The tools and functionality featured may change as we gather feedback from users, incorporate Intermountain Healthcare’s clinical and business content knowledge and apply new innovations. Click here to access the videos.

TRAINING AND EDUCATION
While many individuals will want to see the new iCentra system soon, the actual training will take place six weeks before a region goes live on the new system so that learning happens closer to when teams will start using the system on a day-to-day basis. This will maximize the value of the training and help users retain more knowledge. Additionally, all employees will have access to trainers and super users (onsite teams who have expert knowledge of iCentra) for support during the first few weeks after go live.

To learn more visit intermountain.net and search for “iCentra” or email your questions to iCentra@imail.org.

GO LIVE WHEN TEAMS ARE READY TO ENSURE PATIENT SAFETY
The iCentra implementation dates for each region are somewhat fluid as leaders are focused on a task-oriented implementation instead of a time-oriented implementation. A task-oriented implementation means that every six weeks teams conduct a “milestone completion” check-in with all the various project teams to assess whether they have completed project goals and benchmarks required to pass the milestone. Examples of tasks that are currently being worked on include data migration, system interface construction (clinical and revenue cycle), diagnosis-specific order sets and nursing documentation by unit.

If all milestones are met, then all project teams move forward to the next phase, taking on the next set of tasks that must be completed for the implementation. If the milestones have not been met, additional resources are added to close the gaps and timelines are adjusted accordingly.

This approach to determining when teams will begin using iCentra will help us better ensure patient care and safety, maintain continuity of business operations, and minimize the time and risk of the transition period.

URBAN SOUTH REGION WILL BE THE NEXT TO USE ICENTRA
The Urban South Region hospital leadership and the Timpanogos Region Medical Group leadership announced that all Medical Group clinics in Utah County; Utah Valley Regional, American Fork Hospital and Orem Community Hospital; and affiliated physicians using HELP2 will be the next to start using the iCentra system.

This announcement started the 5-7 month planning process for transitioning to iCentra. Teams will likely start using iCentra a couple months after the hospitals and clinics in the Urban North Region begin using it. The final go-live date will be determined once the region leadership knows that all teams will be adequately prepared and trained.

If you have questions, please contact Mark Briesacher, MD, at mark.briesacher@imail.org.
At Intermountain, we help people live the healthiest possible lives. Shared Accountability is our approach to achieve three important goals: 1) the best health for those we serve; 2) the best care for patients; and 3) affordable and sustainable costs. This approach helps us fulfill our mission and our vision to be a model healthcare organization, providing extraordinary care in all its dimensions.

Our three key strategies include redesigning care, engaging patients, and aligning financial incentives. Shared Accountability involves everyone in improving care: physicians, patients and health plan members, healthcare organizations, payers, and the community. Here are current highlights:

**PHYSICIAN PAYMENT MODEL**
Everyone benefits from high-quality, high-value care. Intermountain is working with physicians to develop a model that rewards hospitals and physicians for providing the right care rather than just more care. A beta physician payment model has been underway since fall 2013. This includes a small number of patients at 11 Medical Group and four affiliated clinics. The model pays for care provided and also includes payment for meeting quality, service, and total cost of care goals.

Tools developed for the model give physicians data to support care decisions. Clinicians can see current performance and feedback on service, quality, and total cost of care goals. They can also see overall population health metrics, patient risk scores, and variances in how care is provided.

Over the past several months, physicians participating in the beta have been highly engaged in sharing feedback. Working with these physicians, we are learning from and evaluating the model structure, measurements, and data tools. We will consider modifications as we prepare for future expansion.

**PHYSICIAN NETWORK**
Intermountain and SelectHealth are developing a new physician network for a commercial Shared Accountability health plan product. The focus is on high-value healthcare. Physicians will help lead this effort by providing evidence-based care and by helping patients become more engaged in their care. The focus will be similar to the beta and will include a payment model rewarding physicians for delivering evidence-based care and engaging patients.

**CARE MANAGEMENT**
Intermountain has launched two care management pilots: 1) Personalized Care Clinic, operated by the Intermountain Medical Group on the Intermountain Medical Center campus; and 2) Community Care Management through hospital case management teams in the Urban North and Southwest Regions.

Combined, these pilots serve about 1,600 patients with multiple and/or complex health concerns.
Caregivers help patients address healthcare needs and social or economic challenges that can make controlling their health overwhelming.

**SHARED DECISION-MAKING**

Pilots of Shared Decision-Making tools are moving forward at select Intermountain Medical Group clinics, with plans for future expansion. These tools promote dialogue between patients and providers. They empower patients to make health decisions that are best aligned with their values and goals.

**PERSONALIZED PRIMARY CARE/ADVANCED PRIMARY CARE**

All Intermountain Medical Group primary care clinics are participating in this patient-centered model of healthcare delivery. Implementation by affiliated physician clinics should be complete in 2015. With this approach, patients have more personalized care from their primary care physicians to manage their specific health needs. Working with care managers, patients have enhanced support through the full spectrum of appropriate care.

For more information about our Shared Accountability strategy, please contact Brent Wallace, MD, at brent.wallace@imail.org.
It Happened Here: Hospital-acquired Pressure Ulcers

Preventing pressure ulcers is an important patient safety issue. It is also a reportable event if the pressure ulcer is acquired during hospitalization. The stories below all happened at an Intermountain facility.

**ADULT SCENARIO - SURGERY PATIENT**
A 71-year-old male presented with sudden aortic dissection requiring intervention. He also had ischemia to right lower extremity requiring emergency fem-fem bypass. He coded for a short time. His course was further complicated by Klebsiella pneumonia, later colon removal, placement of ileostomy, sepsis and a tracheostomy. He was very unstable and unable to be turned regularly. After several days, a Stage III pressure ulcer was found on his coccyx. The Wound Care Team was notified, and treated the patient. They also discovered an un-staged pressure ulcer on his left heel.

**PEDIATRIC SCENARIO- OXYGEN DEVICE**
A young child with chronic respiratory failure was admitted to the medical unit on BiPAP. Three days prior to discharge, a wound consult was obtained for a Stage II pressure ulcer on the forehead and Stage III pressure ulcer on the bridge of the nose caused by the BiPAP mask, which the parent had been tightening.

As a provider it is your responsibility to document the presence of pressure ulcers on your patients. The Center for Medicare and Medicaid Services does not allow reimbursement for hospital acquired pressure ulcers of stage 3 or greater. Many other payers have the same reimbursement rule.

**Reminder:** All information contained in the above scenarios is confidential and physicians should not share with patients and/or families.

If you have questions, please contact Jeanne Nelson at jeanne.nelson@imail.org.
Online consumer rating sites are quickly gaining popularity, especially those focused on physician ratings and reviews. Recent studies prove that these sites can influence patients on which physicians they choose to see. A study by the Journal of the American Medical Association showed that among those who sought online physician ratings in the past year, 35 percent reported selecting a physician based on good ratings and 37 percent had avoided a physician with bad ratings (SOURCE).

With this in mind, here are some ideas and strategies to use when it comes to physician rating sites:

- Physicians should differentiate opinion from factually false statements on these sites. If necessary, write a diplomatically worded note to the website’s administrator, asking the site to consider whether a particular post complies with its terms of use policies.
- Do not panic over an isolated negative review. You should make most patients happy, but the public understands you cannot make everyone happy.
- Contact site posters directly if possible. Acknowledge the patient’s issue and offer to rectify the situation if possible.
- Consider developing or utilizing existing social channels or other means for seeking feedback from patients, especially those who have had a positive experience.
- Remember that an apology in appropriate situations can go a long way.
The CV Clinical Program continues to have great successes in many areas:

- So far this year, 100% of patients presenting to our heart hospitals with a STEMI have experienced door to balloon time of less than 90 minutes. In addition, in the urban central region, this perfect timeliness has also been achieved for patients transferred in from the four surrounding hospitals.

- We are working on updated lipid management guidelines based on the recent AHA standards which should be available next month.

- We have worked with a multidisciplinary team to create very informative atrial fibrillation management guidelines that are available on our CV website, which also features many guidelines and appropriate use references all clinicians can review.

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

As a follow-up to last quarter’s report:

• The Diabetes Prevention Program (DPP) has enrolled 300 patients to date, and participants have achieved a 5% weight loss with none of the participants being diagnosed with diabetes during this phase.

• The Hypertension Care Process is now complete along with all of the associated education materials, and clinical teams are piloting the reporting tools.

• The Choosing Wisely® dashboard continues to grow. In addition to evaluating the rate of imaging for patients with low back pain, the number and types of labs ordered at well exam visits, antibiotic utilization, cervical cancer screening and HPV testing, we will be adding additional measures such as testosterone measurement with two serum tests, on two separate days, prior to implementing therapy later this month. Other health systems are reaching out to our team to learn from our experience with our Choosing Wisely® dashboard.

To support transforming dialysis services at Intermountain, The Primary Care Clinical Program will be implementing a new governance structure to manage the Chronic Kidney Disease (CKD) patient population. This new and innovative approach will contribute to Intermountain’s mission to be a model healthcare system.

The Intermountain Lower Respiratory Tract Infection team has announced an important update for the treatment of outpatient pneumonia confirmed by radiographic imaging. In the last 18 months, macrolide resistance (azithromycin, erythromycin, and clarithromycin) among Streptococcus pneumonia isolates has increased. This likely results from “ZPAK” prescribing for chest colds and sinus infections, and perhaps under-vaccination with PCV 13 (Prevnar) in children. Children vaccinated with PCV 13 have greatly reduced carriage of most multi-drug resistant pneumococcal strains. Pneumococcus remains the most common and deadly bacteria that causes pneumonia. Fortunately, pneumococcal activity remains 100% for ceftriaxone and amoxicillin (clavulanate in Augmentin contributes nothing against streptococci). Azithromycin remains effective against other community respiratory pathogens.

For treatment of confirmed pneumonia, we now recommend Doxycycline monohydrate 100 mg bid PO for 7 days, or Azithromycin 500 mg PO daily for 3 days plus Amoxicillin 1000 mg PO tid for 7 days. Doxycycline monohydrate is 1/5th the cost of the other compound and has less GI toxicity. Levofloxacin remains an effective antibiotic for outpatients with confirmed pneumonia, but should be reserved for outpatients with moderate disease, especially those with recent antibiotic exposure.

If you have questions, please contact Sharon Hamilton at sharon.hamilton@imail.org.
Women and Newborn Clinical Program

Women
In view of the fact that the FDA recently issued a warning and ACOG followed up with a statement on laparoscopic power morcellation of uterine fibroids, the Intermountain Healthcare GYN Development team has evaluated the current literature on this topic. (Also noted was the fact that Ethicon has recently removed their power morcellation devices from the marketplace.)

The team concluded that extreme caution should be exercised when considering the use of laparoscopic power morcellation for fibroids and that detailed informed consent is of the utmost importance. Also, the following four ACOG preoperative considerations need to be taken into account:

1. Increasing age. The incidence of uterine cancers, particularly leiomyosarcoma, increases with age. Women younger than 35 years seem to have the lowest incidence. The highest incidence of uterine sarcoma is in women over the age 65.
2. Menopausal status. Women who are perimenopausal or postmenopausal, particularly postmenopausal women with symptomatic fibroids, are at increased risk of occult malignancy.
3. Uterine size or rapid growth. Rapid growth or large leiomyomas may increase concern for the presence of an occult malignancy, but have not been shown to be predictive of leiomyosarcoma.
4. Certain treatments or hereditary conditions. Women who have undergone certain treatments (e.g., tamoxifen or pelvic radiation) or have certain hereditary conditions (e.g. Lynch Syndrome or hereditary leiomyomatosis and renal cell cancer) are at an increased risk of a uterine malignancy. In these cases power morcellation should not be used.

This information is taken from the ACOG Power Morcellation and Occult Malignancy in Gynecologic Surgery Special Report.

Newborns
As many of you know, Utah will begin Critical Congenital Heart Defects (CCHD) screening using pulse oximetry in October, 2014. This is a legislative mandate that requires that all newborns in the state of Utah be screened for CCHD following birth. Those newborns who fail the oximetry screening will need to have an echocardiogram to determine whether they have a critical congenital heart defect.

Intermountain intends to start this screening in July for newborns born or cared for in our larger hospitals that have ready access to neonatal echocardiography. The University of Utah Division of Pediatric Cardiology is currently working with the Utah Department of Health to put in place a program to facilitate follow-up of failed screens in our rural hospitals in Utah, including Intermountain facilities. A CCHD Screening Implementation Toolkit is expected to be released by the Department of Health in June. More details will follow via email from the W&N Clinical Program later in June and will be available here.

If you have questions, contact Teri Kiehn at teri.kiehn@imail.org.

The Regional Education Consultants would like to share the following fact sheet about Neonatal Abstinence Syndrome (NAS) Education:
NAS Neonatal Abstinence Syndrome Education #15917
(women and newborn)
Clinical Program and Service Line Updates

Intensive Medicine Clinical Program

Early identification and prompt treatment of patients presenting with sepsis continues to be a top priority for 2014. Past experience has shown that when compliance to an evidenced based sepsis bundle increases, mortality decreases. Intermountain has successfully decreased mortality to around 9% for patients with severe sepsis or septic shock that are admitted directly to the ICU from the emergency department (ED). Mortality for patients who develop severe sepsis on acute care inpatient settings and transfer to ICU can be as high as 40%. The IMCP believes the greatest impact on hospital mortality for the inpatient population can be made by providing education for early identification of sepsis and implementation of the sepsis bundle on acute care floors while continuing to improve the compliance of the sepsis bundle for patients admitted from the ED to the ICU. The following goals have been set for 2014:

- Achieve 95% compliance to a computerized training module
- Increase in sepsis bundle compliance from 24% to 40%
- Relative decrease in hospital mortality in the board goal population by 10% (from 17% to 15.3%)

In connection with bundle compliance, important improvements in patient outcomes and adherence to our care process models can be achieved through the use of standardized electronic provider order sets throughout our system. Over the past year much effort has been focused on the creation of the following standardized order sets surrounding the care of sepsis:

- CPOE Sepsis Admission Order Set
- CPOE Sepsis ICU Admission Order Set
- CPOE Sepsis Limited Order Set
- CPOE Sepsis ICU Limited Order Set

More detail on the severe sepsis and septic shock bundle can be found [here](#). More detail on the sepsis order set can be found [here](#).

If you have any questions, please contact Terry Clemmer, MD at terry.clemmer@imail.org or Nancy Nelson at nancy.nelson@imail.org.
**Growth of Structured Reporting in Imaging Services**

Intermountain affiliated and employed radiologists are working actively to transition away from free-form individual dictation of imaging studies to standardized structured reporting. The use of voice recognition technology facilitates this by allowing for the creation of templates that can be automatically loaded at the time of dictation and form a structure upon which reports are generated. The transition process will be gradual, but clinicians will notice increasing uniformity/consistency of imaging reports over time.

There are several key benefits for moving to the structured format:

1. Improved completeness and uniformity in content of the report
2. Improved format uniformity
3. More consistent reporting of measurements
4. Facilitation of storage of discrete data into the EMR for use in medical decision support and other computerized processes

Creation of optimal structured reports is a multidisciplinary process. Teams of radiologists are working actively with their clinical colleagues in other specialties to create the appropriate structures. Active projects are underway in pediatric imaging, musculoskeletal, and chest imaging. The collaborative effort of clinical colleagues in building these standardized structures is welcomed and greatly appreciated.

If you have any questions, please contact Keith White, MD, at keith.white@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). These data are 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 CTs system wide. In 2013, pediatric radiologists piloted a process to conduct 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 in 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 questions, please contact Keith White, MD, at keith.white@imail.org.
Pediatrics Update

A recent five-year review of pediatric adverse events reported to the FDA does not reveal new information but is a reminder of less commonly known side effects. Here are a few highlights:

1. Three ADHD medications, methylphenidate (Ritalin, Concerta, etc), lisdexamfetamine (Vyvanse) and atomoxetine (Strattera), do have a potential for causing or worsening psychiatric effects such as aggression, suicidal behaviors and hallucinations. While a suicidal behavior warning only appears in the atomoxetine labeling, it has been reported in all three. A new warning from the FDA MedWatch program adds priapism as a potential risk for methylphenidate which deserves a conversation with male patients.

2. Ibuprofen had an unexpectedly large number of cases of severe skin reactions, including Stevens-Johnson syndrome. The FDA MedWatch issued a recent warning about this based on this review.

3. Montelukast (Singulair) continues to have reports of psychiatric effects such as suicidal behaviors, aggression and depression.

In addition, the last few years have seen a purposeful manufacturer reduction in the acetaminophen content of combination medications. The most recent one is the brand name, Lortab Elixir. They are changing the hydrocodone content also while the more often used generic versions are not. The brand Lortab will be 10 mg hydrocodone per 15 mLs rather than the traditional 7.5 mg per 15 mLs. The inpatient pharmacies have committed to only stocking the generic version and recommend caution in outpatient prescriptions.

If you have questions, please contact Carolyn Reynolds at carolyn.reynolds@imail.org.
Choosing Wisely® for Low Back Pain

Intermountain’s Pain Management Services developed low back pain guidelines, clinician support and patient education with two goals in mind: To support PCP care of patients with low back pain and to eliminate unnecessary procedures. These goals help support the Primary Care Clinical Program Choosing Wisely initiative, which strives to reduce unnecessary healthcare.

Low back pain materials include patient and provider education and tools:

1. Low Back Pain Care Process Model (CPM): Provides guidance for primary care providers on the diagnosis and treatment of acute and chronic low back pain to drive consistent and appropriate treatment.

2. Low Back Pain Best Practice Flash Card: Provider tool that summarizes key decision points or notes from the CPM as a quick reminder.

3. Low Back Pain Fact Sheet: Educates patients about the causes of acute low back pain, how to prevent and relieve it, when to see a doctor and myths and facts about low back pain — including the fact that imaging isn’t always necessary.

4. Spinal MRI Order Form: Supports appropriate imaging orders by including a list of appropriate indications for MRI; also helps identify medical necessity and provide pre-authorization documentation.

These guidelines and processes help reduce inappropriate imaging, which also reduces out-of-pocket costs for patients. They also help clinicians communicate with patients about why imaging and other procedures may be unnecessary. You can find these materials on the Primary Care or Pain Management Services pages of intermountain.net, or you can order copies from i-printstore.com.

If you have any questions, please contact Bridget Shears at bridget.shears@imail.org or Linda Caston at linda.caston@imail.org.
Acute respiratory infection is a leading cause of outpatient visits and hospitalization especially in winter and spring. Most of the acute respiratory infections are due to viral agents, with primary or secondary bacterial infections occurring less frequently. Without definitive diagnosis, patients with viral infection are more likely to receive unnecessary antibacterial agents. Therefore, laboratory tests providing accurate, timely determination of the infectious agents associated with viral respiratory disease are important.

Intermountain’s Laboratory Services has recently implemented a new technology, FilmArray, for the rapid identification of respiratory viruses. The FilmArray is an FDA-cleared multiplex polymerase chain reaction (PCR) test that integrates sample preparation, amplification, detection and analysis all into one system. It requires just a few minutes of hands-on-time and its turnaround time is just about an hour, giving you faster results which may lead to better patient care.

The FilmArray Respiratory Virus Panel detects 15 viral agents in respiratory specimens using PCR. The average turn-around-time (TAT) is 1.4 hours, in contrast to 7 hours documented previously, when samples were tested using direct fluorescence assay (DFA). During the study period, rhinovirus was detected in 20% and coronavirus in 6% of samples using FilmArray; these viruses would not have been detected by DFA.

Although current treatment for respiratory viral infection is limited to influenza A and B, detection of other viral agents is valuable because clinical suspicion of viral respiratory tract infections can be confirmed, additional work-up and therapy can be avoided, and clinicians, patients and families can be reassured.

For the DFA testing performed in previous years, nasal wash was the preferred specimen type. The collection of nasal wash sample results in the generation of aerosols, and therefore procedure rooms had to be closed for 30 minutes before the rooms could be used again. Replacing nasal wash with mid-turbinate swab increased efficiency by eliminating the 30 minute room closures.

FilmArray testing is currently being offered by the Laboratory Service at Primary Children’s Hospital, McKay-Dee Hospital, Dixie Regional Medical Center, Utah Valley Regional Medical Center and the Central Laboratory on the IMED campus.

If you have questions, please contact Steve Mikkelsen at steve.mikkelsen@imail.org.
Behavioral Health Update

Review of Involuntary Civil Commitment Laws:
What is a Blue Sheet, a Pink Sheet, and a White Sheet?

Every day at Intermountain Healthcare facilities, we provide services for patients who may need to be held for a mental health evaluation. If the patient is deemed to be a danger to themselves or others because of a mental illness, they can be held under involuntary commitment laws. These laws are specifically defined legal processes, and it is essential that all of us understand the requirements and limitations of the provision of those laws.

Utah, like every other state, has its own laws establishing criteria for the use of involuntary civil commitment for both adults and children. Utah’s involuntary commitment laws state that a person who is a substantial danger may be held for involuntary evaluation. Substantial danger is defined (Utah Code 62A-15-602) as a person, who by his or her behavior or due to mental illness, is at risk or exhibits a strong possibility to:

1. Attempt suicide
2. Inflict serious bodily injury to himself or herself
3. Suffer serious bodily injury due to an inability to provide basic necessities of life
4. Cause or attempt to cause serious bodily injury or engage in harmful sexual contact

Both adults 18 years and older and children under 18 may be temporarily, involuntarily committed.

The 3 types of Involuntary Commitment forms are commonly known as:

1. BLUE SHEETS - these forms are completed and signed by a licensed Utah physician. They commit the patient to a specific designated facility for the purpose of receiving a complete mental health evaluation. These blue sheets expire after 24 hours. They may be cleared by a licensed physician. LINK
2. PINK SHEETS - these forms are generally completed by a police officer or mental health-designated examiner and are for the purpose of transporting the patient to a designated mental health facility to allow for a mental health evaluation. LINK
3. WHITE SHEETS - these forms are petitions to the court, signed by a licensed physician after a mental health evaluation has been completed. These petitions are reviewed and signed by a judge and allow the facility to hold the patient until a formal commitment hearing can be held.

Important points to remember:

1. A person on any form of involuntary commitment does not lose any of their civil rights. The patient can sign contracts, buy and sell items, vote, and make choices about their medical care and treatment. He or she can refuse medications or lab tests. If medications or other treatment are deemed necessary to treat the mental illness, a legal hearing must be held and a separate order must be given.
2. Informed consent is not needed during a life-threatening medical emergency which necessitates medical treatment to preserve the life of the patient or to prevent a serious impairment of the patient’s health. Treatment should be given and the justification for treatment should be carefully documented in the patient’s chart. Care provided during a life-threatening medical emergency can be provided whether or not the patient is on an involuntary hold.

If you have questions, please contact Mark Foote, MD at mark.foote@imail.org.
Pharmacy Services Update

Intermountain Pharmacy Services has been transforming over the past year with the goal of providing fully integrated pharmacy services across the care continuum. There are several new services that have been or are being created and a few things that you can do to help us better serve our patients.

Intermountain Home Delivery Pharmacy
On January 2, 2014, Intermountain Pharmacy Services officially launched the Home Delivery Pharmacy. In the first five months, the Home Delivery Pharmacy has delivered nearly 6,000 prescriptions to the homes of SelectHealth patients. To enroll in Home Delivery Pharmacy, visit www.intermountainrx.org. Additionally, later this year a “mail at retail” option will be available to all patients who fill prescriptions in our community pharmacies. Best of all, prescriptions can now be requested using our website or Intermountain’s Health Hub app on your Apple or Android device, for either home delivery or to be picked up at the pharmacy. Health Hub is Intermountain’s official “container app” for consumers and patients. One of the nine apps contained in Health Hub is specific to pharmacy. In addition to listing the community pharmacy locations, patients and family members can refill prescriptions and check the status of their orders. To download the applications, visit App Store link of iOS phones or Google Play link for Android phones.

In-room Discharge Delivery and Medication Counseling Service
To ensure patients go home with their medications in hand and are properly counselled, Intermountain Pharmacy Services currently offers in-room discharge (or bedside) delivery and medication counseling at IMED, Primary Children’s, LDS, Cottonwood Apothecary, Riverton/Southridge, Utah Valley, American Fork and Sevier Valley. By June 30, 2014, this service will be available at our Watson Dixie, LTD, Budge, Sandy and Orem community pharmacy locations. Year to date, over 15,000 prescriptions have been delivered through this service. Please write discharge orders as soon as possible to promote timely discharges for patients.

Multiple-Dose Medications for Patient Discharge Procedure
In order for patients to take home the multi-dose medications (e.g., inhalers, creams, eye drops) they received during their inpatient stay, a current discharge prescription or medical record order must be written. In addition, the medication must be properly labeled and prepared by a pharmacist in accordance with state and federal laws for use outside of the hospital. To promote medication compliance after discharge and to decrease waste, please ensure that you prepare the needed documentation so that we are able to provide these medications to our patients.

Intermountain has 25 Community Pharmacies Ready to Serve You and Your Patients
Intermountain Healthcare owns and operates 25 community pharmacies. The pharmacy team members in these pharmacies are eager to provide you and your patients with high quality pharmaceutical care.

If you have questions, please contact Nannette Berensen at nannette.berensen@imail.org.
CRE, CRAB and Isolation

Multi-Drug Resistant Organisms (MDRO) can infect our patients, be transmitted easily from person to person and by nature of their antibiotic resistance be difficult to treat. We have dealt with antibiotic resistant Gram negative rods, methicillin resistant Staphylococcus aureus (MRSA) and vancomycin resistant enterococcus (VRE) for many years. Fortunately each challenge has been met with development of new, effective antibiotics. Additionally, the carbapenem class of antibiotics remained active against most of the resistant gram negative rods. Recently, carbapenem resistant Enterobacteriaceae (CRE) and carbapenem resistant acinetobacter (CRAB) have arisen as a new threat to our patients and our healthcare system and to the global health community. These organisms are resistant to antibiotics of “last resort” and there are currently very few treatment options.

Enterobacteriaceae, as you may remember, are a family of organisms that naturally colonize the human GI tract. The most commonly encountered types of CRE are Klebsiella species and E. coli, however we have detected the resistance gene in other Enterobacteriaceae. CREs have most commonly been associated with hospitalization and receipt of care in long term care facilities. Some of the CREs are linked to receiving medical care in other parts of the world and are detected when patients return home and become ill. When CRE and CRAB cause infections the mortality rate has been reported as high as 40%. Once CRE and CRAB are detected in a community or hospital it can be very difficult to eradicate. Within Intermountain we have seen several patients both colonized and infected with these severe MDROs. It is in the best interest of our patients and our system to limit their spread.

The following principles are taken from a document published by the CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). We wish to remind our medical staff of these principles so that we can gain your support in implementing these measures when a case of CRE is encountered in your facility:

1. The Microbiology Labs at Intermountain Healthcare have developed protocols to better detect CRE and CRAB. As soon as CRE or CRAB has been identified, laboratory staff will immediately alert members of our infection prevention teams and by doing so our infection prevention committees.

2. Once a patient with CRE or CRAB is identified he/she should be immediately placed on CONTACT ISOLATION and 1:1 nursing care should be established. In this situation, use of gloves and gowns upon entering the patient room is MANDATORY regardless of whether patient contact is intended. In some Intermountain Healthcare facilities, this is known as ENHANCED CONTACT ISOLATION. In others this is stringent enforcement of contact isolation. Hand hygiene before and after with our alcohol based sanitizer is part of contact isolation.

3. It should be remembered that the use of antibiotics is directly correlated to development of resistance. One of our strongest control measures for CRE and CRAB is the efforts of all of us to prevent spread of these organisms in healthcare facilities, use antibiotics wisely and limit use of antibiotics of last resort. Our antibiotic stewardship programs continue to help in this effort.

Currently, within our system we see several of these infections every year. They remain sporadic and rare. Sadly, we have seen a recent increase in these infections and want to act now to help educate our medical staff to the important control measures we will be using to respond to these problematic organisms.

If you have questions, please contact Joan Golden at joan.golden@imail.org.
Reverse Isolation No Longer Applicable for the Typical Neutropenic Patient

Since the year 2000 “reverse isolation” has been removed from the Centers for Disease Control (CDC) isolation guidelines and is no longer considered best practice. The practice of reverse isolation commonly causes confusion, and anxiety for patients, families and healthcare workers. Despite this physicians continue to order neutropenic or reverse isolation for their immunocompromised patients.

In the majority of circumstances, the CDC standard isolation guidelines are sufficient for protection of most immunocompromised hosts, if they are followed strictly and are accompanied by good hand hygiene.

Hand hygiene has been the focus of extensive research recently, summarized in the CDC’s Guideline for Hand Hygiene in Health-Care Settings. Adherence to published guidelines is especially important when dealing with the immunocompromised host.

Reverse isolation has been extensively studied in the granulocytopenic patient. Most studies that showed improved outcomes for patients in reverse isolation did not adequately control for other variables. When careful hand hygiene is utilized and food and supplies are handled appropriately, reverse isolation offers no additional benefit in reducing infection in the typical granulocytopenic patient, so for the typical neutropenic patient, there no longer appears to be a role for this modality.

This practice should be abandoned for all but a select group of patients in specialized facilities. Recent CDC Isolation Guidelines recommend the use of a protective environment for allogeneic hematopoietic stem cell transplant patients. Components of the protective environment include such engineering designs as:

- High-efficiency particulate air (HEPA) filtration of incoming air,
- Directional air flow with positive room air relative to the corridor,
- Well-sealed rooms to prevent flow of air from the outside,
- Ventilation to provide more than 12 air changes per hour,
- Scrubbable surfaces rather than upholstery and carpet, and
- Routinely cleaning crevices and sprinkler heads.

Intermountain facilities that currently have Protective Environmental Rooms include Dixie Regional Medical Center and LDS Hospital.

For the typical neutropenic patient standard precautions will be implemented.

References taken from Association of Professionals in Infection Control (APIC) Text Online 2014.

If you have questions, please contact Joan Golden at joan.golden@imail.org.
SelectHealth has recently launched an initiative called Every Patient, Every Year to encourage members to see their Primary Care Provider (PCP) for preventive services every year. The reason for this initiative is threefold:

1. To improve the health and wellness of the SelectHealth population
2. To improve quality indicators for HEDIS and Medicare Star ratings for SelectHealth Advantage
3. To accurately document and code chronic medical conditions for risk adjustment purposes

As part of this initiative, SelectHealth will identify members who have not been seen or who have not had their chronic conditions addressed in the last year and send their information to the clinic provider on record as the PCP, asking them to schedule an appointment with their patient to address their preventive care needs and to evaluate, document and code all chronic medical conditions. In some cases, SelectHealth will also send the member a reminder letter to see their PCP. In addition, SelectHealth will continue to communicate preventive benefits to members and encourage them to take an active role in their own health and wellness.

For SelectHealth Advantage (Medicare) members, SelectHealth now covers a preventive exam (CPT codes 99385-99387 and 99395-99397) with no out-of-pocket cost for the patient. A Preventive Exam can be combined with an Annual Wellness Visit (AWV) (HCPCS codes G0438 and G0439) or an E&M (CPT codes 99211-99213) on the same date of service, and SelectHealth will make a payment for two of the three codes on the same date of service when they are billed appropriately, and when the documentation supports billing both codes (Link to attached coding sheet). A co-pay will apply if an E&M code is billed.

Commercially insured SelectHealth members may also be seen for a Preventive Exam (CPT codes 99381-99387 and 99391-99397) with no out-of-pocket cost for most, or for an E&M visit (CPT codes 99201-99205 and 99211-99215), which will require a co-pay or co-insurance. If the member’s deductible has not been met, there may be additional costs. A Preventive Exam and an “established patient” E&M code (CPT codes 99211-99213) may be billed on the same date of service if a -25 modifier is attached to the E&M code and the documentation supports coverage of both services.

Comments or questions may be directed to your SelectHealth Provider Relations representative at 800-538-5054 or at provider.relations@selecthealth.org.
CMS released a reminder on May 5 that Advanced Beneficiary Notice (ABN) forms are not applicable to Medicare Advantage plans. CMS further clarified that notices “similar” to the ABN are also not appropriate for use with Medicare Advantage enrollees. In the memo, CMS noted that patients on a Medicare Advantage plan are entitled to an “advance determination of whether services are covered prior to receiving such services.” Therefore, an ABN or an ABN alternative form, which states a service may not be covered, is not permitted for use for beneficiaries with Medicare Advantage Plan coverage. Instead, a pre-service denial or approval through the prior authorization process is required for SelectHealth Advantage members.

For more information, please follow this link to the CMS memo, which also contains instructions on which notices are applicable and approved for use in the Medicare Advantage program.

If you have questions, please contact Dot Verbrugge, MD, at dot.verbrugge@selecthealth.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. The following is a list of recent technologies reviewed and Committee recommendations:

<table>
<thead>
<tr>
<th>Technology</th>
<th>Date Reviewed*</th>
<th>Committee Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corus CAD Gene Expression Test</td>
<td>3-18-14</td>
<td>Deny as Investigational. Current evidence has not demonstrated the clinical utility of the test. See Medical Policy #442</td>
</tr>
<tr>
<td>Third Eye Retroscope</td>
<td>4-29-14</td>
<td>Deny as Investigational. There is a lack of evidence demonstrating improved health outcomes as it relates to morbidity from developing colon cancer or mortality. See Medical Policy #551</td>
</tr>
<tr>
<td>MammaPrint</td>
<td>4-29-14</td>
<td>Approved as Medically Necessary effective 6/1/14. Current evidence has demonstrated clinical utility of this test for select patients meeting specified criteria. See Medical Policy #281</td>
</tr>
<tr>
<td>VWING Vascular Access Guide</td>
<td>4-29-14</td>
<td>Deny as Unproven. Current evidence is inadequate to determine the safety, efficacy, performance durability or cost effectiveness of the device. See Medical Policy #550</td>
</tr>
</tbody>
</table>

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

Other technologies currently under active assessment by the M-Tech Committee are 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:

- Noninvasive Skin Imaging
- Negative Pressure Wound Therapy
- Total Body Photography
- MRgFUS for Essential Tremor
- Urolift for Enlarged Prostates
- MRgFUS for Uterine Fibroids
- MRgFUS for Prostate Cancer
- MRgFUS for Bone Metastases
- Oncotype DX for Colon Cancer
- Decipher Prostate Cancer Classifier
- iStent for Glaucoma
- Knee Resurfacing
- Vermillion QVA1 Test for Ovarian Cancer
- Confirm MDx Test for Prostate Cancer
- VEMP Testing
- TENS for Migraines
- Prosigna Breast Genetic Test
- EpiFix Bioengineered Skin
- NeuroPace System for Treatment of Intractable Epilepsy

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 Ken Schaecher, M.D. FACP, M-Tech Committee Chairman, at 801-442-7927.

All SelectHealth medical policies and technology assessments can be viewed on our website. Go to 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.

If you have questions, please contact Ken Schaecher, MD at ken.schaecher@selecthealth.org.

Continued on next page
Physician Payments Sunshine Act (CMS Open Payments)

OVERVIEW:

- CMS program to increase public awareness of financial relationships between healthcare industry and physicians by collecting and making public information on payments or transfers of value between drug and device manufacturers and physicians or teaching hospitals.

- The law requires drug and medical device manufacturers to submit this data annually to CMS. CMS will then make the data publicly available and searchable on a website each year. CMS will allow for disputing the data prior to publication.

- The types of payments or transfers of value that are reportable include consulting fees, speaker fees, honoraria, gifts, entertainment, food and beverage, travel and lodging, education, research activities, charitable contributions, royalties or licenses, current or prospective ownership or investment interest, and grants.

- Payments or transfers of value made both directly to a physician and indirectly through a third party will be reported, as will payments to a physician that are subsequently passed to a third party, such as a charity.

CURRENT STATUS:

- In June of this year, drug and device manufacturers will begin reporting payments to physicians or teaching hospitals made from Sept. 1 to Dec. 31, 2013.

- Physicians can register to review reported payments beginning June 1 and will be able to begin reviewing and disputing incorrect information on July 1.

- Reported information will then be made public by Sept. 30, 2014.

- General information on the program and information on registering to review reported data is available at this link.

If you have questions, please contact Brad Nokes at brad.nokes@imail.org.
LiVe Well Through Gardening!

By: Liz Joy, MD, MPH

Nearly a third of US households participate in some form of gardening, representing an estimated 36 million households. Not surprisingly, gardeners who grow fruits and vegetables are more likely to consume recommended amounts of fruits and vegetables, and a recent (and local) study of community gardeners found that they have a lower mean body mass index (BMI) compared to non-gardeners living in the same community. Gardening is also one of the most commonly practiced forms of exercise. A 2009 survey by the National Gardening Association found that, on average, gardeners spend 4.9 hours a week in the garden, with the majority (57%), spending three hours or more. Gardening activities, digging, bending, planting and raking are considered moderate to vigorous in intensity, and burn an estimated 200-400 calories per hour. The Physical Activity Guidelines for Americans recommend that adults achieve at least 150 minutes per week of moderate intensity activity each week - so the average gardener is getting nearly 300 minutes per week. No need for the stair climber after that!

As great as gardening is for our physical health, gardeners often point out that the primary benefits relate to psychological health. A review of urban community garden research found that the most commonly demonstrated benefits of community gardens were social benefits, such as community building, resilience and social interaction. Gardening is also a way to “give back” to your community. Ninety-five percent of community gardeners give away some of the produce they grow to friends and families in need, while 60% donate to food assistance programs.

Intermountain Healthcare is planting a community garden at the Park City Medical Center, and will be breaking ground later this month. We hope to see more LiVe Well Gardens on Intermountain properties in the near future. Replacing gardens for grass is a strategy to promote healthy employees, create a healing space for patients and “cultivate” community; thereby supporting efforts to LiVe Well at work, at home and in our communities.

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