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DEAR COLLEAGUES,

Welcome to the 11th installment of Intermountain Med Staff News, a quarterly newsletter for our credentialed practitioners. We continue to work to improve communication between Intermountain and our medical staff, and hope that you will find timely information and news that will keep you informed and up to date.

Med Staff News is easy to navigate: click on any article in the table of contents and you will be taken directly to that article. Of course, you can also read the entire newsletter.

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

Sincerely,

Brent Wallace, MD
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Assistant Vice President
Physician Relations and Medical Affairs
susan.dubois@imail.org
(801) 442-2840
### APRIL 2016 - BOARD GOALS PROGRESS

<table>
<thead>
<tr>
<th>Clinical Excellence</th>
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<tbody>
<tr>
<td><strong>Complete Zero Harm Error Prevention training in hospitals and leadership methods training in the Medical Group</strong></td>
<td>Of Concern</td>
</tr>
<tr>
<td><strong>Reduce hospital-acquired infection rate (CLABSI, CAUTI, SSI Colon, SSI Abd Hyst) by 20%</strong></td>
<td>On Track</td>
</tr>
<tr>
<td><strong>Reduce the system-wide rate of Adverse Drug Events with harm by 20%</strong></td>
<td>Off Track</td>
</tr>
<tr>
<td><strong>Reduce the incidence of patients with hospital-acquired pressure ulcers by 20%</strong></td>
<td>Off Track</td>
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<tr>
<th>Patient Engagement</th>
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<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td>Rating Hospital Stay 8-10</td>
</tr>
<tr>
<td><strong>Medical Group</strong></td>
<td>Rating Clinic Experience as Excellent</td>
</tr>
<tr>
<td><strong>SelectHealth</strong></td>
<td>Rating patient Health Plan 8-10</td>
</tr>
<tr>
<td><strong>SelectHealth Share Members</strong></td>
<td>40% Meeting Health Behaviors to be on track</td>
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<thead>
<tr>
<th>Operational Effectiveness</th>
<th>Complete #1 plus 3 more of the following to be on track:</th>
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<tbody>
<tr>
<td><strong>#1</strong></td>
<td>iCentra will have at least three installations in 2016</td>
</tr>
<tr>
<td></td>
<td>iCentra will have at least four installations in 2016</td>
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<tr>
<td></td>
<td>At least 15 Care Process Models will be embedded into iCentra with a mechanism to track compliance</td>
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<tr>
<th>Physician Engagement</th>
<th>Complete 3 of the following to be on track:</th>
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<tbody>
<tr>
<td></td>
<td>75% of affiliated physician practices that request iCentra Physician Portal will have access to the application</td>
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<td></td>
<td>Physicians in the “accountable” networks participate in performance-based incentives for SelectHealth Share, Advantage and Community Care products</td>
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<tr>
<td></td>
<td>Transparent quality reports will be available to individual physicians / clinics involved in SelectHealth accountable products</td>
</tr>
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<td></td>
<td>Geographic committees will demonstrate impact in key areas, which will be defined by the end of the first quarter</td>
</tr>
<tr>
<td>Community Stewardship</td>
<td>Achieve at least 95% of cashflow target AND:</td>
</tr>
<tr>
<td></td>
<td>All hospitals adopt a 3-year strategy to address prioritized community health needs; hospitals engage both community and internal partners in these needs (15 for entry, 22 for stretch)</td>
</tr>
<tr>
<td></td>
<td>Demonstrate normalized “trend” of total cost for SelectHealth large-group products (7.5% for entry, 5.5% for stretch)</td>
</tr>
<tr>
<td>Employee Engagement</td>
<td>Achieve at least two of the following to be on track:</td>
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<tr>
<td></td>
<td>Increase LiVeWell Index to 4.13</td>
</tr>
<tr>
<td></td>
<td>Achieve a Gallup Accountability Index Score of 4.41</td>
</tr>
<tr>
<td></td>
<td>Achieve a Gallup Grand Mean score of 4.15</td>
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<tr>
<td></td>
<td>Increase the Extraordinary Employee Experience 2015 baseline index by 5%</td>
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If you have questions, please contact Brent Wallace, MD, at Brent.Wallace@imail.org.
INTERMOUNTAIN SYSTEMWIDE INITIATIVES

INTERMOUNTAIN FOUNDATION PILOTS CAREGIVER APPRECIATION PROGRAM

As you know, at Intermountain Healthcare, our mission is to help people live the healthiest lives possible. Dedicated caregivers like you play a vital role in fulfillment of this mission. For this reason, beginning spring 2016, Intermountain Foundation piloted a Caregiver Appreciation program that provides an opportunity for patients to honor a caregiver whom they credit with making a difference in their lives.

A select group of discharged in-patients from five Intermountain hospitals (Dixie Regional Medical Center, Intermountain Medical Center, McKay-Dee Hospital, Park City Medical Center, and Utah Valley Hospital) recently received a package in the mail that included a card with the following message:

“Imagine for just one moment where we would be without modern medicine. It’s difficult to put into words the importance that healthcare plays in our lives. Inevitably, there will be times when we will place our health, or the health of a loved one, in the hands of somebody else. It is in these moments that we are grateful for the talented men and women who dedicate their lives to providing the best care possible.

Please join us in honoring those caregivers whose dedication, expertise, and compassion have made an impact in your life, or the life of someone you know. If there’s a special physician, nurse, technician, or anyone else at an Intermountain hospital or clinic to whom you would like to show your gratitude, please use the enclosed card to write a personal note of thanks. We will then send them your thank you message together with a special certificate recognizing their outstanding service.”

The Foundation is excited, but not surprised, that responses from grateful patients are already being received. Knowing that Intermountain patients frequently express their appreciation to our caregivers verbally, it appears that many are also enthusiastic about having the opportunity to do so through this appreciation program.

As mentioned in the note above, the Foundation will be sending caregivers across the system letters containing the patient’s message, along with a certificate of appreciation.

As the Caregiver Appreciation program builds momentum in 2016 with the five pilot hospitals, the Foundation plans to add more patient populations over the course of the next few years, eventually mailing to select in- and out-patients from each Intermountain hospital and clinic.

The Foundation is honored to share with our medical professionals these special tributes and join with Intermountain patients in expressing our gratitude for your efforts and success in providing the very best in patient care.

Physicians who would like to learn more about the Foundation’s work are encouraged to contact David Flood, Vice President (David.Flood@imail.org) and Chief Development Officer, or Nancy Gregovich, Foundation Operations Officer (Nancy.Gregovich@imail.org).
NEW COMMUNITY RESOURCE TOOL

Have you ever had a patient that needed a community resource? Perhaps you discovered during their visit that they could use low-income food resources or help paying for their prescriptions. Whatever the need, do you know how to locate these services for your patient?

Intermountain Healthcare now has a solution to help you and your patients! We have partnered with the United Way and their 211 Information and Referral database to create an online, centralized platform to find community resources. The website is embedded into Intermountain.net and optimized for easy searching. All Intermountain care managers have been trained on how to use the tool to locate resources.

With over 9,000 services in the statewide database, the 211 tool is the best place to get your patients the non-medical, community help they need. The goal is that this tool will replace all the outdated binders, folders, and copies of copies that are floating around the system. The website launched a year ago and is steadily growing in use.

You can locate the tool on Integrated Care Management’s community site: https://m.intermountain.net/casemanagement/resources/Pages/211-Search.aspx. It can also be accessed from the e-resources tab on HELP2 and iCentra. A link on the physician portal is coming soon. While the tool is fairly intuitive, there is training to help users optimize their searching and learn about additional features on the site. Next time you need a community resource for your patients, think about using 211.

For more information, contact Mark J. Ott, MD, Central Region Chief Medical Director, at Mark.Ott@imail.org

SMALL MOLECULES, MASSIVE RESULTS: MASS SPECTROMETRY AT INTERMOUNTAIN

Accurate and Sensitive Analysis of Drugs and Hormones

Intermountain Healthcare recently acquired its first tandem mass spectrometer (LC-MS/MS) and testing on this platform commenced in May 2016 at Central Laboratory. This powerful technology provides higher sensitivity and specificity for detecting a spectrum of molecules at minute concentrations from a variety of biological matrices. Urine and blood drug testing, therapeutic drug monitoring, and esoteric hormone analysis are within the scope of this technology.

The first testing to be offered on LC-MS/MS at Central Laboratory is urine drug testing in support of emergency departments and rehab facilities across Intermountain. Unfortunately, in the state of Utah, we are seeing an increased incidence of drug overdose where the pharmaceutical armamentarium to treat pain and disease becomes itself a source of malady— explicated by Paracelsus (1493-1541) “Sola Dosis facit venenum” i.e., “The dose makes the poison.” Fortunately, each hospital laboratory across Intermountain Healthcare rapidly evaluates patient
PROF b: INTERMOUNTAIY CME MEDICAL DIRECTOR MARC JACKSON, MD

In May 2015, Intermountain CME named Marc Jackson, MD its first ever Medical Director. Dr. Jackson has been with Intermountain since 2003, has been the Director of the Maternal-Fetal Medicine Development (MFM) Team since 2009, and has served as the director of MFM at Dixie Regional from 2005-2007 and 2010-2012. In addition, he has served in CME capacities since 1999 in a previous role in Philadelphia, and began working closely with CME at Intermountain shortly after his arrival on various iterations of CME Committees, including for the current Intermountain CME program.

In this newly created CME role, Dr. Jackson works closely with CME Director SarahAnn Whitbeck and AVP Susan DuBois to provide leadership and strategic direction for CME, as well as the following:

- Ensuring program compliance with accreditation criteria of the applicable accrediting bodies (ACCME, ANCC, ACPE, etc.)
- Planning and executing the CME Steering Committee and CME Committee meetings in accordance with the CME Program Charter
- Evaluating the CME Program
- Prioritizing projects
- Serving as physician liaison with Clinical Programs, other areas providing accredited education, and all course directors, assisting with resolution of conflicts, compliance issues, or other matters as needed

Specimens for commonly abused and toxic drugs, supporting clinical evidence of a particular toxidrome. However, first-line urine drug tests have significant limitations around sensitivity and specificity requiring subsequent confirmatory testing by LC-MS/MS which is a definitive, gold standard method that identifies and quantitates parent drugs and their primary metabolites across multiple drug classes.

Nearly half of Intermountain patients with a positive drug screen are positive for more than one drug class. The recently validated LC-MS/MS assay at Central Laboratory is therefore designed to quantify 51 drugs from 8 general drug classes en bloc, in a single 8-minute analysis. This approach significantly reduces turnaround-times and testing costs as specimens are not analyzed multiple times by different methods. Insourcing drug confirmation testing further allows us to keep patient data within our health system and reduces send-out laboratory costs. By designing the method within Intermountain, it is customized to best serve our patient population while aligning with recent 2016 CMS and SelectHealth restructuring of urine drug test reimbursement as an effort to reduce cost and to encourage appropriate test utilization.

The line-up of tests that will be offered by LC-MS/MS at Central Laboratory in 2016 - 2017 includes panels for direct-to-mass spectrometry testing as a workflow for monitoring prescription compliance, illicit drug abuse, and polypharmacy for patients enrolled in pain management programs.

Undoubtedly, mass spectrometry will be an enduring feature in the physiognomy of clinical laboratory diagnostics. The mass spectrometry toolbox at Intermountain now comprises quantitative LC-MS/MS as well as accurate MALDI-TOF platforms used in fast identification of a myriad of microbial pathogens, transforming clinical microbiology and providing a significant benefit to our patients.

Consistent with the quality of personnel across Intermountain, Laboratory Services has incredible team members who strive for quality and robust practices, are dedicated to Zero Harm and are committed to ensuring continual and robust performance of this powerful technology.

If you have any questions, please contact Kelly Doyle at kelly.doyle@imail.org.
UPCOMING CME ACTIVITIES

You can access the schedule below to sign up for events, as well as access eCME activities and your transcripts, at the following links:

- **Course Schedule**
  https://intermountainphysician.org/intermountaincme/Pages/Course-Schedule.aspx

- **eCME Offerings**
  https://intermountainphysician.org/intermountaincme/Pages/ecme.aspx

- **Transcripts**
  https://intermountainhealthcare.org/pace-web/auth/classesList.html

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<thead>
<tr>
<th>Date</th>
<th>Title</th>
<th>Location</th>
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<tbody>
<tr>
<td>Friday, June 18</td>
<td>Educators’ Summit 2016</td>
<td>Utah Valley University</td>
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<tr>
<td>Wednesday, August 3</td>
<td>Simulation Facilitator Course</td>
<td>LDSH Simulation Center</td>
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<td>Friday, August 5</td>
<td></td>
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<tr>
<td>Thursday, August 25</td>
<td>Huntsman-Intermountain Cancer Care Program Annual Meeting</td>
<td>Huntsman Cancer Institute, Auditorium</td>
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<tr>
<td>Friday, August 26</td>
<td>Mental Health Integration Retreat</td>
<td>Doty Family Education Center, Intermountain Medical Center</td>
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<tr>
<td>Tuesday, September 6</td>
<td>Medical Group Clinician Forum</td>
<td>Marriott - City Creek</td>
</tr>
<tr>
<td>Wednesday, September 7</td>
<td>Medical Group Clinician Forum</td>
<td>Marriott - City Creek</td>
</tr>
<tr>
<td>Saturday, September 10</td>
<td>Clinical Learning Day - South Region</td>
<td>Zermatt Resort</td>
</tr>
<tr>
<td>Saturday, September 10 -</td>
<td>Cardiovascular and Thoracic Surgery Core</td>
<td>Doty Family Education Center, Intermountain Medical Center</td>
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<tr>
<td>Tuesday, September 13</td>
<td>Curriculum Review</td>
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<tr>
<td>Friday, September 13 -</td>
<td>Utah Certificate of Pallative Education</td>
<td>Ronald McDonald House</td>
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<tr>
<td>Wednesday, September 21</td>
<td>Intensive Medicine Clinical Program Conference</td>
<td>Thanksgiving Point</td>
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<tr>
<td>Wednesday, September 21</td>
<td>Integrated Care Management Conference</td>
<td>The Falls at Trolley Square</td>
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<tr>
<td>Thursday, September 22</td>
<td>Integrated Care Management Conference</td>
<td>The Falls at Trolley Square</td>
</tr>
<tr>
<td>Friday, September 23 -</td>
<td>Excellence in Trauma Care Conference</td>
<td>Canyons Resort</td>
</tr>
<tr>
<td>Saturday, September 24</td>
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If you have any questions, please contact SarahAnn Whitbeck at Sarahann.Whitbeck@imail.org.

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA)

In April of 2015 Congress passed the Medicare Access and Chip Reauthorization Act (MACRA). This legislation put in motion some of the most comprehensive changes to Medicare’s physician payment methodology seen in the last 25 years. The bipartisan legislation replaced the Sustainable Growth Rate (SGR) with a new approach to paying clinicians for value and quality care.

Quality Payment Program

On April 27, CMS put out a proposed rule that outlines their new two-path Quality Payment Program approach:

1. The Merit-Based Incentive Payments (MIPS) starting in 2019 consolidates three existing performance programs – Physician Quality Reporting System (PQRS), Medicare Electronic Health Record (EHR) incentive, and the Value-Based Modifier (VBM) – into four MIPS program performance categories: 1) Quality 2) Resource utilization 3) Clinical practice improvement activities 4) Advancing care information. CMS will phase in a penalty/reward system of 4% to 9% with additional bonuses available for high-value performers. In 2026 a .25% Physician Fee Schedule increase will be put in place for MIPS participants.

2. Advanced Alternative Payment Models (APMs) offer clinicians exemption from MIPS. Health and Human Services proposed that Advanced APMs could be CMS Innovation Center Models, Shared Savings Program tracks, or statutorily required demonstrations where clinicians accept dual-sided risk for providing value-based care. The models must meet criteria for payment based on quality measurement and the use of EHRs. The proposed rule includes a list of CMMI models that qualify as Advanced APMs. To qualify clinicians have to receive enough payments or see enough of their patients through Advanced APMs — participation requirements increase over time as specified in the statute. CMS offers a reward system of 5% incentive payment from 2019-2024. In 2026 a 0.75% Physician Fee Schedule increase will be put in place for Advanced APM participants.

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Payment adjustments and bonuses will begin in 2019 based on the 2017 proposed performance period. MACRA is a budget neutral or “zero-sum game” environment rewarding high-performing providers at the expense of others.

CMS is seeking public comment on the rule through June 27 and is expected to issue a final rule in late Q4 2016. To view the final rule: https://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-and-alternative-payment-model-incentive-under


SHARE ACCOUNTABILITY UPDATE: GEOGRAPHIC COMMITTEES HELP WITH TRANSITION TO POPULATION HEALTH

To help improve the health and care provided to patients enrolled in “population health” plans—such as SelectHealth Share, SelectHealth Advantage, and SelectHealth Community Care—Intermountain’s Geographic Committees are working with physicians who participate in Shared Accountability networks that support these plans.

The plans pay physicians based not only on services provided but also on quality, service, and budget metrics. The Geographic Committees work with participating physicians in each Intermountain region to review the metrics associated with the populations covered by the plans.

In 2014, Intermountain established Geographic Committees in each of Intermountain’s four regions—North, Central, South, and Southwest—as well as for Primary Children’s Hospital. Each committee includes eight physicians and four administrative leaders who serve two-year terms representing the Intermountain Medical Group, affiliated physicians, and the region’s hospitals. Committees are led by physician and administrative co-chairs, who report progress to Laura S. Kaiser, Intermountain’s Executive Vice President and Chief Operating Officer. The committees work closely with Intermountain’s Population Health Department, led by Vice President Joe Mott, which includes Stephen Barlow, MD, Medical Director for Population Health. The committees also work closely with Brent Wallace, MD, Chief Medical Officer for Intermountain.

The committees address such aspects of care as timely access to clinics and hospitals, service excellence, clinical quality, use of resources, total cost of care, and other shared objectives. The committees look at the entire continuum of care, including preventive and wellness services, care provided in clinics and hospitals, and services provided after patients leave our clinics and hospitals.

“The work of our Geographic Committees is a core system-wide priority,” said Kaiser. “Each region’s committee is implementing goals in at least three key areas related to quality, cost, and service. This work is central to our Shared Accountability approach and our mission of helping people live the healthiest lives possible.”

If you have any questions, please contact Joe Mott at Joe.Mott@imail.org.

TELEHEALTH 2015 ACCOMPLISHMENTS AND 2016 GOALS

In 2015, TeleHealth Services worked closely with clinical program medical directors to provide services like Crisis Care, Critical Care, Newborn Critical Care, and Stroke Evaluation in nearly every Intermountain hospital.

“By the end of 2015, Intermountain had more than 650 patient rooms connected to the TeleHealth system,” says Tara Larkin, TeleHealth Operations Director. “And after the first year of full implementation, we’re seeing positive results.”

Some of those results include:

- Patients in need of a Crisis Care evaluation now only have to wait an average of 23 minutes to see a behavior health worker via TeleHealth – compared to the hours it may take for a social worker to drive to the hospital for an in-person visit.
- McKay-Dee was able to retain its certification as a primary stroke center after the departure of their
on-site neurologist, in part due to TeleHealth’s stroke program.

- The stroke program has also helped improve door-to-needle (when tPA administration is appropriate) times across the system, in many cases faster than the national standard with a median response time of 4 minutes, and a door to needle time of 58 minutes.

- More than 1 in 5 newborns in need of resuscitation or other specialty assistance, who otherwise would have been transferred, were able to get the care they needed closer to home avoiding a transfer for the baby and costs to the family.

**PLANS FOR THE UPCOMING YEAR**

In 2016, the TeleHealth team will expand and improve existing programs, and support new projects including Infectious Diseases and various Pediatric subspecialties like Nutrition, Trauma, and Urology, while also refining and implementing improvements to the technology that will make it easier to use, in more places.

- **Infectious Diseases:** At a national antimicrobial stewardship forum at the White House, Intermountain Healthcare committed to ensuring all of our acute care hospitals will have antimicrobial stewardship programs that follow CDC and IDSA best practices by the end of 2017. An infectious diseases TeleHealth program which extends infectious diseases physician expertise to our rural healthcare settings is a key component to meeting that commitment.

- **In-patient Bed Monitoring:** Based on interest across the organization in a monitoring system for patients that are at a falls risk, this project will increase patient safety, as well as increase efficiency of employees by decreasing the need for Patient Safety Attendants (PSA).

- **Pediatric Nutrition:** Registered Dietitian Nutritionists (RDNs) will use TeleHealth to extend access to the Nutrition Care Process, which involves nutrition assessment, diagnosis, plan of care, monitoring, and evaluation. The program is designed to help increase patient compliance with nutrition care plans and decrease patient readmission rates.

- **Pediatric Trauma:** When children in the greater Intermountain West region are severely injured they are most often stabilized at a health care facility close to their home and then transferred to Primary Children’s Hospital for specialized pediatric trauma care. The Pediatric Trauma program is aimed at reducing transfers, lessening the burden of travel on families of patients, and saving costs.

- **Pediatric Urology:** Investigators can get writing and design assistance with research posters, publicity, and journal publications of manuscripts.

“We’re really excited to get even more programs off the ground,” Tara says. “We’re really expanding access so patients can get the care they need as close to home as possible – and that really makes a difference for our patients and their families.”

*Contact Tara.Larkin@imail.org for questions.*

**SEVEN COMMUNITIES HAVE SEEN MORTALITY RATES DROP SINCE CRITICAL CARE TELEHEALTH SERVICE WAS IMPLEMENTED**

A new study shows the dramatically positive impact of Intermountain Healthcare’s Critical Care TeleHealth service, which connects caregivers in Intermountain’s hospitals with critical care specialists online and via video. The study includes 18 months’ worth of data, collected since the Critical Care element of TeleHealth went live in May 2014. Its key findings:

- ICU mortality in Intermountain’s community hospitals that use TeleHealth has dropped a relative 42 percent from 2.65 percent before implementation to 1.55 percent after.

- Hospital mortality in Intermountain’s community hospitals that use TeleHealth has dropped by a relative 40 percent.

- They implemented the CVCP’s heart failure identification and risk assessment tool to focus clinicians’ activities on the right patients.

- At the same time, there was a significant increase in the acuity of illness in these same hospitals.

“These are important results,” says Bill Beninati, MD, Medical Director for Critical Care TeleHealth at Intermountain. “We’ve created a new team that combines...”
the strengths of the bedside team, a remote team of critical care specialists, and TeleHealth services. This team allows more patients to be cared for in their home communities — with a better chance of surviving and going home.”

More data show that TeleHealth is not only saving lives, it’s saving money. In our first year of partial implementation, the Critical Care TeleHealth program has helped Intermountain reduce our charges to insurance providers by $3.3 million — and reduce the costs of providing care by $4.3 million. “The result has been an overall financial benefit of $1.03 million, which supports one of the major premises of Intermountain’s high-reliability initiatives: Better care costs less,” says Dr. Beninati.

“Early in the development of our critical care program, we chose not to seek reimbursement directly from patients,” he says. “That makes it a little harder to demonstrate a direct return on the investment provided by TeleHealth services. However, as Shared Accountability becomes more prevalent, these savings will represent a greater financial gain for our patients, our payers, and for Intermountain.”

He adds: “Our overall goal with the Critical Care program is to provide quality patient care and improve outcomes — including length of stay, mortality rates, and efficiency of patient management. Our 18 months’ worth of data shows we’re meeting those goals.”

HOW THE CRITICAL CARE TELEHEALTH SERVICE WORKS
Critical Care provides support to 19 ICUs across the Intermountain system and to Star Valley Medical Center — a non-Intermountain facility in Afton, Wyoming. Critical Care has a team of 22 doctors and 20 nurses located in Midvale, Utah, who collaborate with bedside teams in Utah, Idaho, and Wyoming. They proactively monitor more than 260 beds 24/7 and provide real-time clinical support to patients and caregivers, ensuring consistent, high-reliability care for every patient.

The Result
Teamwork between bedside caregivers and the TeleHealth providers improves patient care and keeps critically ill patients close to home. Dr. Beninati says: “The virtual presence of an additional critical care nursing support and consultations with our critical care physicians during emergency situations reduce the need to transfer patients to larger facilities. This allows patients to recover with the full support of their home community, and it decreases costs.”

Dr. Beninati led efforts to publish results from the program, which he presented at a conference of the annual American Telemedicine Association in May. An article in Healthcare Business Insiders provides in-depth information on the benefits of TeleHealth’s Critical Care program. You can read the article here.

For more information, contact Dr. Bill Beninati at Bill.Beninati@imail.org.

HAVE AN IDEA FOR HOW YOU CAN USE TELEHEALTH IN PATIENT CARE? HERE’S HOW TO GET YOUR PROGRAM STARTED

The TeleHealth team’s primary function is to enable clinical care using TeleHealth technology – and there are a LOT of use cases many of you may have. If you want to launch a TeleHealth project in your clinical area, here’s what the process for implementing looks like:

→ SUBMIT A PILOT PROJECT REQUEST
After submitting a pilot project request and working with program leadership to define a business case,

continued on next page
the TeleHealth Guidance Council votes on approval. Each business case consists of four main areas:

- **Program Description** (including rationale, objectives, benefits, outreach opportunities, etc.)
- **Operations Model** (including staffing model, space needs, scheduling and registration, clinical documentation, billing and reimbursement, etc.)
- **Financial Plan** (including validated pro forma, 3-5 year plan, etc.)
- **Implementation Plan** (including rollout schedule, outcomes and evaluation, technology, RFP/RFI, etc.)

**EVALUATE THE PILOT**

TeleHealth programs regularly undergo quality reviews. Based on recommendations from program leadership, the Guidance Council will vote (at least yearly) to expand (with new available technology like TeleHealth carts, etc.) continue, or terminate the program.

If the Guidance Council determines the Pilot successful, and a good candidate for expansion, they will recommend it to the Clinical Operations Leadership Team (COLT) and Business Management/Population Health technology review committee. These committees weigh clinical, operational, and digital health strategy against enterprise alignment, then vote on expanding a TeleHealth program.

**EXPAND THE PROGRAM**

If funding is approved for the program, it will start to be implemented system wide. The implementation checklist includes:

- MOU (service contract) approval
- Four (4) executive board approvals
- Communications plan
- Physician contracts updated
- Privileging and credentialing
- State licensing (if needed)
- Clinical workflow defined
- Equipment/platform installed
- Clinical acceptance testing
- Mock simulation
- Go-live approval
- Go-live
- 30-60-90 day reviews

*To submit a pilot program request, please contact Kari Waring at Kari.Waring@imail.org or Tara Larkin at Tara.Larkin@imail.org for questions.*
iCentra is Live in Utah County Facilities and Surrounding Intermountain Clinics

iCentra went live at Utah Valley Hospital, American Fork Hospital, Orem Community Hospital and surrounding Intermountain Medical Group locations early Saturday morning, April 30, 2016. Physicians, clinicians, staff, region leaders, and iCentra project and support teams put in many extra hours over the weekend and throughout the first two weeks to support people through this transition. This implementation is the third one in the past 7 months and brings the entire South Region, the Medical Group clinics in the Central Rural and Timpanogos regions, and an estimated 35% of the Revenue Cycle Organization up on iCentra.

“I was highly impressed with our employees and physicians as I rounded in our three hospitals over the weekend,” says Steve Smoot, South Region Vice President. “Our teams have been very engaged as we prepared for go-live. We can expect challenges in the coming days and weeks as we learn the system, but with continued patience and focus, I’m confident we will be successful.”

As we celebrate the positive and dedicated attitudes of our colleagues in the South Region, we also need to acknowledge the providers and staff in the North Region who went first and taught us valuable lessons moving forward. “After the first go-live, we took a step back to listen and better evaluate the needs of the North Region and the regions that were going to follow,” says Mark Briesacher, Senior Vice President for Clinical Integration and Executive Lead for iCentra. “We focused on listening to people and watching the teams work together to better understand their daily workflows and needs.” As a result, iCentra teams have worked to improve the training and preparation process as well as the support structure available during and after go live. South Region hospitals and clinics will continue to have additional support from region leadership, at-the-elbow physician coaches and super users, and consultants.

The iCentra teams are currently focused on continuing go-live support for the South Region, maintaining good service levels for the North Region, training for Park City-Heber, and prepared for a Cerner code upgrade June 1st. Additionally, initial work in the Southwest region has begun.

This foundational work is bringing together people, introducing new technology and tools, and helping us better understand how clinical teams do amazing things each day in the care of our patients. Thank you for your leadership and support for iCentra.

Please send any questions or comments to icentra@imail.org. You may also visit www.intermountain.net/icentrasouth for more information.
PROTECTING PATIENT PRIVACY: PHYSICIANS POISED TO LEAD INTERMOUNTAIN CULTURE

During a recent privacy investigation, we discovered something that we already knew—protecting patient privacy is not easy and it is not convenient. Privacy issues can be very complex with seemingly gray areas. It is permissible at Intermountain, and also under HIPAA, to review a patient’s protected health information (PHI) for the purpose of treating the patient. In this case, the PHI was so interesting that physicians and staff from multiple departments were discussing it, taking photos of it, and sharing it long after the patient left the facility.

As we peeled back the layers, we discovered that the conduct in question was considered okay. Employees were not deliberately violating privacy rules; instead, employees thought that sharing a sensitive and interesting x-ray for weeks after the patient left the facility was acceptable because nobody stopped to think about it.

A recent cover title of the Harvard Business Review screamed in bold orange block letters, “You Can’t Fix Culture.” In the dictionary, corporate culture is defined as “the philosophy, values, behavior, dress codes, etc. that together constitute the unique style and policies of a company.” Are we helpless in creating a culture of patient privacy?

Physician leadership is invaluable when administrative actions like these are necessary. One of the most powerful influences on company culture is the tone that leaders set. At the scene of this recent incident, the Hospital CEO and the Regional Compliance Officer were busy clarifying gray areas and resetting expectations. Physicians are poised to set the tone for patient privacy because of their everyday involvement in patient care activities.

“Many people have an innate responsibility for their actions, but too many avoid it in the name of ease,” stated Brendon Burchard about responsibility in his book, The Motivation Manifesto. For some employees, it is easier not to worry about patient privacy; however, Mr. Burchard is right that “when someone favors ease over duty, many suffer.” If colleagues take pictures of patient x-rays or text patient information to friends, family, or co-workers, we all suffer.

According to Mr. Burchard, as leaders it is our duty to “activate and encourage a more responsible nature in those we work with; . . . when those we work with fail to protect patient privacy let us help them see the full spectrum of negative consequences they are creating for themselves and others,” and “if we are unwilling to point out when someone is being irresponsible in their duties and behavior, then we are unfit to lead.”

At Intermountain, the Hippocratic Oath, the Healing Commitments, and HIPAA regulations are honored and important, and physician leadership is critical for success. Physicians are poised at the top for influencing Intermountain’s privacy culture.

If you have any questions, please contact Emily Haley at Emily.Haley@imail.org.
IT HAPPENED HERE - MULTIPLE PATIENTS EVENTS

CASE #1
Incorrect Vaccine Given to Approximately 6 Employees at Flu Shot Clinic. Flu vaccine for the flu shot clinic was kept in 2 large Styrofoam containers. One box of Tdap was put into the containers with the flu vaccine. Both types of vaccine come in green boxes. Six doses of Tdap were given to employees before it was discovered that Tdap was being given rather than flu vaccine.

WHAT DO YOU THINK?
What may have caused this event: Boxes containing different immunizations were packaged in look-alike boxes and stored together.

What Error Prevention techniques could have prevented this: Team member checking and team member coaching prior to administering a medication. In a high reliability organization, it would be impossible to grab the wrong box of medication. Could ARCC (Ask a Question, Make a Request, Voice a Concern, Use Chain of Command) be deployed and the vaccine manufacturer be notified to change packaging?

CASE #2
Intermittent Breakdown in Computer Message Log Function – HELP 2. Clinic discovered discrepancies with lab results that were incorrect or were documented on the wrong patient’s chart. Multiple patient issues were discovered in Intermountain clinics. Some of these include:

• When a message was sent to another staff member (not patient-specific) it attached to a patient chart (about 20 patients identified).
• When a message was documented on a specific patient, the message log associated with a different patient’s MRN number (1 patient identified).
• When the referral section of message log was used, instead of sending the referral through to the appropriate clinic, a message was sent to a different patient via My Health (2 patients identified).
• Priority messages sent via Message Log to a provider arrived several hours later and were sent with the wrong patient name and date/time stamp (1 patient identified).

WHAT DO YOU THINK?
What may have caused this event: A computer glitch.

How was this recognized: This problem was identified by a Patient Service Representative (PSR) who recognized an error-then using STOP and RESOLVE, spoke up in daily huddle to bring to the attention of her peers and leaders so that potential PHI issues can be resolved.

CASE #3
Temperature Malfunction on Medication Refrigerator. Over approximately 1 month, 350 patients received vaccines that had been stored at a temperature lower than manufacture recommendations. The refrigerator temperature had been checked and found to be out of range and therefore had been adjusted and recalibrated to the correct temperature. The clinic was notified by Vaccines for Children (VCF) approximately 1 month later that there was a discrepancy in the clinic’s temperature log. The fridge was serviced and determined to be functioning properly. There was concern that the thermometers provided by VFC and the corporate vendor Hi-Tek have a significant variance and alarms did not trigger. Manufacturers were contacted to determine viability of the vaccines at the low temperatures.

QUALITY & PATIENT SAFETY UPDATE

continued on next page
WHAT DO YOU THINK?

**What may have caused this event:** Variability in the thermometers provided by two different vendors – one was residential grade, other commercial or pharmaceutical grade.

**What Error Prevention techniques could have prevented this:** Suggest that the facility request resolution using the **SBAR** format- Situation, Background, Assessment and Recommendation/Request. Determine one thermometer to be the standard, continue to monitor and log the medication refrigerator and report variances.

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**CASE #4**

**Courier Service missed a lab pick-up.** Lab discovered that the specimen batches from 2 days prior were never picked up by the courier service, (21 patients identified). Upon discovery, staff went through the specimens to find out which ones were no longer viable (8 patients identified) vs. those that were stable and could be send to Central Lab for testing/processing. A stat courier was then called and the specimens appropriately sent. Some repercussions may include: possible missed diagnosis, and patient inconvenience needing to return for additional testing.

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WHAT DO YOU THINK?

**What may have caused this event:** Breakdown in communication about need for specimens to be picked up and processed, and a courier who was not familiar with the pick-up area.

**What Error Prevention techniques could have prevented this:** Some type of **Hand-off** should be used communicating to Courier Service regarding specimen pick-ups. Going forward Courier Service will use **STOP and RESOLVE** if questions arise.

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*For questions, please contact Jeanne Nelson at Jeanne.Nelson@imail.org.*
HIGH RELIABILITY ERROR PREVENTION – THE TOOLS AND TECHNIQUES NECESSARY TO GET TO ZERO HARM

We are making great progress along our journey in our efforts to educate everyone on the Error Prevention techniques specifically selected for success at Intermountain Healthcare. Throughout our entire system, (including Medical Group) as of May 5, 2016 we have:

- Begun development of Error Prevention training specifically for short term medical residents.
- Investigated the possibility of training unique employee groups who work in our hospitals and clinics but are not clinicians.
- Scheduled some physician-only classes to accommodate the unique schedules of practitioners.
- Initiated engagement and training with Homecare.
- Held three root cause analysis training sessions, educating our risk, quality and dept. managers on the process to perform root cause analysis.
- Held webinars for senior leaders defining their new role and accountability in the root cause process. Created new tools for use in root cause analysis work.
- Created new tools for use in root cause analysis work.
- Piloted and deployed iReport, the web-based system for reporting events.
- Rolled-out SafetyNet for event management.
- Established and activated regional Safety Event Review Panels (SERPs) which include physician membership.
- Developed Zero Harm signage and posters for hospitals and clinics.
- Improved computer screen savers with Zero Harm messaging.
- Created new Zero Harm Icons: ZH Hero, ZH Moment, Getting to ZH, ZH Hints.
- Planned logistics for upcoming Safety Coach Training.
- Deployed Continuous Improvement (CI) huddle boards and training videos in acute care hospitals, Homecare and Medical Group.

We are all, individually and collectively, responsible to learn and then practice the three safety and reliability Error Prevention Commitments with the six accompanying specific techniques (communication/people skills). When utilized and incorporated into our daily work habits, we can be successful in reducing harm to our patients and ourselves.

Thanks for your commitment to this important work.

For questions, please contact Robin Betts at Robin.Betts@imail.org.
The New York Times recently reported that suicide in the United States has risen to the highest level in 30 years. The rise was particularly steep for women and middle-aged Americans. The increases were significant enough that the National Center for Health Statistics established a new suicide rate of 13 per 100,000 people, the highest since 1986. Suicide is currently one of the top 10 leading causes of death within all age groups (10-64).

Source: NCHS, National Vital Statistics System, Mortality

Given these alarming statistics the Behavioral Health Clinical Program, along with the Primary Care Clinical Program, urge all providers to screen patients for depression at least annually using the PHQ-2. If positive, the remaining questions that make up the PHQ-9 can be asked to further investigate the nature and relative severity of the depression. If necessary, providers should be prepared to administer the Columbia Suicide Severity Rating Scale (C-SSRS). Pediatric and adolescent versions of the screening questions are also available as part of the Depression Care Process Model.

Significant reductions in suicide rates is possible, as exemplified by Henry Ford Health System’s Zero Suicide...
goal. Since the initiative started 11 years ago, suicide rates amongst the Medical Group’s HMO members is down 80%. Methods enacted by Henry Ford included: improving access to behavioral health care using new care models such as same-day psychiatric evaluations and drop-in therapy groups; increasing patient safety by restricting means of suicide; redesigned patient encounter structures where providers recognized that histories of behavioral health needs resulted in increased risk of suicide.

As we move into a population-based methodology, it is imperative that proper screening for both medical and psychological disease risks be conducted. As we help our patients normalize mental health, and consider it an actionable item during routine visits, perhaps we can have an impact on these alarming trends within the regions that Intermountain serves.

If you have any questions, please contact the Behavioral Health Clinical Program at BHCP@imail.org.

Cardiovascular

CARDIOVASCULAR CLINICAL PROGRAM SPRING UPDATE

The Cardiovascular Clinical Program has been focusing our efforts to support the success of iCentra. We have produced over 80 Power Plans (iCentra order sets) for cardiology, CV surgery, vascular surgery, and thoracic surgery based on input from all interested physicians. The development and implementation has been very enlightening about best practice and reducing variation. We also are adding decision support for many of our processes. In particular, we are working closely with the Cerner team to replicate our HELP2 electronic discharge tool.

Heart failure (HF) enhancements are also a major focus. We have worked with the emergency department for best care of heart failure patients presenting there. Our inpatient HF identification and risk stratification tool continues to assist all the hospitals to provide best practice to these patients. Of note, is that our hospitals have some of lowest HF readmission rates in the country.

If you have any questions, please contact Donald L. Lappé, MD, FAHA, FACC; Donald.Lappe@imail.org.

Imaging Services

INTERMOUNTAIN HEALTHCARE GETTING PACS UPGRADE

Intermountain Healthcare Imaging recently performed a much needed upgrade to our AGFA Picture Archive and Communication System (PACS). PACS is the enterprise image storage, retrieval, and review system for all of Intermountain radiology imaging, as well as for various other departments that store studies long-term.

Our current AGFA system operates on a 32-bit operating system, which limits the number of records that can be stored in the database. We have exceeded the number of records allowable, which causes delays and instability in the system. The upgraded system is designed to run on a 64-bit operating system, which allows for billions of records to be stored in the database. Intermountain can expect to continue to add studies into the system for more than a decade, without exceeding the maximum allowable record limit. As such, the expectation is that we will see improved

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performance in viewing and retrieving studies, and should expect a more stable environment, overall.

The AGFA Impax upgrade took place late Friday night on May 20th, with the cutover to the new system in the early hours on Saturday. The transition from the old system to the new system should be transparent to end users, who review images on AGFA Impax. There are minor changes to the user interface, and training should not be required, except for minimal training for radiologists.

Imaging Services is also working with supplier partners to provide image viewing capabilities outside of Imaging, with products like ResMD, our Enterprise Viewing solution. ResMD, like AGFA Impax, offers viewing solutions for our affiliate and referring physicians. As we advance in development with these suppliers, our desire is to offer mobile solutions for viewing from your mobile devices, as well as other features to enhance your productivity and clinical needs.

Enterprise Imaging Information Systems continues to look for ways to improve the performance and stability of our systems, and optimally meet the needs of our users.

If you have any questions, please contact Gregg Stout at Gregg.Stout@imail.org.

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**Intensive Medicine**

**ABCDE CARE PROCESS BUNDLE IN THE ICU**

The **ABCDE bundle is the framework adopted** by the Critical Care Development Team (CCDT) to organize the management of delirium, sedation and mobilization of intensive care unit (ICU) patients. ABCDE stands for (A) Assessment and management of pain, (B) coordination of both awakening and breathing trials, (C) Choice of sedatives or not to sedate all, (D) Delirium monitoring and management, and (E) Early Mobility. Consistent and accurate delirium assessment has been an educational focus of CC nurses at Intermountain over the last year due to the significant human and financial cost associated with its incidence. Delirium occurs in up to 80% of ICU patients and has been recognized as one of the most significant predictors of negative outcomes. Delirium is an independent predictor of mortality, length of stay, and ventilator duration, as well as long-term cognitive and functional deficits that significantly reduce quality of life. The harms are cumulative such that each additional day spent in delirium is associated with an increased risk of prolonged hospitalization, physical and cognitive disability, and death. The economic burden associated with delirium is estimated to be as high as $16 billion annually. In 2008, the Centers for Medicare and Medicaid Services considered tying hospital incidence of delirium to reimbursement, as it is in the long-term care domain, thus recognizing the importance of this care process. In addition to published literature from other groups around the country, there are several large initiatives ongoing throughout the U.S. to investigate short- and long-term clinical outcomes with ABCDE implementation. The Society of Critical Care Medicine specifically states that the elements of ABCDE should be standard practices in all ICUs.

The IMCP believes that there is significant opportunity to improve the long-term outcomes of our critically ill population through reliable application of the ABCDE bundle. In addition to recent efforts to increase reliability of the RN delirium assessment (D), spontaneous awakening and breathing (B) trials are being standardized to improve compliance and reduce variation across ICUs. We’ve made progress in understanding our baseline sedative (C) utilization across ICUs to inform guideline development for improved use. The Central Region is addressing the exercise and mobility bundle element (E) in a systematic way through a multidisciplinary pilot project. The pilot is designed to reveal opportunities for improved communication, appropriate resourcing, documentation standards and more broadly to improve work across disciplines to ensure that our ICU patients are moving at least twice daily. Outcomes from this pilot will be formalized this summer and will inform a broader strategy for the system.

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These parallel efforts will contribute to a more coordinated standard of care for ICU patients. Perhaps most challenging is integrating these elements into the daily plan of care that requires engaging all members of the care team. Transforming behavior in the ICUs from life or death episodic care to a more holistic long-term view is a paradigm shift that requires the commitment and collaboration of clinicians, patients, and their families.


Please send questions to Nancy Nelson at Nancy.Nelson@imail.org.

Musculoskeletal

NEW PATIENT EDUCATION FOR TOTAL JOINT REPLACEMENT SURGERY PATIENTS

The Musculoskeletal Clinical Program (with support from Patient and Provider Publications) will be publishing a comprehensive new resource for total joint replacement patients entitled, Your Guide to Joint Replacement.

The Musculoskeletal Workgroup conducted a “deep-dive” audit of existing materials and gathered feedback from the 7 facilities conducting most surgeries, yielding these findings:

- Materials provided to patients included an out-of-date booklet and fact sheets as well as independently produced materials inconsistent in accuracy, health literacy, messaging, and use of the Intermountain brand
- Consistent gaps in patient understanding and expectations about:
  - Level of pain after surgery
  - Exercise and general mobility requirements
  - Discharge destination requirements
  - Self-care related to constipation and swelling
  - Pain management
  - Following precautions related to hip dislocation

Aligning Patient Education with Program Goals

To standardize Intermountain patient education and meet program goals (e.g., early mobility, fall/infection prevention, enhanced patient satisfaction [especially in terms of pain management], and increased discharge to home) our patient education must focus on:

- Helping patients understand that they and their caregivers can effectively manage their recovery at home. In the past, patients spent more time in the hospital following joint replacement and often were discharged to a care facility. Today, most patients are going home in 1 to 2 days.

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Incorporating best practices from published research as well as data collected at Intermountain facilities (see figure 1 on previous page) that link pre-op education, especially classroom education to:

- Optimal patient-reported outcomes and reduced pre-operative anxiety
- Alignment of patient expectations regarding pain and functional capabilities
- Reduced length of stay following surgery with no associated increase in surgical complications or readmissions

Establishing a “foundational” set of joint replacement patient education as a companion to classes offered in person, via DVD, and online (in the future) as well as a vetted source of content that can be quickly and effectively pushed out to patients as fact sheets and via other media in “digestible chunks” at the time and place that best fits individual patient learning styles.

YOUR GUIDE TO JOINT REPLACEMENT

Your Guide to Joint Replacement offers Intermountain total joint replacement surgery patients standardized, best-practice content that can be customized based on the joint replaced, the surgeon, the facility, and special health considerations of the patient. This toolkit is a cost-effective way to quickly align education objectives.

Getting the Right Results

Beginning Q3, the Musculoskeletal Clinical Program will compare patients who either do or do not receive the toolkit and participate in pre-op educational opportunities with:

- HCAHPS scores related to patient satisfaction
- Discharge destination
- Readmission within 30 days

Using this data and feedback from providers and patients, the Musculoskeletal Workgroup will begin work on the next phase of our patient education vision (illustrated in figure 2 below).


Ibrahim et al, BMC Medicine 2013, 11:37

For more information, contact Hugh West, Medical Director (Hugh.West@imail.org) or Joan Lelis, Operations Director (Joan.Lelis@imail.org), Musculoskeletal Clinical Program.
Neurosciences

ISCHEMIC STROKE CPM, PATIENT EDUCATION, AND MOVEMENT DISORDERS DEVELOPMENT TEAM

The Neurosciences Clinical Program and Stroke Development Team have been updating the ischemic stroke Care Process Model (CPM) based on recent research findings. Recent trials, including MR. CLEAN, SWIFT PRIME, ESCAPE, and EXTEND IA, have all shown the benefit of endovascular treatment, in addition to tPA, in patients with acute ischemic stroke. The ischemic stroke CPM has been modified to include, in appropriate stroke sub-groups, an interventional arm for treating practitioners. All of the major hub hospitals – IMed, McKay-Dee, Utah Valley and Dixie Regional – have neuro-interventional capabilities to treat these patients and improve their outcomes. Even patients who originate from surrounding and rural hospitals, if transferred quickly enough, may also benefit from interventional treatment. The updated Emergency Management of Acute Ischemic Stroke CPM as well as other CPM’s and guidelines can be found on the Neurosciences Clinical Program Clinical Guidelines and CPM’s page.

In addition to updating the stroke CPM, the Stroke Development Team has been working in coordination with the ED Development Team on a tool to educate stroke patients about the benefits and risks of treatment options. The resulting tool simplifies the explanation to patients in a manner that can be easily discussed in emergent treatment situations. The education tool is now available for use by practitioners throughout the Intermountain system. The tool can be found here:

- Ischemic Stroke Treatments Fact Sheet
- Ischemic Stroke Treatments Fact Sheet (Spanish)

Finally, we are proud to announce the approval and formation of another development team in the Neurosciences Clinical Program: Movement Disorders. Intermountain Medical Center has recruited a Movement Disorders physician, Dr. Katherine Widnell, a neurologist with extensive training in research and treating patients with these types of disorders. Dr. Widnell will chair the development team and work with local and regional providers in establishing care pathways for these complex patients. She will begin her practice in early fall.

Please send questions to Jeremy Fotheringham at Jeremy.Fotheringham@imail.org.

Oncology

ADVANCING INTERMOUNTAIN’S ONCOLOGY INITIATIVES

Oncology Clinical Program (OCP) and Strategic Visions in Healthcare (http://www.strategicvisionsinhealthcare.com). Workstreams are being formed and activities are being prioritized, which will help us develop a 3-5 year strategic plan (system-wide) for Cancer Services. Our goal is to achieve a consistent level of comprehensive, high-quality cancer care at all our locations, an excellent experience for our patients across the cancer continuum, expansion of research, and strong alignment with our cancer specialty physicians.

We are pleased to announce the grand opening of our Intermountain Precision Genomics Cancer Research Clinic, which is located on the Intermountain Medical Center.
Campus. This clinic was designed to expand our industry-sponsored clinical trial program (including early phase trials), which will provide our patients access to targeted investigational therapeutics, based on mutation status. This clinic will be co-lead by Drs. Craig Nichols and Ramya Thota.

iCentra activities and efforts continue. For 2016, the OCP has prioritized building standard chemotherapy order sets (chemo regimens). We have identified 258 requiring build; to date, we have built 213 regimens. By June, we plan on moving approximately 100 of these regimens from the test to production environment. Our ultimate goal is to have all 258 built and ready for production by the end of the year.

We continue to collaborate with the NW NCORP (http://ncorp.cancer.gov/findasite/profile.php?org=1657) Administrators. We are currently working on developing content for the NW NCORP website, where Intermountain Healthcare’s Cancer Care Delivery Research (CCDR) component of the grant will be heavily featured.

In collaboration with the Supply Chain Organization (SCO), we are pleased to announce we are in the final stages of executing our agreement with the American Society of Clinical Oncology (ASCO) to participate in CancerLinQ (http://www.instituteforquality.org/cancerlinq) as one of 40 vanguard institutions. We are anxious to transition to the adoption and implementation stages of this project.

In collaboration with the Healthcare Transformation and Population Health Management Departments, we continue to measure our 2016 physician quality indicators; we are also actively developing our 2017 proposed measures. Finally, we are actively working with the SCO and other institutions (i.e., Stanford University) to evaluate oncology specific and vendor-driven care process model software systems, which are designed to deliver the highest quality evidence-based care at the lowest possible cost.

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

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**Pediatrics**

**RISK OF HYponATREMIA WITH USE OF HYpotONIC IV FLUIDS**

**SITUATION**

There is a risk of hyponatremia with the routine use of D5-IMB, No. 48, or D5 ¼ NS IV fluids in the infant and pediatric population (excluding NICU).

**BACKGROUND**

Recent cases of death, reported by the Institute for Safe Medication Practices (ISMP), have prompted urgent recommendation to hospitals to reassess their protocols, order sets, and access to hypotonic IV fluids to avoid tragic, unintentional deaths associated with use of hypotonic solutions for maintenance IV fluids in infant and pediatric patients. Sites across the country and in Europe are requiring that most hypotonic saline solutions are removed from general pediatric areas.

The evidence supporting concern is mounting. A recent meta-analysis of 10 randomized control trials demonstrated significantly higher risk of developing hyponatremia with use of hypotonic IV fluids, as compared to isotonic fluids (Wang et al. Pediatrics 2014). Conclusion of the analysis is “Isotonic fluids are safer than hypotonic fluids in hospitalized children requiring maintenance IV fluid therapy.”

**ASSESSMENT**

The risk of hyponatremia is increased with the use of hyponatremic solutions, occasionally with devastating outcomes.

**RECOMMENDATION**

Hypotonic solutions i.e. D5-IMB and its equivalent, D5-¼ NS and Dextrose No. 48, will be removed from pediatric order sets / power plans. We also encourage removal of these fluids from floor stock in pediatric units / areas throughout Intermountain Healthcare.

If you have any questions, please contact Carolyn Reynolds at Carolyn.Reynolds@imail.org.
**Pharmacy Services**

**UTAH LEGISLATURE REINFORCES USE OF PRESCRIPTION DRUG DATABASE**

According to the Department of Health, Utah ranks fifth in the nation for prescription opioid-related deaths. In Utah, six people die every week from overdosing on prescription opioids. From 2000 to 2014, Utah experienced a nearly 400 percent increase in deaths from prescription opioid abuse. In 2012, 820 Utahns were hospitalized as a result of prescription opioid abuse, with total hospitalization charges exceeding $15 million.

The State of Utah is responding to this growing opioid abuse epidemic with legislative change: the **BH 375 Prescribing Drug Abuse Amendments** that fall under the jurisdiction of the Utah Division of Occupational and Professional Licensing (DOPL). In essence, the bill—effective May 10, 2016—requires prescribers and dispensers to consistently refer to Utah’s Controlled Substance Database (CSD) to determine whether a patient may be abusing opioids and to communicate with each other to make an informed, professional decision regarding whether the prescribed opioid is medically justified, notwithstanding the results of the database search.

No penalty can be given by the DOPL to the prescriber or dispenser upon any action or lack of action to meet these new requirements. Rather, the bill offers a reminder, encouraging providers to take greater responsibility and engage in proactive measures to prevent opioid abuse.

The bill reinforces the objectives of the Opioid Community Collaborative (OCC)—a partnership between Intermountain, the Utah Department of Health, and other organizations—to decrease opioid abuse and misuse in Utah. The bill also prompts a reminder for providers to avoid prescribing and dispensing opioids to treat chronic or post-operative pain whenever possible, but when medically necessary giving appropriate, limited dosage and amounts of these medications.

Staying vigilant of our patients’ opioid use and taking measures to protect their health and safety is our responsibility.

*If you have any questions about the new bill, please contact Mike Jensen, Pharmacy Compliance Manager, at Michael.Jensen2@imail.org or 801-507-8147.*

**MEDICATION SAFETY BRIEF**

While there are many benefits to the use of electronic prescribing (e-Prescribing) systems, there are some unintended consequences that may contribute to medication errors or adverse drug events. One example of this includes when prescribers cancel or discontinue a prescription that was previously sent to the patient’s preferred pharmacy. In this scenario, no communication is sent to the pharmacy to notify staff that the prescription has been discontinued and is no longer needed by the patient. While this issue was previously described in the October 2015 Drugs & Decisions Newsletter, there continues to be confusion among clinicians at Intermountain Healthcare and other organizations. While Cerner continues to work toward solutions that will create 2-way communication between prescribers and community pharmacy locations, this functionality does not currently exist. If a prescriber no longer wishes for a patient to receive specific medication(s), he/she must contact the pharmacy to specifically communicate this information.

*Please e-mail questions to Sabrina Cole at Sabrina.Cole@imail.org.*
Primary Care

DIABETES PREVENTION
To date we have had 2,667 participants in the Diabetes Prevention Program (DPP) referred from over 258 providers and 88 clinics. To further our reach to prevent diabetes, we will be implementing a pilot of the Omada Prevent program beginning in July. We estimate that we have avoided or delayed 51 cases of diabetes since the program began, which has saved roughly $400,000.

Below are some figures that demonstrate our success.

HIGH BLOOD PRESSURE
We continue to make progress in high blood pressure control within our system. The number of patients who have received counseling as well as treatment with medications continues to increase as we strive to increase the number of patients in control.

Our partnership with the Utah Million Hearts coalition continues. The Utah Million Hearts Coalition, in conjunction with the National Million Hearts initiative, aims to prevent heart attacks and strokes by improving clinical blood pressure measurement in Utah through accurate blood pressure measurement and control. This group has recognized the following clinics for excellence in blood pressure measurement:

- Budge Internal Medicine Clinic – Silver Level
- Heber Valley – Silver Level
- Merrill Gappmayer Family Medicine Center – Silver Level
- Moroni Clinic – Bronze Level
- Mt Pleasant Clinic – Silver Level

May is National High Blood Pressure education month and the High Blood Pressure Development Team wrote an article for Intermountain Stories sharing patient success stories, created a blog for patients in the community surrounding the importance of screening and maintaining blood pressure control, and coordinated text messages sent out through the LiVe Well team.

If you have any questions, please contact Sharon Hamilton at Sharon.Hamilton@imail.org.

Surgical Services

APPENDICITIS CARE PROCESS MODEL

A Surgical Service Clinical Program committee of general surgeons from multiple Intermountain facilities is developing a standardized Care Process Model (CPM) to manage appendicitis in patients of all ages. This CPM does not focus on diagnostic pathways nor how to perform an appendectomy. The goals of the appendicitis CPM are:

- Clinical continuity
- Improved outcomes
- Protection from litigation
- Opportunity to study problems where limited information is available

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These goals will be achieved through standard guidelines of pre-op, post-op, and follow-up orders and through improved communication between surgeons and Emergency Department physicians in the pre-op phase and surgeons and nursing in the pre-op and post-op phases. The CPM outlines a multi-disciplinary approach to treatment once appendicitis has been diagnosed. It focuses on the operative pathways for the management of a ruptured and non-ruptured appendicitis, but also includes options for both the non-operative management of non-ruptured appendicitis and interventional radiology abscess drainage for ruptured appendicitis. It also provides the following standardized physician order sets and guidelines within the iCentra system:

- Pre-surgery treatment and care management
- Post-surgery treatment and care management
- Protection from litigation
- Discharge criteria and care management

The order set will be placed in the surgeons’ favorite folder for your use along with guidelines for care. When writing orders in iCentra, please use this CPM order set.

If you have any questions, please contact Dr. Skarda at David.Skarda@imail2.org or David Kay at David.Kay@imail.org.

Women & Newborns

ANTENATAL CORTICOSTEROIDS IN THE LATE PRETERM BIRTH PERIOD IN WOMEN AT RISK FOR PRETERM DELIVERY: A GAME-CHANGING PRACTICE

The use of antenatal steroids for the prevention of respiratory and other neonatal morbidities associated with preterm birth has been a highly successful practice for women expected to deliver before 34 weeks gestation. The recently published results of the Antenatal Late Preterm Steroids trial, which included many enrollees from Intermountain facilities (Intermountain Medical Center, Utah Valley Hospital, LDS Hospital, and McKay Dee Hospital), indicate that the use of antenatal steroids should be extended to pregnancies at high risk for late preterm birth (delivery 34.0 week to 36.6 weeks gestation). These findings are of significant clinical importance because late preterm births account for 70% of all preterm births.

The trial was conducted by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, Maternal-Fetal Medicine Units Network and was a double-blind, placebo-controlled randomized controlled trial that enrolled women with a singleton gestation at high risk for preterm delivery between 34 weeks 0 days through 36 weeks 5 days of gestation. The study involved treatment with either 2 doses of betamethasone (12 mg intramuscularly) 24 hours apart or a matching placebo. The primary outcome of the study was a composite endpoint describing the need for specific respiratory support modalities within 72 hours after birth. Tocolysis was not used as a part of the protocol, and clinical management decisions after study drug administration were at the discretion of the provider.

https://mfmu.bsc.gwu.edu}
The most common indication for enrollment was preterm labor (28%), followed by delivery for gestational hypertension or preeclampsia (26%) and ruptured membranes (22%). The study found a significant decrease in the primary outcome - the need for respiratory support - (14.4% in the placebo group vs 11.6% in the betamethasone group; relative risk, 0.80, 95% confidence interval, 0.66-0.97, P = 0.02). There were also significant decreases in the rates of severe respiratory morbidity. There were no differences in maternal outcomes such as mode of delivery, clinical chorioamnionitis, or endometritis.

Based on the findings of this trial, the Women and Newborns Clinical Program will be implementing the use of antenatal steroids for the prevention of neonatal respiratory morbidity in pregnancies at high risk for late preterm birth throughout Intermountain facilities.

If you have any questions, please contact Ware Branch at Ware.Branch@imail.org.
THE CHANGING LANDSCAPE OF GENETIC TESTING IN THROMBOPHELIA

Intermountain Healthcare is fortunate to have Scott Stevens, MD and Scott Woller, MD, two national experts in the field of thrombosis, to assist local providers on clinical decisions in thrombosis. Earlier this year they published “Guidance for the evaluation and treatment of hereditary and acquired thrombophilia”. This article provides clinical guidance for thrombophilia testing in five clinical situations:

1. Provoked venous thromboembolism.
2. Unprovoked venous thromboembolism.
3. Relatives of patients with thrombosis.
4. Female relatives of patients with thrombosis considering estrogen use.
5. Female relatives of patients with thrombosis considering pregnancy.

The article addresses key areas in clinical decision making concerning genetic testing and carefully evaluates the sensitivity, risks, and benefits of genetic testing. In most situations the article recommends avoidance of genetic testing in thrombophilia. Those selected patients who merit testing should participate in shared decision-making due to the long term implications of the results and treatment. Consulting Dr. Stevens and Dr. Woller on genetic testing in thrombophilia may be the optimal approach for evaluation and management.

SelectHealth strongly encourages providers to read the article. This is a game changer!


For questions, please contact Jessica Strong at Jessica.Strong@imail.org.

TECHNOLOGY ASSESSMENT (“M-TECH”) NEWS AT SELECTHEALTH

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

<table>
<thead>
<tr>
<th>Technology</th>
<th>Date Reviewed*</th>
<th>Committee Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>UroLift® for the Treatment of BPH</td>
<td>March 22, 2016</td>
<td><strong>Covered for Commercial and Medicaid plans only.</strong> Since the last review (July 2014) additional information has been published with outcomes beyond 24 months supporting durability. Current evidence has illustrated the clinical utility of UroLift for the treatment of BPH. Coverage limited to once per lifetime in men age &gt;50. Also limited to max of 6 implants per procedure. <strong>See Medical Policy #553</strong></td>
</tr>
<tr>
<td>Ligament-Sparing Knee Replacement Surgery</td>
<td>March 22, 2016</td>
<td><strong>Not Covered for Any Line of Business.</strong> Current evidence has not illustrated an improvement in patient outcomes associated with ligament-sparing knee replacement vis-à-vis conventional knee replacement. <strong>See Medical Policy #579</strong></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 to include the following. As the reviews are completed, notices will be sent to stakeholders accordingly to inform them as to SelectHealth’s coverage determinations:

- Bariatric Surgery
- Cologuard for Colorectal Cancer Screening
- Colon Cancer Recurrence Testing
- ConfirmMDx Prostate Cancer Test
- Decipher Prostate Cancer Classifier
- Enterra Gastric Pacemaker for Gastroparesis
- Hemorrhoid RFA Ablation
- iStent for Glaucoma
- Magnetic Resonance-guided Focused Ultrasound (MRgFUS) for Bone Cancer
- Magnetic Resonance-guided Focused Ultrasound (MRgFUS) for Uterine Fibroids
- NovoTTF for Glioblastoma
- Prolaris for Prostate Cancer
- Psych Med Genetic Testing
- SIRT for Liver Cancer
- SphenoCath SPG Block for Migraine Management
- Sublingual Immunotherapy
- VBLOC for Weight loss
- Vectra DA for Rheumatoid Arthritis
- Vermillion OVA1 for Ovarian Cancer

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 login information, and then click on “Policies and Procedures” (left side of page) to be directed to the website.

*If you have questions regarding coverage of these or any other technologies or procedures or if you would like SelectHealth to consider coverage for an emerging technology, please email us at mtech@selecthealth.org or call 801-442-7585.*
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</th>
<th>EFFECTIVE DATE</th>
<th>SUMMARY OF CHANGES</th>
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</thead>
</table>
| 576           | IV Antibiotic Therapy for Lyme Disease (NEW) (NEW)                           | 7/28/2015      | **SelectHealth covers IV antibiotics in the treatment** of Lyme disease in limited circumstances when oral antibiotics have failed to eradicate the infection or patient is unable to take oral antibiotics. Coverage Criteria: A course of up to 4 weeks of intravenous (IV) antibiotic therapy is considered *medically necessary* for individuals with laboratory confirmed Lyme disease whose diagnosis has been established by a board certified infectious disease specialist meeting **ANY** of the following criteria:
  1. Myocarditis associated with second- or third-degree atrioventricular block, or with first-degree heart block when the PR interval is prolonged to 30 milliseconds or greater; or
  2. Persistent or recurrent joint swelling (that is, arthritis) after an initial 1 month trial of oral antibiotics; or
  3. Acute or chronic neurological disease affecting the central or peripheral nervous system, including **ANY** of the following:
     a. Meningitis
     b. Any neurologic syndrome with cerebrospinal fluid (CSF) pleocytosis
     c. Peripheral neurologic syndromes with normal CSF (including radiculopathy, diffuse neuropathy, mononeuropathy multiplex, or cranial neuropathy) if severe or following treatment failure with oral antibiotic therapy
     d. Encephalomyelitis
     e. Encephalopathy.
   And antibiotic used is:
   - Ceftriaxone (Rocephin®), cefotaxime (Claforan®), or Penicillin G
   - Azithromycin (Zithromax®) in individuals with betalactam allergy or intolerance.
   Select Health **does not cover intravenous (IV) antibiotic therapy for individuals with Lyme disease when above criteria are not**
<table>
<thead>
<tr>
<th>POLICY NUMBER</th>
<th>POLICY NAME</th>
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<tbody>
<tr>
<td></td>
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<td><strong>met, including when the following IV drugs are used.</strong> Their use is considered investigational and not medically necessary:</td>
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<td>• Carbapenems (for example, doripenem, ertapenem, imipenem, meropenem)</td>
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<td>• First-generation cephalosporins (e.g., cefazolin)</td>
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<td>• Fluconazole</td>
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<td>• Fluoroquinolones (for example, levofloxacin, moxifloxacin)</td>
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<td></td>
<td>SelectHealth <strong>does not cover other uses of intravenous (IV) antibiotic therapy for Lyme disease that are considered investigational and not medically necessary</strong>, including, but not limited to any of the following:</td>
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<tr>
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<td>1. Prophylactic treatment of individuals who have reported a tick bite but have no clinical findings suggestive of Lyme disease</td>
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<td>2. Treatment of chronic fatigue syndrome or fibromyalgia attributed to Lyme disease</td>
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<td>3. Initial treatment of Lyme arthritis without coexisting neurological symptoms</td>
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<td>4. Treatment of persistent Lyme-associated arthritis after 2 prior courses of antibiotic therapy</td>
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<td>5. Repeat or prolonged courses (greater than 4 weeks) of intravenous antibiotics</td>
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<td>6. Patients with symptoms consistent with systemic exertion intolerance disease fibromyalgia, in the absence of objective clinical or laboratory evidence for Lyme disease</td>
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<td>7. Patients with seronegative Lyme disease in the absence of CSF antibodies</td>
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<td>8. Cranial nerve palsy (e.g., Bell’s palsy) without clinical evidence of meningitis</td>
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<td>9. Antibiotic-refractory Lyme arthritis (unresponsive to 2 courses of oral antibiotics or to 1 course of oral and 1 course of intravenous antibiotic therapy)</td>
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<td>10. Patients with vague systemic symptoms without supporting serologic or CSF studies;</td>
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<td>11. Patients with a positive ELISA test, unconfirmed by an immunoblot or Western blot test</td>
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<td>12. Patients with an isolated positive serologic test in the setting of multiple negative serologic studies</td>
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<td>13. Patients with chronic (&gt;6 months) subjective symptoms (&quot;post-Lyme syndrome&quot;) after receiving recommended treatment regimens for documented Lyme disease</td>
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<td></td>
<td>Repeat or prolonged courses (e.g., greater than 4 weeks) of IV antibiotic therapy are considered not medically necessary.</td>
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<td>SelectHealth does NOT cover repeat PCR-based direct detection of B. burgdorferi as a justification for continuation of IV antibiotics beyond 1 month in patients with persistent symptoms or as a technique to follow therapeutic response. Use in these circumstances are considered investigational.</td>
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<td>SelectHealth does NOT cover the certain other testing used to identify Lyme disease for the purpose of treating or following patients who have undergone treatment of Lyme disease as use of this testing is considered investigational. Excluded tests include the following:</td>
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<td>• PCR-based direct detection of B. burgdorferi in urine samples in all clinical situations</td>
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<td>• Genotyping or phenotyping of B. burgdorferi</td>
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<td>• Other diagnostic testing, including, but not limited to C6 peptide ELISA or determination of levels of the B lymphocyte chemoattractant CXCL13 for diagnosis or monitoring treatment</td>
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<td>• The direct probe technique and the quantification technique for detection of B. burgdorferi</td>
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<td></td>
<td>SelectHealth does not cover intramuscular antibiotics as a treatment of any aspect of Lyme disease. Use of intramuscular antibiotics is considered investigational and not medically necessary.</td>
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<td>SelectHealth does not cover any home healthcare services such as nursing visits to administer non-covered antibiotics, maintenance of central venous catheters, or home care supplies for patients in whom the IV therapy is not covered.</td>
</tr>
<tr>
<td>579</td>
<td>Ligament Sparing Knee Replacement (NEW)</td>
<td>3/22/2016</td>
<td>SelectHealth does NOT cover ligament-sparing knee replacement surgery as it is considered not medically necessary</td>
</tr>
</tbody>
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<tr>
<th>POLICY NUMBER</th>
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</table>
| 578           | Genetic Testing in Hereditary Cardiomyopathies (NEW) | 8/24/2015      | **SelectHealth covers genetic testing for predisposition** to inherited hypertrophic cardiomyopathy (HCM) and some cases of dilated cardiomyopathy (DCM) when determined to be medically necessary based on meeting medical criteria noted below.  
Coverage Criteria:  
Genetic Testing for inherited cardiomyopathy is covered if:  
1. Testing is recommended by a medical geneticist, genetic counselor or cardiologist specializing in inheritable disorders and **ANY one of the following**:  
2. Comprehensive or targeted (MYBPC3, MYH7, TNNI3, TNNT2, TPM1) HCM genetic testing for any patient in whom a cardiologist has established a clinical diagnosis of HCM based on examination of the patient's clinical history, family history, and electrocardiographic / echocardiographic phenotype.  
   a. Mutation-specific genetic testing is recommended for family members and appropriate relatives following the identification of the HCM-causative mutation in an index case  
3. Comprehensive or targeted (LMNA and SCN5A) DCM genetic testing for patients with DCM AND significant cardiac conduction disease (i.e., first-, second-, or third-degree heart block) AND/OR a family history of premature unexpected sudden death.  
   a. Mutation-specific genetic testing is recommended for family members and appropriate relatives following the identification of a DCM-causative mutation in the index case  
4. Mutation-specific genetic testing for family members and appropriate relatives following the identification of a Left Ventricular Non-compaction (LVNC) causative mutation in the index case.  
5. Mutation-specific genetic testing is recommended for family members and appropriate relatives following the identification of a RCM-causative mutation in the index case.  
**SelectHealth does NOT cover genetic testing for inheritable cardiomyopathy the following circumstances.**  
1. Genetic testing is not covered in unaffected individuals except for pathogenic/likely pathogenic site-specific mutations identified in an affected family member. Genetic testing is not indicated in unaffected relatives when a pathogenic mutation has not first been identified in the index patient  

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<td>2. To facilitate screening within the family, and to facilitate family planning in patient with familial isolated DCM</td>
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<td>3. Genetic testing for patients with familial isolated DCM to confirm the diagnosis, unless supporting documentation demonstrates clinical utility related to treatment or future testing requirements</td>
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<td>4. Genetic testing for LVNC patients in whom a cardiologist has established a clinical diagnosis of LVNC based on examination of the patient’s clinical history, family history, and electrocardiographic / echocardiographic phenotype unless supporting documentation demonstrates clinical utility related to treatment or future testing requirements</td>
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<td>5. Genetic testing for RCM patients in whom a cardiologist has established a clinical index of suspicion for RCM based on examination of the patient’s clinical history, family history, and electrocardiographic / echocardiographic phenotype unless supporting documentation demonstrates clinical utility related to treatment or future testing requirements</td>
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### REVISED POLICIES

<table>
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<tr>
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<th>EFFECTIVE DATE</th>
<th>SUMMARY OF CHANGES</th>
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</thead>
<tbody>
<tr>
<td>129</td>
<td>Hyperbaric Oxygen Therapy (HBO2/HBOT) (Revised)</td>
<td>2/3/2016</td>
<td><strong>SelectHealth Commercial Plan:</strong></td>
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<tr>
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<td></td>
<td>Added Coverage for Acute Idiopathic Sudden Senorineural Hearing Loss when following criteria met:</td>
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<td>1. Condition must be present for &lt;14 days;</td>
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<td>2. There must be formal audiometry testing demonstrating hearing loss of ≥ 41Db;</td>
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<td>3. The patient is on concomitant systemic steroids;</td>
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<td>4. Patient age ≤60.</td>
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<td>Also identifies limits on coverage to initial 10 treatments with 10 treatments approvable if patient has improvement identified through further audiometry testing.</td>
</tr>
<tr>
<td>534</td>
<td>Formulas and Other Enteral Nutrition (Revised)</td>
<td>2/12/2016</td>
<td><strong>SelectHealth Commercial Plan:</strong></td>
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<td>Clarification of coverage of enteral supplies which clarifies that supplies are covered if criteria met, even if formula not covered.</td>
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<td>1. <strong>Supplies Only</strong></td>
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<td>In some circumstances the patient/member may be receiving a non-covered enteral feeding such as pureed ‘natural’ food or non-covered “OTC” enteral formula not otherwise covered. In these instances, the patient / member may still qualify for the enteral supplies.</td>
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<td>Enteral supplies may be allowed coverage if the request meets all other criteria except the specific “he requested enteral formula can only be obtained through a pharmacy with a provider prescription.”</td>
</tr>
<tr>
<td>126</td>
<td>Heart Transplant: Adult (Revised)</td>
<td>2/16/2016</td>
<td><strong>Under Commercial Plan criteria,</strong> HIV positivity has been changed from an absolute contraindication to a relative contraindication with criteria as outlined below.</td>
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<tr>
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<td>Relative Contraindications (the following has been added) #2 HIV positivity (can be considered if ALL of the following)</td>
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<td>a. No active or prior opportunistic infections or CNS lymphoma, or visceral Kaposi sarcoma,</td>
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<td>b. Clinically stable and compliant on combination antiretroviral therapy (cART) for 43 months,</td>
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<td>c. Have undetectable HIV RNA, and have CD4 counts 4&gt;200 cells/μl for &gt;3 months).</td>
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<td>Also added criteria #7 to relative contraindications:</td>
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<td>#7 (other than non-proliferative retinopathy) has been added and or persistent poor glycemic control (HbA1C&gt;7.5% despite optimal effort.</td>
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<tr>
<td>POLICY NUMBER</td>
<td>POLICY NAME</td>
<td>EFFECTIVE DATE</td>
<td>SUMMARY OF CHANGES</td>
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</tbody>
</table>
| 125           | Heart Transplant: Adult *(Revised)*             | 2/16/2016      | Changes were made under Commercial Plan Covered Conditions  
|               |                                                 |                | Added:  
|               |                                                 |                | • Chagas Disease  
|               |                                                 |                | Absolute Contraindications:  
|               |                                                 |                | Added:  
|               |                                                 |                | • (other than non-proliferative retinopathy), chronic infections, leg ulcers or persistent poor glycemic control (HbA1C.7.5% despite optimal effort)  
|               |                                                 |                | Deleted  
|               |                                                 |                | • Irreversible kidney disease  
|               |                                                 |                | • HIV positivity  
|               |                                                 |                | Relative Contraindications:  
|               |                                                 |                | Added:  
|               |                                                 |                | • HIV positivity (can be considered if ALL of the following)  
|               |                                                 |                | a. no active or prior opportunistic infections or CNS lymphoma, or visceral Kaposi sarcoma,  
|               |                                                 |                | b. clinically stable and compliant on combination antiretroviral therapy (cART) for 43 months,  
|               |                                                 |                | c. have undetectable HIV RNA, and have CD4 counts 4>200 cells/μl for >3 months.  
|               |                                                 |                | Deleted:  
|               |                                                 |                | • (Body Mass Index >35 kg/m² was added and 130% of ideal body weight was deleted.  
| 406           | Reduction Mammoplasty (Breast Reduction) *(Revised)* | 3/18/2016      | Under Commercial Plan, Criteria for coverage  
|               |                                                 |                | Modified the first 30 days after myocardial infarction (MI) in patients with an ejection fraction (EF) <35%, has been changed to the first 40 days.  
|               |                                                 |                | Also, word “or” has been added to criteria 2c. “…Within 3 months of CABG or PCI with ejection fraction (EF) <35%.  
|               |                                                 |                | 2. As a bridge to ICD risk stratification and possible implantation for patients:  
|               |                                                 |                | a) Had ventricular tachycardia (VT) or ventricular fibrillation (VF) within 48 hours of a myocardial infarction (MI)  
|               |                                                 |                | OR  
|               |                                                 |                | b) The first 40 days after myocardial infarction (MI) in patients with an ejection fraction (EF) <35%  
|               |                                                 |                | OR  
|               |                                                 |                | c) Within 3 months of CABG or PCI with ejection fraction (EF) <35%.”  

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<th>SUMMARY OF CHANGES</th>
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</thead>
</table>
| 172           | Reduction Mammoplasty (Breast Reduction) (Revised)                           | 3/18/2016      | SelectHealth Commercial Plan  
Phrase “Must meet ALL” has been added to under the Coverage Criteria  
Also clarified required of whom can submit documentation for consideration by changing practitioner” to “medical practitioner.”                                                                                                                                                                                                             |
| 500           | Infertility Evaluation and Treatment (Revised)                              | 3/18/2016      | SelectHealth Commercial Plan  
Added:  
• Anti Muellerian hormone (AMH) to Laboratory tests covered as part of the infertility benefit in the evaluation of infertility under female.                                                                                                                                                                                                                      |
| 158           | Oxygen Coverage (Revised)                                                   | 3/24/2016      | SelectHealth Commercial Plan  
Added:  
• Section on portable oxygen concentrators to clarify when these devices are covered.                                                                                                                                                                                                                                                                               |
| 494           | Cytoreductive Surgery (CRS) with Associated Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (Revised) | 3/24/2016      | SelectHealth Commercial Plan  
Updated references and additional language was added to Summary of Medical Information.                                                                                                                                                                                                                                                                                         |
| 553           | Urolift System for the Treatment of Benign Prostatic Hyperplasia (Revised)   | 4/22/2016      | SelectHealth Commercial Plan  
Modified coverage from not covered to covered with limitations which include:  
• Coverage only for men >50 years old  
• Limit number of implants per procedure to 6  
• Limit one procedure per lifetime  
SelectHealth Community Care:  
Policy now reflects Urolift being covered under Community Care.                                                                                                                                                                                                                                                                                                         |
| 506           | Joint Replacement Using Makoplasty (Revised)                               | 4/8/2016       | SelectHealth Commercial Plan  
Clarified exclusion to include not only total hip arthroplasty, but also unicompartmental knee arthroplasty                                                                                                                                                                                                                                                                                  |

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<tbody>
<tr>
<td>337</td>
<td>Cryoablation for Renal Cell Carcinoma (RCC)</td>
<td>4/22/2016</td>
<td>SelectHealth Commercial Plan</td>
</tr>
<tr>
<td></td>
<td><em>(Revised)</em></td>
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<td>Re-worded the policy for clarification:</td>
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<td>Conditions for which coverage of cryoablation therapy in the treatment of renal</td>
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<td>cell carcinoma are allowed include (ANY One Criteria):</td>
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<td>1. Patients who in the opinion of their surgeon and primary care provider could</td>
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<td>not tolerate a partial/total nephrectomy due to other underlying chronic</td>
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<td>medical conditions,</td>
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<td>2. Patients with reduced renal function identified by a glomerular filtration rate</td>
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<td>≤60 ml/min, serum creatinine ≥2.0, with a BUN to creatinine ratio &lt;20/1,</td>
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<td>3. Patient who are symptomatic from the tumor and have a poor long-term predicted</td>
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<td>survival outcome due to metastatic renal cancer or other medical co-morbidities,</td>
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<td>4. Patients renal mass is less than or equal to 3 cm.</td>
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<tr>
<td>554</td>
<td>Emergency Behavioral Health Services</td>
<td>5/5/2016</td>
<td>SelectHealth Commercial Plan</td>
</tr>
<tr>
<td></td>
<td><em>(Revised)</em></td>
<td></td>
<td>• Added language to clarify the definition of emergent state.</td>
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</table>

*Please contact Ken Schaecher with questions, at Ken.Schaecher@selecthealth.org.*
It really concerns me to know that 25 percent of our new employees in the Central Region leave Intermountain during their first year on the job. Our turnover rate drops dramatically after the first year, but that first-year rate is incredibly disruptive and expensive for our teams.

There are a lot of reasons why new employees leave their jobs, but to me, one reason we can all help control is helping our staff increase the meaning they find in their work. All of us ought to feel like we make a difference when we come to work — and part of making a difference is being valued and appreciated by our colleagues.

I’m lucky: I’ve felt like I was valued in my work ever since I was very young. My first job was as a paperboy, delivering the Salt Lake Tribune in the farmland and neighborhoods of Sandy. I did that for six years, from age 8 to 14. I earned a dollar per subscriber per month — which looking back makes the work almost seem like child slave labor — but the pay was only part of the reward.

I got up at 4:30 to deliver 200 papers, and I started doing my route not because it appealed to me, but because my parents really believed in work — and the more, the better. I remember knowing that my subscribers had signed up for the paper and expected it to be there on their porches when they got up in the morning. Meeting their needs was very satisfying to me. I carried my papers in a basket on my bike, and I remember pedaling my bike down the street, aiming the papers at the porch as I went past. It was a real thrill to see the paper thud onto the porch. When I missed the porch and hit the bushes, I got off my bike, ran up the sidewalk, and fixed my mistake — that was quality control, and it was important in part because I had to stop by my customers’ houses every month to collect their subscription payments. If my service wasn’t good, either I’d hear about it or I’d ruin my chances of getting a tip.

I loved that job — and every job I’ve had since then, as a landscaper, a cement worker, a bank teller, and a nursing home attendant. The paychecks were great, and the feeling of doing a good job, and the joy of finishing things, always made me happy.

I also learned great lessons at work. When I was pouring and finishing cement — working to build houses in West Jordan — my coworkers and I learned to survey the lot in order to center the footings we poured. On one house we were in a hurry and didn’t double-check the footings before we poured them, and once they we were set, we found the house wasn’t sitting square on the lot. My boss handed me a sledgehammer and said: Here you go, Mark — break ’em out and do it right. We had a backhoe, and we could have used that to break up the footings, but using a sledgehammer taught me a lesson that’s been very important to me in every operation I’ve performed: Take the time to do it exactly right the first time.

Sharing the meaning and the joy we find in our work — and working together to overcome our challenges — strengthens
our teams and helps us enjoy our work. I hope you’ll help do that with your colleagues who are new on the job. Reach out to them, ask how they’re doing, and tell them how you do what you do and what it means to you. Doing that with our new employees will help reduce our turnover rates, improve our staffing, and make our work more meaningful for our colleagues, and for us.

I believe our work in healthcare is especially meaningful because everything we do makes someone’s life better — and because helping others be healthy and happy makes us happy ourselves.

If you have any questions, please contact Mark J. Ott, MD at Mark.Ott@imail.org.
ACTIVE BODIES, ACTIVE MINDS

General George Patton said, “An active mind cannot exist in an inactive body.” Truer words were never spoken. It doesn’t matter if you are old, or if you are young, there is a direct relationship between physical activity, physical fitness, and cognitive health and performance.

Numerous studies have examined physical activity and academic performance in school-aged children. The state of California has led the pack in this effort. Below is a diagram showing the relationship between student performance on the “Fitnessgram” test, and the results of standardized testing. (Fig 1)

Note the direct relationship between the fitness and test results for elementary, junior high, and high school students. Other states have examined this as well, and found similar results. In the past 5-10 years, studies involving more than 25,000 students ranging from 5th grade to 12th grade have demonstrated that students who are fit have higher standardized test scores in reading, math, science, and social studies.

While the mechanism by which activity and higher levels of fitness improve academic performance is not clearly understood, one can hypothesize that several aspects contribute to the observed relationship. Physical activity improves the circulation of blood flow in the body, including blood flow to the brain; and it raises levels of endorphins – both of which may reduce stress, enhance attention, and even result in a calming affect – which in turn may result in the observed improvements in academic performance. The amount of activity or the absolute level of physical fitness to achieve these benefits is also unknown, but even studies promoting the use of stand-up desks in the classroom are associated with improved classroom behavior.

At the other end of the age spectrum, physical activity and fitness also have a cognition enhancing effect. Studies of older adults with either mild cognitive impairment or Alzheimer’s have examined treadmill walking as a treatment, and have demonstrated improvements in both fitness and cognitive function among those patients exposed to the exercise intervention. A recent rodent study found that mice who did more wheel running had more brain gray matter compared to the sedentary rodents. Another study in humans, from the Framingham Offspring Study found that study subjects with higher measured fitness had bigger brains (total cerebral brain volume), and performed better on cognitive testing (Trials B-A).

If we take a step back and think about how exercise has such a positive effect on cognitive performance, it’s not hard to see how lifelong exercise protects the brain by reducing oxidative stress, and increasing the blood flow of oxygen and other substrates to the brain on a regular basis.

Figure 1. California Standardized Test Scores Relative to Performance on Fitness Test
In addition, regular exercisers are less likely to be obese, to develop diabetes, high blood pressure and other conditions that predispose to stroke.

While I am a big proponent of the Exercise is Medicine program, I am an even bigger supporter of the “exercise your life” concept, and “be active your way.” As physicians we need to promote activity to (nearly) every patient every day. Likewise, we need to maintain, even bolster our own cognitive performance with regular moderate to vigorous physical activity.

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