DEAR COLLEAGUES,

In our continuing efforts to improve communication between Intermountain and credentialed practitioners, we are pleased to present the 7th installment of Intermountain Med Staff News, our quarterly newsletter for the medical staff. We hope that you will find timely information and news that will keep you informed and up-to-date. To make navigation easy, you can click on any article noted in the table of contents that is of interest to you and you will be taken directly to that article or, of course, you can read the entire newsletter.

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

Sincerely,

Brent Wallace, MD
Chief Medical Officer
Intermountain Healthcare
brent.wallace@imail.org
(801) 442-3866

Susan DuBois
Assistant Vice President
Physician Relations and Medical Affairs
susan.dubois@imail.org
(801) 442-2840
2015 is off to a good start! Thank you for your leadership as we work toward meeting our goals.

Sincerely,

Brent Wallace, Chief Medical Officer

Kim Henrichsen, VP Clinical Operations and Chief Nursing Officer

### MARCH 2015 – BOARD GOAL PROGRESS

<table>
<thead>
<tr>
<th>Clinical Excellence</th>
<th>Create the foundation and framework for “Zero Harm” (eliminated all avoidable medical errors)</th>
<th>Goal is on track</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Engagement</td>
<td>Achieved</td>
<td>Goal is on track</td>
</tr>
<tr>
<td>Hospital</td>
<td>Value Based Purchasing Patient Experience Domain</td>
<td>On Track</td>
</tr>
<tr>
<td>Medical Group</td>
<td>Rating Clinic Experience as Excellent</td>
<td>On Track</td>
</tr>
<tr>
<td>SelectHealth</td>
<td>Rating their Health Plan 8-10</td>
<td>Not measured yet</td>
</tr>
</tbody>
</table>

**Operational Effectiveness**

<table>
<thead>
<tr>
<th>Complete two of the following to be on track:</th>
<th>Goal is on track</th>
</tr>
</thead>
<tbody>
<tr>
<td>iCentra installed in two regions</td>
<td>On Track</td>
</tr>
<tr>
<td>iCentra installed in three regions</td>
<td>Of Concern</td>
</tr>
<tr>
<td>30 med-surg commodity categories will be standardized by June 30, 2015. By the end of the year, achieve at least 90% compliance for these 30 categories and have an additional 30 categories committed to standardization in 2016</td>
<td>On Track</td>
</tr>
<tr>
<td>Demonstrated improvement for enhanced completeness of documentation and coding</td>
<td>Of Concern</td>
</tr>
<tr>
<td>Physician Engagement</td>
<td>Goal is on track</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>75% of affiliated physician practices that request iCentra interfaces will have access</td>
<td>Of Concern</td>
</tr>
<tr>
<td>New payment model in place with physicians participating in the shared accountability product by the end of 2015</td>
<td>On Track</td>
</tr>
<tr>
<td>Geographic region committees will be functioning in at least four regions</td>
<td>On Track</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Stewardship</th>
<th>Goal is on track</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop Value-based SelectHealth Commercial Product for launch by January 1, 2016</td>
<td>On Track</td>
</tr>
<tr>
<td>Achieve 95% of Cash Flow Target</td>
<td>On Track</td>
</tr>
<tr>
<td>Achievement of Community Benefit Initiatives</td>
<td>On Track</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Engagement</th>
<th>Goal is on track</th>
</tr>
</thead>
<tbody>
<tr>
<td>LiVe Well Goal – 70% of employees enrolled in a medical plan will earn the LiVe Well participation incentive for at least one quarter</td>
<td>On Track</td>
</tr>
<tr>
<td>Achieve a Gallup Accountability Index score of 4.33</td>
<td>Not measured yet</td>
</tr>
<tr>
<td>Achieve a Gallup Grand Mean score of 4.15</td>
<td>Not measured yet</td>
</tr>
</tbody>
</table>

If you have questions, please contact Brent Wallace, MD, at brent.wallace@imail.org.
UPDATE ON INTERMOUNTAIN’S PATIENT EXPERIENCE TRANSPARENCY INITIATIVE

Intermountain Healthcare’s transparency initiative is designed to provide clinicians and patients with complete and accurate data. Having access to this type of data will engage patients in making healthcare decisions and will improve overall outcomes in the areas of clinical care, patient safety, and satisfaction by providing clinicians and the healthcare team with meaningful and actionable data about their clinical practice.

For several years, Intermountain Healthcare’s hospitals, Medical Group, and SelectHealth have used a third party to collect patient experience (satisfaction) data and have shared that data with clinicians, but not with the public. In order to get comparable data, Medical Group and SelectHealth adopted a standard survey specifically addressing outpatient visits, which launched on March 1, 2015. Beginning in June, physicians will be able to review their own star-ratings and comments by logging into the Physician Portal and clicking on their profile.

We originally planned to publish provider star-rating data and comments starting June 2015, but we have delayed our plan to publish Intermountain’s public provider directories until late summer. The added time will give physicians a chance to review and understand their data, ask questions, and if applicable, impact their overall ratings before the data is shared with the public.

KEY ELEMENTS OF THE PATIENT EXPERIENCE TRANSPARENCY INITIATIVE

- Patients are notified during the survey that their responses will be used to create a rating and their comments will be posted on Intermountain and/or SelectHealth’s websites.
- All comments will be reviewed. Questionable comments will be flagged, reviewed, and evaluated before posting. Comments that contain vulgar or profane language will not be posted.
- Physicians will need at least 30 patient ratings before their ratings will be posted publicly.
- Ratings will roll off on an 18-month cycle.
- Questions are limited to only the patient/physician interaction at the time of the appointment.

MARK YOUR CALENDARS

Dr. Brent Wallace and Susan DuBois will discuss Intermountain’s transparency initiatives with a focus on patient experience during a webinar that will be held on July 15, 2015 from 7-8 a.m. Instructions explaining how physicians can participate in the webcast will be sent out a few weeks before the event.

This initiative may raise questions or concerns for physicians. If you have questions or would like more information about the initiative, please contact Dr. Brent Wallace, Chief Medical Officer at (801) 442-3866 or via email at brent.wallace@imail.org or Susan DuBois, AVP, Physician Relations and Medical Affairs at (801) 442-2840 or via email at susan.dubois@imail.org.
MESSAGE FROM CHARLES SORENSON, MD
Intermountain Healthcare President and CEO

“At Intermountain, we are known for our commitment to evidence-based care and safety. But it is important to understand that as long as there is a single patient who didn’t receive optimal care, we haven’t finished improving.

“In fact, we are now embarking on a very significant and lasting endeavor to ensure that every patient is safe in our care. We’ve named this effort—Continuous Improvement—Zero Harm—a name that embodies both our process and our ultimate aspiration. The Intermountain approach of setting ambitious goals to improve how we care for patients—and using evidence-based strategies, processes, and tools to achieve those goals—is not new to us.

“Zero Harm will help us consistently apply best practices across the system. Each region will receive an assessment of their current performance in safety and create a plan for teaching and implementing proven tools in clinical and non-clinical situations throughout the continuum of care.

“Whether we are direct caregivers or perform any other role at Intermountain, this is a renewed opportunity to commit to giving the right care to every single patient, every time. Our Intermountain values support us as we each accept the responsibility of earning our patients’ trust every day, with every encounter. We thank you for your dedication to the safety of our patients, and for your engagement in Continuous Improvement—Zero Harm.”

OUR PARTNERS IN ZERO HARM

Intermountain is partnering with Healthcare Performance Improvement (HPI), a national leader in organizational improvement, to build the foundation and methods to support Zero Harm. We will be utilizing HPI’s expertise in the science of high reliability as seen in their success with other industries: naval aviation, commercial aviation, and nuclear power. These industries, like healthcare, “operate under very trying conditions all of the time and yet manage to have fewer than their fair share of accidents.”

—Managing the Unexpected (Weick & Sutcliffe).

HPI has more than 676 healthcare clients. Evidence from their success demonstrates we need to build on the following three strategies to achieve an optimal safety environment where failures and harm are rare:

- **Prevention:** Implement best-practice error prevention techniques and evidence-based leadership methods to prevent the errors that lead to harm and enhance our existing fair and just accountability system.
- **Detection:** Pay attention to near-miss and precursor safety events to detect trends that will lead to serious harm.
- **Correction:** Correct the root causes of Serious Safety Events, and identify trends using continuous quality improvement methods and share lessons learned.

Zero Harm will coincide with what we’ve learned from efforts like ATP, Studer, LEAN, etc. This journey, when embraced and implemented by leaders, physicians, and staff, will result in the significant culture change needed to achieve greater safety and reliability to fulfill Intermountain’s Mission of “Helping people live the healthiest lives possible.”

**HOW ZERO HARM WILL BE LAUNCHED**

Over the next several months, work will begin in each region to conduct:

- A diagnostic review of serious safety events over the last three years
- Leader, staff, and physician interviews
- A determination of a facility-specific Serious Safety Event Rate

Building on this data, Intermountain and HPI will work together to develop a toolkit of techniques to improve safety. By mid-2015, we will begin training and implementing in some regions, where together we will learn, practice, and adopt evidence-based proven safety behaviors. Once trained, you will be expected to incorporate these tools and techniques into your daily work, without exception. This training will involve several key events and education sessions over an 18-month period. By 2017 we will build upon our work and develop sustainability plans for the years ahead.

(Note: Deployment schedules will be flexible to accommodate iCentra implementation.)

continued on next page
DRIVING THIS EFFORT AT THE SYSTEM AND REGIONAL LEVEL

The system Zero Harm Steering Committee is taking the lead and has created six system workgroups, each of which contains members from all regions:

1. Safety Event Management
2. Communications
3. Education
4. Metrics
5. Physician Engagement
6. Facility Integration

Each region has also established a Regional Zero Harm Steering Committee, with the Regional Quality Directors and either a regional CNO or physician lead. These individuals also sit on the system and region Facility Integration Committees. Training will be handled at the local level and your Facility Integration Committee will manage scheduling of each event.

Remember, Zero Harm is NOT a new program, project, or even a new initiative. It IS a culture change in the way we will do things at Intermountain from now on to deliver Extraordinary Care, keeping our patients and employees safe. Zero Harm is Intermountain’s goal. To embed safety in our culture it must be internally driven, owned, led, and sustained by leaders, clinicians, and staff.

We ask you to prioritize this important work.

“Good ideas are not adopted automatically. They must be driven with courageous impatience. Once implemented they can be easily overturned or subverted through apathy or lack of follow-up, so continuous effort is required.”

– Admiral Hyman G. Rickover 1900-1986

THE INTERMOUNTAIN HEALTHCARE SIMULATION CENTER WILL OPEN IN AUGUST 2015

Medical simulation is a learning methodology that uses a created situation or environment to allow clinicians to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions. Intermountain Healthcare has used simulation as an engaging and effective method to teach new and experienced clinicians how to improve their communication and aim for reliability in their practice.

In order to more efficiently train healthcare teams, Intermountain will be opening “The Intermountain Healthcare Simulation Center” in August 2015. This 10,000-square-foot innovative simulation lab will include a variety of rooms, each with TeleHealth capabilities: two acute care and/or outpatient rooms, one intensive care unit bed space, a labor and delivery suite, an operating room, and a homecare apartment. The facility will also have a conference room, three debrief rooms, and a procedure lab with a variety of task trainers.

This new center will give clinicians the opportunity to participate in a broad array of simulation scenarios that will help them improve patient safety, teamwork, and staff communication, as well as support Intermountain’s Zero Harm initiatives. The Simulation Team, based out of Intermountain’s Central Offices, will be available to assist with simulation scenario creation, design, and implementation, as well as lead simulation conferences and trainings. When the center opens it will offer multiple...
courses, including the Intermountain Simulation Facilitator Course, Root Cause Analysis Course, TeleCritical Care Course, and Pediatric Office Emergency Course.

If you have questions about how simulation can help train your team, or for any other information related to simulation, please contact:

Ashley Cassity, RN
Intermountain Simulation Coordinator
ashley.cassity@imail.org

Nancy Bardugon, RN
Intermountain Simulation Director
nancy.bardugon@imail.org

Jared W. Henricksen, MD
Intermountain Simulation Medical Director
jared.henricksen@hsc.utah.edu

TEXTING IS AN EFFECTIVE WAY TO REACH CLINICIANS

In a survey conducted in the Central Region this year, the third most common criticism clinicians expressed was that they do not feel like they know what is going on in their hospital, and they do not feel like they have significant input into the direction healthcare is taking. Traditional outlets to share important information that would help bridge this gap, like staff, department, or division meetings and emails, often miss large segments of our clinicians. That is why we are piloting the use of text message communication with physicians and advanced practiced clinicians (APCs) at Intermountain Medical Center. Our goal is to use this relevant, user-friendly technology to better reach our care providers.

For the past three months, we sent a secure text message about once a week directly to the personal cell phones of about 950 clinicians at Intermountain Medical Center. The messages were about 160 characters long and contained a link that directed clinicians to more details on Intermountain’s Physician Portal. The content covered in these text messages included stories of significant accomplishments by medical staff, important strategic plans for Intermountain Medical Center, information on how to see if one is listed in the soon to become public Sunshine Act Database, as well as news of serious safety events around the Intermountain Healthcare system.

Physicians and APCs can opt out from receiving these text messages at any time. So far 150 (15 percent) of clinicians have opted out, but 85 percent have found the messaging of use. We received many favorable reports showing that clinicians feel engaged by this route of communication. The majority of clinicians opting out are those who rarely, if ever, practice at the hospital, so it appears that the messaging and dialogue the we get back is of use to the clinicians who have some component of their practice at the hospital.

If you have any questions, please contact Dr. Mark Ott at Mark.Ott@imail.org.

ICD-10 TRAINING CONTENT AVAILABLE TO PROVIDERS

Intermountain Healthcare is committed to adopting the new ICD-10 standards scheduled to go live on October 1, 2015. Providers can begin to familiarize themselves with these new standards by reviewing Precyse University’s compliance training content available on Intermountain’s ICD-10 website. The Intermountain Physician Advisory Service (IPAS) will also provide additional training to all inpatient physicians, including affiliated providers, and is currently scheduling training meetings between May and October 2015.

If you have any questions, please contact Masood Safaee Semiromi at masood.safaee@imail.org.
NEW iCENTRA SUPPORT SERVICES AVAILABLE IN NORTH REGION

Intermountain’s central iCentra leadership team reviewed the status of the project’s implementation in Logan Regional Hospital, Bear River Valley Hospital, and surrounding clinics. Based on the team’s review and feedback from our colleagues at these facilities, all future iCentra implementations are delayed. The next implementation dates have not been determined.

The decision to delay the go-live at other facilities reflects Intermountain’s commitment to implement iCentra when all teams are ready. The scheduling change allows for iCentra teams to better apply the lessons learned from everyone who is part of the Logan and Bear River go-live. Through this learning process, the implementation will be better for all other regions going forward.

Information on schedules for implementation, training, and registration will be made available as soon as possible through these channels:

- [Physician iCentra website](#)
- Email or call Marcina at Marcina.Robertson@selecthealth.org or (801) 442-7751

For those live on iCentra now, we have developed a basic support model that immediately offers more direct support. We will continue to improve this model with your ongoing participation and feedback. The following support services are available to physicians and managers.

**PHYSICIAN COACH OR CLINICAL INFORMATICS TEAM**

Scheduled 1:1 time, by appointment, with a Physician Coach or Clinical Informatics team. These individuals are responsible to assist with adoption, training, and partnering with central teams in ongoing workflow improvements and optimization. These teams generally work Monday through Friday (non-holidays) 8 a.m.–5 p.m. and are also available for pre-scheduled appointments during the following times:

- 7–9 a.m.
- 11 a.m.–1 p.m.
- 5–7 p.m.

**To schedule time with your coach,** send an email to northregionphysiciantraining@imail.org or call (435) 716-6050. Appointments should be scheduled at least one day in advance. For critical issues, please indicate the urgency when you initiate the contact.
**ONSITE TECHNICAL SUPPORT TEAMS**

Beginning Monday, May 18, the Information System (I.S.) teams will provide 24/7 onsite technical support in Logan, with 24/7 on-call support for Bear River and surrounding clinics. These technical teams are dedicated to delivering excellent quality service and managing the iCentra issue resolution process on behalf of physicians and employees. They will either fix the issue or help identify a temporary workaround that allows you to remain productive. If they are not able to resolve the issues themselves, they will be accountable for engaging the appropriate specialists and following up with you. They will also inform the Clinical Information team of issues related to training, adoption, and workflow.

To reach the Information Systems support team, call the iCentra Service Desk using the numbers below:

- Logan Regional Hospital ext. 63456
- Bear River Valley Regional Hospital ext. 73456
- Medical Group Clinics (844) 442-4842
- Affiliated Providers (844) 442-4843
- Imaging (801) 442-6018

Thank you for your flexibility and continued commitment to our patients through this process.

*If you have any questions, please email icentra@imail.org.*
IT HAPPENED HERE – DELAY IN DIAGNOSIS OR TREATMENT

Learning From Our Mistakes

CASE #1
A 61-year-old male underwent a laparoscopic-assisted Nissan fundoplication, hiatal hernia repair with mesh, and cholecystectomy. Admitted to the Acute Care Unit on O2 per nasal cannula at 2L. After three hours on the unit, the patient suddenly complained of not being able to breathe and was severely cyanotic from the chest up. Rapid Response called but was changed to a “Code Blue” when the level of consciousness began to decrease. All appropriate staff responded. There was confusion as to which physician was leading the code, which contributed to delays in resuscitation. The patient was given Narcan and became responsive, but remained in respiratory distress. Patient alertness continued to wax and wane, and he was transferred to the Intensive Care Unit where he was intubated per anesthesia. The patient became bradycardic, and CPR was initiated. TeleHealth Monitoring was used. After approximately two hours of resuscitation measures, the patient passed away. Pulmonary embolus was suspected as cause of death, but the autopsy was inconclusive.

What We Learned

- More simulation practice is needed. In this case, there was no clear team leader for code. Many people were talking at once, with several physicians giving orders at the same time (hospitalist, ED, and Primary Care).
- The code was very long, lasting two hours. During this time, the care providers ran out of some of the high-use emergency drugs (Epi and Bicarb) in the crash cart. A pharmacist had to leave and get more medications.

CASE #2
A 73-year-old female was seen in the ED complaining of acute abdominal pain for the past 48 hours. She revealed no significant past medical history when interviewed by the surgeon. Emergency surgery was performed for right strangulated inguinal hernia with repair and small bowel resection. Post-operatively, the patient developed tachycardia, abdominal distension, diarrhea, increased pain, WBC elevation, and ileus. The patient acutely decompensated on 3/23/15 around 11:30, showing signs of aspiration. No Rapid Response was called. The Charge Nurse and House Supervisor were called, and the MD was notified at 11:45. The patient was transferred to the ICU. There was difficulty with intubation due to food/liquid in airway. The patient became bradycardic and coded in the ICU. CPR was performed, but the patient expired.

What We Learned

- Not all patient changes/assessments were communicated as part of hand-offs.
- The nursing care plan was not updated to reflect change in patient status.
- Early use of the Rapid Response team may have prevented the patient death.
- Change in patient status should have been recognized and reported earlier to shift coordinator and MD.

CONFIDENTIAL: This information is for an Intermountain Healthcare Peer or Care Review Committee to evaluate and improve healthcare. See Utah Code 26-25-1, et seq., U.R.C.P. 26(b)(1), or Idaho Code 39-1392, et seq.

If you have questions, please contact Jeanne Nelson at jeanne.nelson@imail.org
DETAINING PATIENTS TO PRESERVE THEIR SAFETY

Patients requiring medical treatment are at times uncooperative or confused and are not willing to remain in our care. In those cases, physicians and clinicians have at times attempted to detain these patients against their will by using the legal involuntary commitment process known as the “Blue Sheet,” implemented by physicians, or the “Pink Sheet,” used by law enforcement. This process is only to be used to detain a patient for a mental health evaluation. It does not allow the physician to detain and treat the patient for medically emergent situations.

In order to detain and treat an uncooperative patient in medically emergent situations the following issues must be clearly documented in the medical record:

1. The patient is uncooperative, i.e. refusing care.
2. There is an immediate threat to the life or health of the patient.
3. The patient’s decision-making ability is impaired, i.e. exhibiting a diminished capacity for making medical decisions due to intoxication, trauma, disease, or mental illness.

In the past, security personnel were advised that they could only assist in detaining patients in the facility if the attending physician implemented the “Blue Sheet” or another legal commitment process. This issue was addressed in consultation with corporate legal and facility safety and security leaders. As of December 2014, security directors at Intermountain facilities are now instructed to have their staff assist in detaining patients both in behavioral health commitment and medical emergency scenarios as requested. We hope this clarifies the process to detain uncooperative patients requiring emergent medical care.

If you have questions, please contact Mark Latkowski at (801) 442-3451.
SELECTHEALTH REQUEST FOR CONFIRMATION OF DIAGNOSES

Many primary care physicians will soon be receiving (or may have already received) a request from Cognisight to confirm that specific diagnoses for selected patients are complete and accurate. We have partnered with Cognisight to perform medical record reviews to capture diagnoses in patient records that were not submitted on claims. This effort is to satisfy a Centers for Medicare & Medicaid Services (CMS) requirement for health plans to compile and report complete diagnostic profiles annually for Medicare Advantage members.

We ask that providers carefully review and determine which, if any, of the diagnoses listed on the form were recognized, considered, and/or treated during the referenced 2014-noted encounter. The form must be signed and dated within one year of the date noted at the top of the addendum form.

If you have questions about this process, please contact Jason Brockett at (801) 442-7977 or jason.brockett@selecthealth.org.

MEDICAL POLICY BULLETIN

The following tables contain a directory of policies, effective dates, and a summary of changes. You can access the full policy text by going to physician.intermountain.net/selecthealth/policies and searching by policy number.

NEW POLICIES

<table>
<thead>
<tr>
<th>POLICY NUMBER</th>
<th>POLICY NAME AND LINK</th>
<th>EFFECTIVE DATE</th>
<th>SUMMARY OF CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>556</td>
<td>Responsive Cortical Neurostimulation in the Treatment of Epilepsy (NEW)</td>
<td>9/16/2014</td>
<td>New policy was developed following an M-Tech review for Neuropace. Commercial Plan covers responsive cortical neurostimulation in the treatment of epilepsy when criteria are met. SelectHealth Advantage follows commercial plan policy as there are no specific guidelines for responsive cortical neurostimulation in the treatment of epilepsy. SelectHealth Community Care may cover subject to the Utah Medicaid coverage status of codes applied to the procedure. These codes will need to be found on the State of Utah Medicaid Look Up Tool to confirm coverage. For covered codes, since there are no specific Utah Medicaid criteria, commercial plan policy will apply.</td>
</tr>
<tr>
<td>POLICY NUMBER</td>
<td>POLICY NAME AND LINK</td>
<td>EFFECTIVE DATE</td>
<td>SUMMARY OF CHANGES</td>
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<tr>
<td>557</td>
<td>Radiofrequency Ablation of the Genicular Nerve (NEW)</td>
<td>9/1/2014</td>
<td>New policy was developed for Radiofrequency Ablation of the Genicular Nerve. Commercial Plan does NOT cover radiofrequency ablation of the genicular nerve in the treatment of osteoarthritis or any other indication as SelectHealth has found this procedure to be not medically reasonable and necessary since current evidence is insufficient to determine the efficacy and safety of this technology. SelectHealth Advantage does NOT cover radiofrequency ablation of the genicular nerve in the treatment of osteoarthritis or any other indication as SelectHealth has found this procedure to be not medically reasonable and necessary since current evidence is insufficient to determine the efficacy and safety of this technology. SelectHealth Community Care does NOT cover radiofrequency ablation of the genicular nerve in the treatment of osteoarthritis or any other indication as SelectHealth has found this procedure to be not medically reasonable and necessary since current evidence is insufficient to determine the efficacy and safety of this technology.</td>
</tr>
<tr>
<td>558</td>
<td>Interspinous Fixation (Fusion) Devices (NEW)</td>
<td>10/6/2014</td>
<td>New policy was developed for Interspinous Fixation (Fusion) Devices. Commercial Plan does NOT cover interspinous fixation devices alone for decompression of spinal stenosis or in combination with spinal fusion as they are considered experimental and investigational. SelectHealth Advantage limits coverage of interspinous distraction devices/spacers to their FDA approved indications. Any other use of these devices is NOT covered as investigational. SelectHealth Community Care does NOT cover interspinous fixation devices. There are no specific guidelines for interspinous fixation (fusion) devices, commercial plan policy will apply.</td>
</tr>
<tr>
<td>559</td>
<td>Sphenopalatine Ganglion (SPG) Injection in the Management of Headaches (NEW)</td>
<td>11/5/2014</td>
<td>New policy was developed for Sphenopalatine Ganglion (SPG) Injection in the Management of Headaches. Commercial Plan does NOT cover sphenopalatine ganglion (SPG) block for the treatment of acute and chronic headaches as current evidence is insufficient to determine efficacy and safety of this procedure. SelectHealth Advantage does NOT cover this procedure consistent with CMS (LCD) L34775 and L34779. CMS does not list headaches as a covered diagnosis for these procedures, commercial plan policy will apply. SelectHealth Community Care does NOT cover sphenopalatine ganglion (SPG) block for acute and chronic headaches.</td>
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<tr>
<td>POLICY NUMBER</td>
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| 560            | Magnetic Resonance Guided Focused Ultrasound For Essential Tremor (NEW) | 12/3/2014 | New policy was developed for Magnetic Resonance Guided Focused Ultrasound for Essential Tremor.  
Commercial Plan Policy does NOT cover magnetic resonance guided focused ultrasound in the management of essential tremor as it is considered investigational.  
SelectHealth Advantage does NOT cover magnetic resonance guided focused ultrasound in the management of essential tremor as SelectHealth has determined to be not medically reasonable and necessary.  
SelectHealth Community Care does NOT cover the procedure as C9734 is a non-covered code with the State of Utah Medicaid Program. |
| 561            | Vectra DA for Management of Rheumatoid Arthritis (NEW) | 1/9/2015 | New policy was developed for Vectra DA Blood Test for Rheumatoid Arthritis.  
Commercial Plan does NOT cover Vectra DA blood test for rheumatoid arthritis as it is considered investigational.  
SelectHealth Advantage does NOT cover Vectra DA blood test as there are no specific guidelines from the local MAC, Noridian – jurisdiction F, commercial plan policy will apply.  
SelectHealth Community Care does NOT cover Vectra DA as there are no Utah Medicaid specific guidelines, commercial plan policy applies. |
| 562            | Corneal Hysteresis Testing (NEW) | 1/12/2015 | New policy was developed for Corneal Hysteresis Testing.  
Commercial plan does NOT cover as the procedure is considered investigational.  
SelectHealth Advantage does NOT cover the procedure consistent with (LCD) L24473 and L27445.  
SelectHealth Community Care does NOT cover as code 0181T is a non-covered code with the State of Utah Medicaid program and code 92145 has no coverage status at this time of the review. |
| 563            | Total Body MRI For Li-Fraumeni Syndrome (NEW) | 4/21/2015 | New policy developed following an M-Tech review for total body MRI for Li-Fraumeni Syndrome.  
SelectHealth covers total body MRI for cancer surveillance in patient with Li-Fraumeni syndrome. |
<table>
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</thead>
<tbody>
<tr>
<td>236</td>
<td>Robotic Assisted Surgery (REVISED)</td>
<td>9/29/2014, 2/24/2015</td>
<td>The addition of the Heller myotomy was added to the covered procedures in the robotic policy. “For cancer indications only” added after pharyngeal procedures under Commercial Plan Policy.</td>
</tr>
<tr>
<td>246</td>
<td>Mechanical Insufflation-Exsufflation Therapy for the Clearance of Airway Secretions (Coughassist device) (REVISED)</td>
<td>9/29/2014</td>
<td>An extensive revision was done on the Mechanical Insufflation-Exsufflation Therapy for the Clearance of Airway Secretions (Coughassist device). Commercial Plan covers mechanical insufflation-exsufflation devices as medically necessary for patients with neuromuscular disorders with significant impairment of chest wall and/or diaphragmatic movement resulting in difficulty clearing secretions, a demonstrated reduction in peak cough expiratory flow rate of &lt;3L per second and for whom standard treatments (e.g., chest percussion and postural drainage, etc.) have not been successful in adequately mobilizing retained secretions. SelectHealth Advantage covers mechanical insufflation-exsufflation device consistent with Medicare Local Coverage Determination L12744. Where Medicare policy does not explicitly outline coverage, commercial plan policy will apply. SelectHealth Community Care covers mechanical insufflation-exsufflation devices for Traditional Medicaid, subject to prior authorization, using criteria in the Medicaid Look up tool for code E0482. This device is not covered for Non-Traditional Medicaid. Code A7020 is covered up to every five years with quantity limit applied consistent with the State of Utah Medicaid Program.</td>
</tr>
<tr>
<td>538</td>
<td>Gene Expression Testing for Indeterminate Thyroid Nodule Biopsy (REVISED)</td>
<td>10/13/2014</td>
<td>A revision of Gene Expression Testing for Indeterminate Thyroid Nodule Biopsy with the criteria under the Commercial Plan Policy has been clarified.</td>
</tr>
<tr>
<td>357</td>
<td>Genetic Expression Profiling for Monitoring Acute Rejection in Cardiac Transplant Patients (ALLOMAP) (REVISED)</td>
<td>8/28/2014</td>
<td>A revision was made to the Gene Expression Profiling for Monitoring Acute Rejection in Cardiac Transplant Patients (ALLOMAP). The revision of the policy changed #2 under criteria for coverage from &gt;18 years to &gt;15 years and #11 exclusion criteria &lt;15 years was added.</td>
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<td>POLICY NUMBER</td>
<td>POLICY NAME AND LINK</td>
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<td>SUMMARY OF CHANGES</td>
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<tr>
<td>260</td>
<td>DNA Analysis of Stool for Colon Cancer Screening (Pregen, Pregen-Plus and Cologuard) (REVISED)</td>
<td>10/15/2014</td>
<td>A revision was made to the DNA Analysis of Stool for Colon Cancer Screening (Pregen, Pregen-Plus and Cologuard) policy. The addition of Cologuard was added to be covered by SelectHealth Advantage Plan and the coding for this test for Medicare is 81479, as Medicare does not cover HCPC S3890.</td>
</tr>
<tr>
<td>320</td>
<td>Interspinous Distraction Devices/Spacers (REVISED)</td>
<td>10/8/2014</td>
<td>Former &quot;X-Stop&quot; policy extensively revised to include many other devices.</td>
</tr>
<tr>
<td>497</td>
<td>Genetic Testing: Lynch Syndrome Screening/Testing for Colorectal Cancer (REVISED)</td>
<td>10/20/2014</td>
<td>The revision was made under the Commercial Plan Policy with the addition of the following language: *In instances where tissue specimen are not available, genetic testing for MLH1, MSH2, MSH6, and PMS2 will be allowed without first doing Immunohistochemistry.</td>
</tr>
<tr>
<td>493</td>
<td>Molecular Profiling of Tumors to Guide Cancer Therapy (REVISED)</td>
<td>11/14/2014</td>
<td>A revision was made to the Molecular Profiling of Tumors to Guide Cancer Therapy policy. The addition of FoundationOne has been added to the policy as NOT covered.</td>
</tr>
<tr>
<td>281</td>
<td>Gene Expression Profiling in the Management of Breast Cancer (REVISED)</td>
<td>1/1/2015</td>
<td>A revision was made to the Gene Expression Profiling in the Management of Breast Cancer. MammaPrint has been added to the policy as covered when criteria are met.</td>
</tr>
<tr>
<td>415</td>
<td>Breast Tomosynthesis (REVISED)</td>
<td>1/9/2015</td>
<td>A revision was made to remove from noncovered to covered effective 1/1/15 as outlined in the policy. Updated codes were added to the policy.</td>
</tr>
<tr>
<td>185</td>
<td>Negative Pressure Wound Therapy (Vacuum Assisted Wound Closure) (REVISED)</td>
<td>1/20/2015</td>
<td>A revision was made to the Negative Pressure Wound Therapy (Vacuum Assisted Wound Closure) following an M-Tech review of the SNaP® device. SelectHealth now covers NPWT using the nonmechanical SNaP® device in limited circumstances.</td>
</tr>
<tr>
<td>289</td>
<td>Genetic Testing: Cystic Fibrosis (REVISED)</td>
<td>2/11/2015</td>
<td>An extensive revision done on the Genetic Testing: Cystic Fibrosis (CF) policy. Most of the revision is under the Commercial Plan Policy for who would be covered for the test.</td>
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<tr>
<td>POLICY NUMBER</td>
<td>POLICY NAME AND LINK</td>
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<tr>
<td>553</td>
<td>Urolift System® For The Treatment of Benign Prostatic Hyperplasia (REVISED)</td>
<td>1/1/2015</td>
<td>SelectHealth Advantage now covers this procedure consistent with Medicare Local Coverage Determination L24308.</td>
</tr>
</tbody>
</table>
| 474           | Genetic Testing: BRCA1 and BRCA2 For Breast and Ovarian Cancer (REVISED) | 2/20/2015 | Changes in the policy:  
  - Diagnosed at any age with ≥1 close blood relatives* on the same side of the family diagnosed with breast and/or epithelial ovarian/fallopian tube/primary peritoneal cancer less than 50 years.  
  - Diagnosed at any age and there are ≥2 close blood relatives* on the same side of the family with breast cancer or epithelial ovarian, fallopian tube, or primary peritoneal cancer at any age. |
| 540           | Hereditary Cancer Syndrome Multiplex Gene Panels (REVISED) | 3/1/2015 | Under the Commercial Plan Policy section clarification was made to the three criteria that need to be satisfied for coverage. |
| 243           | Artificial Spinal Disc Replacement (REVISED) | 12/16/2014 | SelectHealth Commercial Plan now covers Mobi-C for both one-level and two-level total disc replacement. All other covered cervical discs remain covered only for a single level. |
| 223           | Continuous Glucose Monitoring (CGM) Systems With and Without Real Time Monitoring (REVISED) | 3/6/2015 | Extensive changes to this policy were made including changes to the coverage the professional CGM device. Changes included:  
  - Type 1 or type 2 diabetic patients on insulin with HgbA1C (A1C) changed from >7 to >7.5  
  - Type 1 or 2 diabetic patients on insulin with recurrent hypoglycemic events  
  - Type 1 or 2 diabetic patients on insulin with recurrent wide glucose excursions (daily fluctuation of 200 mg/dl or more)  
  - Changes were also made to personal real-time continuous glucose monitoring for home use. These changes included: Coverage for Type 1 diabetic patients age lowered from age 8 to ≥2 for Dexcom monitor only  
  - Reduced requirement for self-testing from ≥6 to ≥4  
  - Changed the requirements for elements within the section called “replacements will only be allowed when ALL of the following criteria are met:”  
    - Reduced requirement from 80 percent compliance to 50 percent compliance with the devices within a 90-day period instead of 30 days.  
    - Reduced requirement of three diabetic medical provider visits to two diabetic medical provider visits within 12 months. |
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<th>SUMMARY OF CHANGES</th>
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</table>
| 223           | CGM Systems With and Without Real Time Monitoring (continued) | 5/4/2015 | **Commercial Policy**  
Replacements:  
2-Documentation is provided demonstrating the member has used the device at least 50 percent of the time for a 30-day period without the past 30 days.  
3d-The member demonstrates stability or improvement in the A1C level. |
| 492           | Oral Appliances for Sleep Apnea (REVISED) | 5/7/2015 | Clarification was made under Commercial Plan policy under, the patient does not have any of the following:  
1-Temporal Mandibular Joint was replaced by Temporal Mandibular Joint Syndrome or other TMJ-related pathological processes. |
| 444           | Transcatheter Aortic Valve Implant (TAVI) Transcatheter Aortic Valve Replacement (TAVR) (REVISED) | 4/3/2015 | Policy now includes the coverage of Transcatheter valve-in-valve aortic valve replacement when criteria are met. |
| 453           | Genetic Testing: Heritable Thoracic and Abdominal Aneurysm and Dissection (TAAD) Disorders (REVISED) | 4/6/2015 | This policy used to be called Genetic Testing: Marfan Syndrome. An extensive revision was done to this policy. |
| 105           | Human Stem Cell Transplantation (HSCT), Bone Marrow Transplantation (BMT) (REVISED) | 3/19/2015 | Revision includes the following information from FEHB:  
For FEHB Plans only, the following are also covered:  
1. Epithelial ovarian cancer  
2. Childhood rhabdomyosarcoma  
3. Advanced Ewing sarcoma  
5. Advanced Childhood kidney cancers  
6. Mantle Cell- (Non-Hodgkin lymphoma) |
| 227           | Synthetic Skin Substitutes (REVISED) | 4/21/2015 | Following an M-Tech review, it was determined that EpiFix Dehydrated Human Amnion/Chorion Member Allograft is now covered. |

*If you have questions, please contact Jill Peterson at jill.peterson@selecthealth.org.*
NEW STRATEGIC PLAN APPROVED

In April, the Behavioral Health Clinical Program presented a strategic plan that addresses the current and projected behavioral health needs of the local population. This plan was unanimously approved and will be implemented immediately.

As part of the new strategic plan, behavioral health services will expand in every Intermountain region and will implement the following key objectives:

1. Establish clinical and care performance standards using evidence-based guidelines, care process models, and current best practice standards that span the continuum of care
2. Identify the services and providers needed to meet the needs of patients with behavioral health conditions and implement these along the spectrum of services and continuum of care
3. Develop operational components and connectivity between all services over the course of three years

During 2015, mental health integration will have a larger presence and increased services in all Medical Group clinics and select Specialty Clinics as part of personalized primary care. The design and early implementation of regionally located Behavioral Health Access Centers will also begin this year. These centers will aid in the referral and placement process of patients into the appropriate levels of care. Finally, there will be increased coordination efforts between payer contracting, local mental health authorities, community partners, and social services to help better meet the behavioral health needs of the population served.

If you have questions, please contact Carolyn Tometich at carolyn.tometich@imail.org.
**Cardiovascular**

**IMPROVING CARDIOVASCULAR CARE**

*This year, our focus* for the Cardiovascular Clinical Program is on continuing to improve the care of our heart failure patients, both inpatient and outpatient. Our four cardiovascular surgery programs continue to have exceptional outcomes, which are monitored through the Society of Thoracic Surgery database. We are also partnering with the Primary Care Clinical Program to optimize the management of hypertension and hyperlipidemia.

**iCENTRA UPDATE**

We continue to utilize the order set functionality within iCentra, which helps us support complex patient treatments plans. All cardiovascular physicians systemwide helped refine this process by providing feedback through direct meetings and email. The Logan cardiologists have been particularly helpful throughout this process.

*If you have questions, please contact Donald Lappe at donald.lappe@imail.org.*

**Endoscopy Development Team**

**CHOOSING WISELY – WHEN TO INDICATE UPPER ENDOSCOPY**

Upper endoscopy is a common procedure used to help diagnose and manage gastroesophageal reflux disease (GERD). Recent studies though suggest that as many as 38 percent of upper endoscopy procedures used in relation to GERD are not medically necessary. In fact, 39.4 percent of procedures referred by primary care physicians and 33.3 percent initiated by gastroenterologists did not adhere to the American College of Physicians’ 2012 recommendations for properly indicating upper endoscopy. Inappropriate use of medical procedures like this generates unnecessary costs and exposes patients to harm without improving outcomes.

The Clinical Guidelines Committee of the American College of Physicians reviewed evidence regarding the indications for and yield of upper endoscopy procedures in the setting of GERD. Following this review, the committee determined three best practice recommendations clinicians should follow when indicating upper endoscopy procedures:

- **UPPER ENDOSCOPY IS INDICATED IN MEN AND WOMEN WITH HEARTBURN AND ALARM SYMPTOMS (DYSPHAGIA, BLEEDING, ANEMIA, WEIGHT LOSS, AND RECURRENT VOMITING)**

- **UPPER ENDOSCOPY IS INDICATED IN MEN AND WOMEN WITH:**
  - Typical GERD symptoms that persist despite a therapeutic trial of four to eight weeks of twice daily proton-pump inhibitor therapy.
  - Severe erosive esophagitis after a two-month course of proton-pump inhibitor therapy to assess healing and rule out Barrett esophagus. Recurrent endoscopy after this follow-up examination is not indicated in the absence of Barrett esophagus.
  - History of esophageal stricture who have recurrent symptoms of dysphagia.

- **UPPER ENDOSCOPY MAY BE INDICATED:**
  - In men older than 50 years with chronic GERD symptoms (symptoms for more than five years) and additional risk factors (nocturnal reflux symptoms, hiatal hernia, elevated body mass index, tobacco use, and intra-abdominal distribution of fat) to detect esophageal adenocarcinoma and Barrett esophagus.
  - For surveillance evaluation in men and women with a history of Barrett esophagus. In men and women with Barrett esophagus and no dysplasia, surveillance examinations should occur at intervals no more frequently than three to five years. More frequent intervals are indicated in patients with Barrett esophagus and dysplasia.
Intermountain Healthcare and SelectHealth encourage providers to follow current evidence-based recommendations in order to optimize outcomes and decrease risk to patients.

**References**

Nicholas J. Shaheen, MD, MPH; David S. Weinberg, MD, MSc; Thomas D. Denberg, MD, PhD; Roger Chou, MD; Amir Qaseem, MD, PhD, MHA; Paul Shekelle, MD, PhD, for the Clinical Guidelines Committee of the American College of Physicians* Ann Intern Med. 2012; 157(11):808-816. doi: 10.7326/0003-4819-157-11-201212040-00008

If you have any questions, please contact Michael J. Sossenheimer, MD at (801) 944-3144.

**DATA ANALYSIS SHOWS VALUE OF TELEHEALTH IN INTERMOUNTAIN ICUS**

Since May 2014, Intermountain Healthcare has implemented TeleHealth technology in 256 ICU beds across the system, connecting them to a team of critical care nurses and intensivists at Intermountain’s Supply Chain Center. This team uses audio, video, and patient data to proactively monitor patients and collaborate with bedside caregivers 24 hours a day, 7 days a week. Now, early analysis shows that this partnership is making a difference in our community hospitals: risk of mortality is down, costs are decreasing, and higher acuity patients are staying closer to home.

The data shows that community hospitals have seen a statistically significant 59 percent reduction in risk of mortality (dropping 1.1 points from 2.7 percent to 1.6 percent), a 7 percent reduction in ICU length of stay, and a cost savings of $150 per patient. Total length of stay across the organization hasn’t changed significantly since implementation, but analysis shows higher acuity patients are being managed at the community hospitals’ ICUs with an upward trend in acuity in the tertiary ICUs noted as well.

“**This data really shows the impact of what we’re trying to do here. Other systems have seen these kinds of reductions and more, so we expected results like this and will continue to measure the impact of our teamwork with the bedside going forward.**”

– Dr. Bill Beninati, Medical Director of the Critical Care TeleHealth program

If you have any questions, please contact Marni Chandler-Nicoli at marni.chandler@imail.org.
MEDICAL NECESSITY DOCUMENTATION REQUIRED

The Centers for Medicare & Medicaid Services (CMS) now require that medical necessity be documented for major joint replacement procedures. This rule, which went into effect on September 8, 2014, states that CMS-provided medical necessity criteria be documented within the patient’s records, either in his or her hospital chart or clinic chart. To ensure that the criteria are met, CMS also authorized reviews of hospital charts for major joint replacement procedures. If the medical necessity criteria are not clearly stated in the hospital documentation, the physician and/or hospital payment will be at risk for denial or post-payment recoupment.

In an effort to promote compliance with this new rule, we partnered with the Surgical Services Clinical Program to devise a standardized medical necessity checklist based on the CMS criteria. This checklist is not meant to be the medical necessity documentation, rather a checklist of the documentation that should be in the patient’s hospital or clinic chart. We began implementing the use of this checklist on April 1, 2015. When a patient’s surgery is scheduled, the surgeon documents and verifies that the checklist information is either available in the patient’s hospital chart or the patient’s clinic chart.

In addition to launching this clinical initiative, we are also pleased to welcome three new development team medical directors to the Musculoskeletal Clinical Program:

- **Clinical Information Systems Development Team Medical Director:** Ben Widmer, MD
- **Fracture Development Team Medical Director:** Warren Butterfield, MD
- **Total Joint Development Team Medical Director:** Nate Momberger, MD

Dr. Widmer and Dr. Momberger currently practice orthopedic surgery at TOSH, and Dr. Butterfield practices orthopedic surgery at Dixie Regional Medical Center. These three physicians have proven records of excellence as well as a clear vision for quality orthopedics at Intermountain Healthcare. We know they will be great assets to our team.

If you have any questions, please contact Hugh West, MD, at hugh.west@imail.org or Joan Lelis, RN, at joan.lelis@imail.org.

PROGRESS ON FIRST-YEAR INITIATIVES

As we progress through our first year as the Neurosciences Clinical Program, we are pleased to report on our various initiatives:

**New Team Leadership:** We are currently interviewing medical director candidates for our Concussion Management Team and Neurosurgery Development Team, and we will announce the selected leaders shortly.

**Telestroke Services Rollout:** Telestroke services are now active in the entire Central Region. The next hospitals to rollout out telestroke services will be McKay-Dee Hospital, Dixie Regional Medical Center, Utah Valley Regional Medical Center, Logan Regional Hospital, and Bear River Valley Hospital. The expected go-live date is at the end of June.

**Emergency Department Seizure Treatment:** Dr. Tawyna Constantino will be partnering with the ED Development Team to identify opportunities for common care pathways related to seizure treatment.

**Concussion Management:** We developed several “straw man” patient care algorithms to support concussion management in primary care and sports medicine clinics. We are also currently evaluating a new concussion management software platform in coordination with Cleveland Clinic.

**Optimizing Neuro Critical Care Management:** We developing iCentra order sets for the establishment of...
Oncology

ADVANCING INTERMOUNTAIN’S ONCOLOGY INITIATIVES

OUTCOMES-BASED RESEARCH
The Oncology Clinical Program, under the leadership of Dr. William Sause and Mr. Brad Bott, focused the last six months on re-invigorating our cancer disease-specific development teams. Meetings held with these development teams resulted in over 25 outcomes-based research feasibility projects.

Mr. Bott was also selected by the National Cancer Institute (NCI) to act as a primary reviewer for NCI-sponsored Cancer Care Delivery Research (CCDR) clinical trials (adult and pediatric). Mr. Bott acts as primary reviewer on two NCI committees: the Cancer Care Delivery Research Steering Committee (CCDRSC) and the Patient Advocate Steering Committee (PASC). Mr. Bott will serve a three-year term on both committees.

PRECISION MEDICINE INITIATIVE
Intermountain Precision Genomics has developed a groundbreaking technology called ICG100. This comprehensive test uses state-of-the-art, next generation sequencing to find and target a patient’s individualized somatic mutations.

DNA is extracted from the patient’s tumor specimen and is sequenced for 96 cancer-related genes, which are commonly altered. This uses an in-solution, oligo-capture sequencing method. This test offers high coverage (>100X) and detects all classes of genomic alterations, including indels (insertions/deletions), translocations, copy number alterations (CNAs), and point mutations. Our approach is viable and well suited for all sample types including formalin-fixed, paraffin-embedded (FFPE), fresh tissue, and plasma.

Additionally, we have developed a comprehensive analytical pipeline that accommodates the diverse variants generated by the unique sequencing chemistry. This integrated service utilizes a collaborative molecular tumor board that consists of expert scientists and physicians in genomics. This interdisciplinary tumor board indicates effective treatment options based on genomics data and clinical relevance.

Any oncologist in the country can order ICG100 through a simple web-based interface. Through this interface oncologists can view genomic results and molecular tumor board interpretation, as well as make treatment selections and drug orders with ease and convenience. ICG100 is cost effective and offers high sensitivity coverage, superior ability for clinical management, identification of actionable CNAs, genomics-driven personalized treatment, and precision cancer care. For more information, please visit www.precisioncancer.org or call (435) 251-5780.

GENETIC COUNSELING
Genetics is an ever more important factor in the management of cancer, both in terms of assessment of inherited risk factors and in therapies tailored specifically for a patient’s tumor. Decisions on a wide array of genetic tests available for these various situations are becoming more and more difficult.

Given these increasing complexities, the need for genetic counselors at Intermountain Healthcare in supporting patients and providers as they make these decisions has grown substantially.

To keep pace with these demands, the number of cancer-specific genetic counselor positions in the Intermountain system has grown from just one a few years ago to now five counselors: one in the North Region (Ogden), two in the Central Region (IMED), one in the South Region, and one counselor to provide clinical services for the Southwest Region and to support the Intermountain Genomic Center located in St. George (soon to be filled).
These counselors oversee and support risk assessment and genetic testing for inherited cancer conditions, such as hereditary breast and ovarian cancer (HBOC). They are also integrated into the systemwide hereditary nonpolyposis colorectal cancer (HNPPC or Lynch syndrome) screening protocol done on all resected colon cancers in the system. Complexities in genetic testing in these areas have increased to the extent that SelectHealth only covers HBOC testing if guided by a genetic counselor, ensuring that the right test is done for a patient who truly meets testing criteria.

Going forward, the role of genetics in cancer prevention, diagnosis, and treatment will continue to gain importance, and the cancer genetic counseling services at Intermountain will need to grow and mature to meet these needs. Plans to recruit a senior genetic counselor at the director level to coordinate cancer genetic counseling services across the system are in the final stages. Integral to these plans is the goal of close coordination between the Oncology Clinical Program, Clinical Genetics, and the Intermountain Genomics Center in providing high-value care to all Intermountain patients.

**ONCOLOGY CLINICAL TRIALS OFFICE**

The Oncology Clinical Trials (OCT) Office provides physician investigators with centralized support (systemwide) for clinical trial activation, patient enrollment, regulatory support, and quality and timely data management, while promoting patient safety and clinical research compliance. Julie Ballard is the OCT manager and over the last year has been a tremendous asset to Intermountain Healthcare in submitting our National Cancer Institute NRG (NCI research base consisting of legacy groups: NSABP, RTOG, and GOG) main member application. This application has been approved, and Dr. Jeffrey Lee is the acting principal investigator. Our NCI Southwest Oncology Group (SWOG) main member application has also been approved, and Dr. Derrick Haslem will act as principal investigator. The OCT Office will be instrumental in supporting clinical research activities for our emerging Neuro Oncology and Phase I clinical trial programs.

**INTERMOUNTAIN BIOREPOSITORY (IBR)**

The Oncology Clinical Program is partnering with the Intermountain BioRepository (IBR) to establish an efficient tissue collection processes in order to begin the collection and storage of consented tissue under “The General Collection Protocol,” which will involve prospective collection of biologic samples of all types for future research studies. The goal is to create a collection of samples that can be used to support Intermountain’s research vision and Precision Medicine Initiative.

The IBR joined the Office of Research at the end of 2011. IBR serves as a centralized resource for research involving Intermountain biologic samples and linked clinical data in the Electronic Data Warehouse (EDW) and Utah Populations Database (UPDB). The IBR is housed at a secure and temperature-controlled location at LDS Hospital and includes over four million archival formalin-fixed, paraffin-embedded tissue blocks dating back to the early 1970s from across the Intermountain system.

Samples from the paraffin repository are being utilized for research, test development, and validation studies conducted by internal, academic, and commercial collaborators. IBR staff have expertise in data management, compliance, and tissue collection. Since 2011, IBR has completed 54 projects (26 commercial, 17 academic, and 11 internal), which have resulted in 19 abstracts and seven publications, with another seven publications in development. So far in 2015, IBR has been involved in 17 research projects, many of which will be resulting in publications. In January of 2015, IBR began collecting tissue prospectively for disease-specific, sponsor-funded projects. This process involves significant contribution from Intermountain surgeons, pathologists, and various internal departments.

**NEW PROGRAMS IN DEVELOPMENT**

**Neuro Oncology:** Beginning in June 2015, Dr. Howard Colman, a neuro oncologist from the University of Utah Huntsman Cancer Institute, will begin treating brain cancer patients in the Cancer Center at Intermountain Medical Center. He is actively working with Intermountain Healthcare leadership on finalizing his contract, which involves clinical care and leadership responsibilities.

**Phase I Program:** Intermountain Healthcare is in the early stages of developing a phase I (first-in-human) investigational drug program at IMED. This program is a collaborative effort between Dixie Regional Medical Center, Intermountain Precision Genomics, IMED, the Oncology Clinical Program, and the Oncology Clinical Trials Office. Two academic medical oncology positions are posted, which will lead this program. A committee and charter have been formed to develop the program, including clinical space redesign and staffing. This program is a crucial component to our precision medicine initiative, as phase I clinical trials offer investigational molecularly targeted therapeutics.

**Cancer Concierge Program:** The Oncology Clinical Program and IMED leadership, in partnership with Integrated Care Management, are assessing the need for a Cancer Concierge program. This program will be designed...
to streamline the new patient intake process and assist our patients with seamless patient navigation throughout our full menu of cancer services, including specialty and ancillary care/services.

AMERICAN COLLEGE OF SURGEONS — COMMISSION ON CANCER
The American College of Surgeons’ Commission on Cancer surveyed the Central Region Network Cancer Program in February 2015 the North Region Program in March 2015. We are very pleased to announce that both programs received a full three-year re-accreditation.

GRANTS
The Oncology Clinical Program and systemwide regional leadership submitted a letter of support for the Utah Cancer Control Program’s (UCCP) grant application for “Increasing the Implementation of Evidence-Based Cancer Survivorship Interventions to Increase Quality and Duration of Life among Cancer Patients” sponsored by the Centers for Disease Control and Prevention (CDC).

If you have questions about these oncology initiatives, please contact Brad Bott at brad.bott@imail.org or William Sause at william.sause@imail.org.

Pediatrics

PEDIATRIC TONSILLECTOMY AND ADENOIDECTOMY

There are 7,000-7,500 pediatric tonsillectomy and adenoidectomy (T&A) procedures performed each year in Utah. Of these cases:

- < 1 percent are performed on children less than 1 year old
- 38 percent are performed on children 1 to 4 years of age
- 36 percent are performed on children 5 to 9 years of age
- 16 percent are performed on children 10 to 14 years of age
- 10 percent are performed on teens 15 to 17 years of age

The average use rate within Utah is 8.4 cases per 1,000 people. This use rate is higher than in some regions of the United States. Also, there is considerable variability in the use rates of these procedures when comparing counties across Utah. Some counties maintain use rates at 20.0 per 1,000 or 15.0 per 1,000, while others have use rates close to the state average.

Since there is such variability in use rates for these procedures, we are interested in implementing a standard of care. There are national best practice guidelines for T&A that are available, and we will use these as a model to build our standard of care.

We recognize that many conversations about the need for T&A occur in primary care settings, not in ENT clinics. We are working to put a process in place where primary care providers will share a T&A Decision Guide with parents to help them determine if a T&A procedure is right for their child. Read a draft of the T&A Decision Guide.

Tonsillectomy: A Decision Guide

If you are a primary care provider that would be interested in piloting the use of this tool, please contact Carolyn Reynolds at Carolyn.Reynolds@imail.org.
IMPROVING PRIMARY CARE

iCENTRA

The Primary Care Clinical Program continues to define best practices for configuration and implementation in iCentra with a focus on:

- Edge development for care process models (High Blood Pressure, Chronic Kidney Disease, Lipid Management, and Diabetes)
- Certified diabetes education documentation that will be consistent enterprise-wide (including both inpatient and outpatient) and allow for report creation for American Diabetes Association credentialing
- Anticoagulation management including patient self-testing
- Choosing Wisely® alerts embedded into the workflow. One of the benefits of iCentra is that it can guide clinicians towards guideline compliance. For example, the recommended test for Vitamin D deficiency is a Vit-D 25-OH test, but sometimes clinicians inadvertently order Vit D 1,25-OH instead, which is more expensive and gives the incorrect result. iCentra can provide an “alert” that allows the clinician to order the correct test or cancel an unnecessary test simply by clicking on “radio buttons” in the alert. We are currently working with iCentra to develop alerts in nine areas with others under development. These alerts currently are “running in the back ground,” i.e. invisible to the clinician, collecting data on how often the alert would have fired. They will be “activated” when Medical Group / iCentra leadership feel clinicians are settled enough in the work flow that it would be helpful.

The frequency of the alerts being triggered since iCentra went live in the North is:

- Vit 1,25-OH Vit D instead of 25-OH Vit D levels – 19
- Factor V Leiden test (generally not recommended) – 30
- Antithrombin – III (generally not recommended) – 28
- CT scan for acute sinusitis – 10
- Dexa scan for patients without age or clinical diagnosis supporting test – 181

HIGH BLOOD PRESSURE

We continue our focus on rapid cycling for High Blood Pressure management.

- Research has shown for every 34 patients that are in control, one heart attack can be avoided.
- From our reports, in April of 2014 we had 71,130 patients who were in control, and now in April of 2015, we have 75,740 patients who are in control.

By applying the above statistic, this means:

- We have saved an additional 135 people from heart attacks over the course of the year as well as brought over 4,600 more people into control of their high blood pressure.

Additionally, we are participating in the Utah Million Hearts Coalition. Million Hearts is a national initiative co-led by the Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services that has set an ambitious goal to prevent 1 million heart attacks and strokes by 2017. The Utah Million Hearts Coalition aims to prevent heart attacks and strokes by improving clinical blood pressure measurement in Utah.

Likewise, we continue to participate in the American Medical Group Association’s Measure Up/Pressure Down® “Roll Up Your Sleeves” National Day of Action through:

- Intermountain Stories highlighting Intermountain’s work in support of Blood Pressure Control in helping people live their healthiest lives
- A text message campaign regarding the importance of high blood pressure assessment and control from LiVe Well
- Access to “It Takes a Team” Provider Video
- A High Blood Pressure blog on Intermountain.org sponsored by the Primary Care Clinical Program

DIABETES PREVENTION PROGRAM (DPP)

- HPV testing earlier than recommended – 4
- Pap smear testing earlier than recommended or in age group not recommended – 131
- H Pylori IgG (generally not recommended) – 203
- HLA-B27 test in patients without spondyloarthropathy – 40
DOCUMENTING NEGATIVE PRESSURE WOUND THERAPY (NPWT) DRESSING PLACEMENT

This information regarding the documentation of negative pressure wound therapy (NPWT) dressing placement applies to physicians, LIPs, and wound specialists who place NPWT dressings (e.g. wound VAC) in surgical/procedural settings.

IMPACT OF CARE
Recently a surgery patient experienced a complication involving retained sponges from a wound VAC that had originally been placed in the operating room. The Intermountain NPWT form that was developed several years ago was not used. This form was designed to promote consistent, accurate, and complete documentation of wound size and location, as well as the number and types of foam used when NPWT dressings are placed in the surgical setting. Providers are expected to use this form to document placement of NPWT dressings in operative settings until iCentra documentation capability is in place.

Benefits of the Form:
- Provides orders/important information for the next care provider (inpatient or outpatient)
- Eliminates incidents related to unintentionally retained foam pieces through thorough documentation
- Supports Intermountain’s Zero Harm initiative related to prevention of retained foreign objects

KEY POINTS
- Initial placement of a NPWT dressing in the operating room or in a procedural area will be documented using the Negative Pressure Wound Therapy Order Form.

To download the electronic app go to “Physician Apps.” From here, click on the “Best Practice Flashcards” and it will launch an install.

Things to know:
- This app should automatically update as CPMs are updated.
- This is currently only available for iPhones and iPads.
- An android version is in production and should be available in the June.

If you have questions, please contact Tonya Schaffer at tonya.schaffer@imail.org.
Operative staff will ensure that the forms are readily available (e.g. taped to NPWT device or dressing, on procedure cart) and may assist with filling out the form during procedures if requested.

Physician/LIP will sign completed NPWT form.

The white copy should be placed in the medical record. Nursing will send the yellow copy to the follow-up provider or wound and skin specialist.

NPWT education and training is available:

- Vendor resources:
  KCI 24-hour hotline: 1 (800) 275-4524
  KCI website
  KCI physician education

- Intermountain resources:
  CPG: **Negative Pressure Wound Therapy Procedure** (step-by-step instructions for dressing application and removal)
  Intermountain University: CBT

Wound and Skin Specialists (not on site at all facilities but available by phone): call to schedule consults or assistance with NPWT dressing placement (advanced notice is needed to schedule assistance with OR cases)

- Hands-on training can be coordinated by contacting local or regional wound and skin specialists and/or nurse educators. See table for contact information.

**CHECK YOUR KNOWLEDGE**

- Where can I obtain the NPWT form?

- If I have questions or need assistance during placement, who can I call?

- If I desire NPWT dressing placement training, what are my options?

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**WOUND AND SKIN PARTNERSHIPS**

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<thead>
<tr>
<th>HOSPITAL</th>
<th>CONTACT PERSON/PHONE</th>
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</thead>
<tbody>
<tr>
<td><strong>North Region</strong> (McKay-Dee, Logan, Bear River, Cassia)</td>
<td>Rachelle Spurlin, RN McKay-Dee / (801) 977-9900 ext. 6527 Maria Omer, PT McKay-Dee / (801) 387-5146 Cynthia Carman, RN Logan / (435) 770-2950 Maria Rivera, RN Cassia / (208) 677-6505</td>
</tr>
<tr>
<td><strong>Central Region</strong> (Intermountain Medical Center, Alta View, LDS, Riverton)</td>
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</tr>
<tr>
<td><strong>South Region</strong> (Utah Valley, American Fork, Delta, Sevier, Sanpete)</td>
<td>Elsie Garner, RN UV / (801) 357-8156 Mickie Rawlinson Delta / (435) 864-5591 Charisse Russell, RN Sanpete / (435) 462-4147 Lorna Whatcott, RN Fillmore / (435) 743-1522 Julia Bybee, RN Garfield / (435) 676-6811 ext. 1264</td>
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<tr>
<td><strong>Southwest Region</strong> (Dixie, Valley View, Garfield)</td>
<td>Tammy Holloway, RN Dixie &amp; Garfield / (435) 251-2186 Brenda Forbes, RN Valley View / (435) 868-5750</td>
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<tr>
<td><strong>Wasatch Back</strong></td>
<td>Melanie Budd, RN Park City / (435) 658-7375 Terry Wright, RN Heber / (801) 657-4357 Kam Wright, RN Heber / (801) 657-4357</td>
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*If you have questions, please contact Jeannette Prochazka at jeannette.prochazka@imail.org.*
NEW POLICIES IMPACTING WOMEN & NEWBORN CARE

NON-MEDICALLY INDICATED DELIVERY PRIOR TO 39 WEEKS
Non-medically indicated elective delivery prior to 39 weeks of gestation carries risks to the newborn without counterbalancing benefits and is costly in terms of neonatal care. Babies delivered earlier than 39 weeks are two to three times more likely to be admitted to intensive care. Elective delivery earlier than 39 weeks may also increase the rate of cesarean delivery. To mitigate potential complications, SelectHealth and Intermountain Healthcare are enacting the following policy.

Effective July 1, 2015 for all Utah SelectHealth Commercial and SelectHealth Community Care plans:
Every scheduled pre-39 week delivery will be reviewed to ensure the case either: (1) met one or more nationally accepted indications or (2) was approved as an exception by Intermountain Healthcare Maternal Fetal Medicine (with a written note by an MFM physician in the electronic medical record).

For scheduled pre-39 week deliveries found to have not met either of these two criteria, the following financial sanctions will occur:

- **Obstetric provider:** A sanction will be applied to the applicable global maternity claims for the amounts that SelectHealth would have paid toward delivery charges. This will apply to all contracted professional providers.
- **Intermountain facility:** The Intermountain facility at which delivery occurs will be sanctioned for the cost of the delivery.

The SelectHealth member (the patient) will continue to be responsible for paying her normal cost-sharing amounts, but will not be sanctioned. Also, an explanation code will be noted on the Remittance Advice indicating that the services were not allowed due to quality improvement noncompliance (as outlined in the Participating Provider Services Agreement (PPSA)).

To ensure an anticipated, scheduled pre-39 week delivery meets an acceptable indication(s), providers should use the Scheduled Delivery Documentation Form.

CHANGE IN GESTATIONAL AGE FOR DEFINITION OF FETAL DEATH
Effective May 12, 2015, the gestational age for determining stillbirth will go back to 20 weeks. This means that we no longer are required to provide a fetal death certificate and utilize funeral directors for deaths <20 weeks gestation. Utah Code 26-2-14.3 allows the Utah Office of Vital Records (OVRS) to issue a Certificate of Early Term Stillbirth to parents upon request if the gestation is of at least 16 weeks gestation but less than 20 weeks gestation. This is calculated from the day on which the mother’s last normal menstrual period began to the date of delivery. Links to the form that parents can have filled out will be available on the Women and Newborn Clinical Program Website or from the OVRS. For further details refer to [http://le.utah.gov/Interim/2014/pdf/00004746.pdf](http://le.utah.gov/Interim/2014/pdf/00004746.pdf).

If you have questions, please contact Teri Kiehn at teri.kiehn@imail.org.
ACTIVE AGING: OUR PATIENTS AND OURSELVES

The baby-boom generation is one of the largest and fastest growing segments of our society. Baby boomers are those born between 1946 and 1964. By 2029, when the last round of boomers reaches retirement age, the number of Americans 65 and older will climb to 71 million, up from 41 million in 2011—a 73 percent increase. Boomers represent a significant proportion of patients seeking healthcare, and nearly 40 percent of practicing physicians are considered to be “boomers.”

As we strive to achieve the healthcare “triple aim” of better care, better outcomes at the lowest appropriate cost, it behooves both patients and their providers to “live the healthiest lives possible.” A key strategy will be for each and every one of us to maintain an active lifestyle. Numerous publications point to physical activity as the key to health, longevity, and quality of life. A recent publication from JAMA Internal Medicine, entitled “Using Physical Activity to Gain the Most Public Health Bang for the Buck,” stated, “there is no single medication treatment that can influence as many organ systems in a positive manner as can physical activity.”

The Physical Activity Guidelines for Americans were first published in 2008. The recommended level of physical activity for adults 18 and older and for adults 65 and older is essentially the same—aim to achieve 150 minutes per week of moderate intensity physical activity (or 75 minutes a week of vigorous intensity physical activity), along with muscle strength training twice a week. For adults starting from little or no regular physical activity, the recommendation is to start with 10 minutes of walking and gradually increase the duration and intensity of activity to reach the 150-minute mark.

It’s estimated that only 16 percent of adults over the age of 65 meet recommended levels for both aerobic activity and strength training. There is certainly room for improvement! One thing that is abundantly clear is that you are never too old to start. Older adults benefit considerably from a physically active lifestyle. In fact, the impact of physical activity on incident disease and healthcare utilization is so strong that there is a HEDIS (Healthcare Effectiveness Data Information Set) quality measure for physical activity assessment and counseling in adults 65 and older.

The Physical Activity Vital Sign (PAVS) in HELP2 and iCentra is a tool that providers and their teams can use to assess the physical activity level of their patients. The PAVS asks three questions:

1. On average, how many days per week do you perform physical activity or exercise?
2. On average, how many minutes per day do you perform physical activity or exercise?
3. Describe the intensity of your physical activity or exercise (light = casual walk, moderate = brisk walk, vigorous = jogging).

A PAVS score of less than 150 minutes per week of moderate intensity physical activity should prompt a discussion on how to increase activity levels. Furthermore, the “activity prescription” should also include recommendations to be active throughout the day, avoid prolonged sedentary time, and integrate muscle strength training twice a week.

Resistance training is often the poor stepchild of physical activity. Images of Arnold Schwarzenegger’s bulging muscles along with a lack of knowledge regarding what to do and how to do it are often-reported barriers to resistance training. However, there are lots of ways to integrate muscle strength training. First off, you don’t need...
a gym or even gym equipment to strength train. I often recommend the “7 Minute Workout,” available free of charge from the iTunes App store (and for Android). The 7 Minute Workout requires nothing more than the floor, a wall, and a chair. Seven minutes is a bit of a misnomer in that you should perform the routine 3 times to optimize its impact on muscular strength and endurance. There are other options for people as well, including online personal training and exercise videos. A recent study published in Preventive Medicine, found that Pilates Exercise Training significantly improved muscle strength, walking and gait performance, activities of daily living, mood states, and quality of life amongst individuals 60 to 80 years of age.

An active lifestyle is key to healthy aging. In the words of Robert Butler, MD, Director of the National Institute on Aging, “If exercise could be packed in a pill, it would be the single most widely prescribed and beneficial medicine in the nation.” If your patients are struggling to integrate activity into their lives, or you would like a personal exercise prescription, consider a visit to one of Intermountain Healthcare’s LiVe Well Centers (Salt Lake Clinic, Park City Medical Center, Dixie Regional Medical Center). The multidisciplinary team of physicians, physical therapists, and exercise physiologists are there to help you (and your patients) “Get Well, Stay Well, and LiVe Well.”

Sources:


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