DEAR COLLEAGUES
1 Message from Brent and Susan

INTERMOUNTAIN BOARD GOALS
2 2014 Board Goal Achievement Results

INTERMOUNTAIN SYSTEMWIDE INITIATIVES
4 Intermountain’s Patient Experience Transparency Initiative
5 Making Zero Harm Our Culture
5 Intermountain Foundry Rewards Employee Innovation at Inaugural Event
6 Intermountain Health Answers Coming This May
6 New ID Badges in Production
8 Changes to Online Physician Resources

iCENTRA UPDATE
9 iCentra is Live in Box Elder and Cache Counties

SHARED ACCOUNTABILITY UPDATE
11 Making Progress Towards New Commercial Health Plan Product

COMPLIANCE UPDATE
12 Informed Consent Policy Update

QUALITY AND PATIENT SAFETY UPDATE
13 Fact Sheet: Isolation of Patients Infected with Multidrug Resistant Organisms (MDRO) such as CRE or CRAB
14 Fact Sheet: Disinfection of Non-Critical Care Patient Equipment
15 Fact Sheet: Restraint and Seclusion
18 It Happened Here – Patient Suicide

SELECTHEALTH UPDATE
19 M-Tech Reviews Emerging Healthcare Technologies
20 Medical Policy Bulletin

CLINICAL PROGRAM AND SERVICE LINE UPDATE
25 Behavioral Health
26 Imaging Services
30 Intensive Medicine
31 Musculoskeletal
31 Neurosciences
32 Oncology
33 Pain Services
33 Pediatrics
34 Primary Care
34 Surgical Services

FITNESS FEATURE
35 You Have to Walk the Walk
DEAR COLLEAGUES,

In our continuing efforts to improve communication between Intermountain and credentialed practitioners, we are pleased to present the 6th installment of Intermountain Med Staff News, our quarterly newsletter for the medical staff. We hope that you will find timely information and news that will keep you informed and up-to-date. To make navigation easy, you can click on any article noted in the table of contents that is of interest to you and you will be taken directly to that article or, of course, you can read the entire newsletter.

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

Sincerely,

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

Susan DuBois
Assistant Vice President
Physician Relations and Medical Affairs
susan.dubois@imail.org
(801) 442-2840
Thank you for your contributions to our successful year in 2014. We look forward to your engagement and commitment in 2015 with our priorities of Zero Harm, Shared Accountability, Transparency, iCentra, and Physician and Employee Engagement.

Sincerely,

Brent Wallace, Chief Medical Officer
Kim Henrichsen, VP Clinical Operations and Chief Nursing Officer

### OVERALL BOARD GOAL ACHIEVEMENT: 119.2%

<table>
<thead>
<tr>
<th>Clinical Excellence</th>
<th>Clinical Board Goals Achieved</th>
<th>Achieved above target level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Engagement</td>
<td>Achieved</td>
<td>Achieved above target level</td>
</tr>
<tr>
<td>Hospital</td>
<td>Value Based Purchasing Patient Experience Domain</td>
<td>Achieved above target level</td>
</tr>
<tr>
<td>Medical Group</td>
<td>Rating Clinic Experience as Excellent</td>
<td>Achieved above target level</td>
</tr>
<tr>
<td>SelectHealth</td>
<td>Rating their Health Plan 8-10</td>
<td>Achieved above target level</td>
</tr>
<tr>
<td>Operational Effectiveness</td>
<td>Achieved</td>
<td>Achieved at target level</td>
</tr>
<tr>
<td>EMR specification completed for clinics, hospitals, and defined outpatient settings</td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td>EMR training for physicians and other users in targeted areas</td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td>Develop plans for activity based costing, Services Oriented Architecture, and the Clinical Element Model within the Cerner EMR</td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td>EMR functioning in at least 10 Medical Group clinics</td>
<td>Not Achieved</td>
<td></td>
</tr>
</tbody>
</table>

*continued on next page*
### Physician Engagement

<table>
<thead>
<tr>
<th>Achieved – stretch level</th>
<th>Achieved at stretch level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a competitive offering for affiliated physicians to participate on the Cerner EMR</td>
<td>Achieved</td>
</tr>
<tr>
<td>Configure Cerner emergency department EMR with the associated hospital clinical services and have approval for 2015 implementation</td>
<td>Achieved</td>
</tr>
<tr>
<td>Complete baseline assessment and training regarding accurate and complete coding; demonstrate improvement in identified areas</td>
<td>Achieved</td>
</tr>
<tr>
<td>Develop a viable Shared Risk physician network based on shared commitments in all urban regions</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

### Community Stewardship

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Achieved at stretch level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Flow</td>
<td>Achieved stretch level</td>
</tr>
<tr>
<td>Utilization Savings</td>
<td>Achieved stretch level</td>
</tr>
<tr>
<td>Community Benefit Initiatives</td>
<td>Achieved above target level</td>
</tr>
</tbody>
</table>

### Employee Engagement

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Achieved at target level</th>
</tr>
</thead>
<tbody>
<tr>
<td>35% of those completing the Risk Assessment complete one or more Health Coaching modules</td>
<td>Achieved</td>
</tr>
<tr>
<td>50% of those completing the Risk Assessment achieve 325 points or more in the LiVe Well Health Portal</td>
<td>Achieved</td>
</tr>
<tr>
<td>75% of employees use the Krames Health Assessment tool</td>
<td>Not achieved</td>
</tr>
</tbody>
</table>

If you have questions, please contact Brent Wallace, MD, at brent.wallace@imail.org.
For many years, Intermountain Healthcare hospitals, Intermountain Medical Group, and SelectHealth have used a third party to collect patient experience data and have shared that data with clinicians. This summer, Intermountain will begin sharing patient experience data with the public in a transparent manner. Patients seeing a physician as an outpatient in an office visit setting will be asked nine questions about their interaction with the physician. Surveys will be collected for physicians employed by Intermountain Healthcare and independent physicians who participate on one or more of the SelectHealth provider panels.

KEY ELEMENTS OF THE SERVICE QUALITY INITIATIVE

- Dan Jones/Cicero will be the third party vendor that conducts patient surveys, via phone, for both Intermountain Medical Group and SelectHealth. Another vendor will convert answers to a five-point star rating.
- Intermountain Medical Group and SelectHealth have adopted a patient survey that asks the same nine CG CAPHs provider-specific patient experience questions. The CG CAPHs survey is a standardized question set used in clinic or group outpatient settings.
- Patients will be notified during the survey that their responses will be used to create a rating and their comments will be posted on Intermountain and/or SelectHealth websites.
- We began collecting patient surveys using the new questionnaire on March 1.
- All comments will be reviewed. Any questionable comment will be flagged, reviewed, and evaluated before posting. Comments that contain vulgar or profane language will not be posted.
- Physicians will have access to their own data and any comments made by logging onto Intermountain’s physician portal beginning in April.
- Physicians will need at least 30 patient ratings before their ratings will be posted publicly.
- Ratings will roll off on an 18-month cycle.
- Our target date for posting physician-specific star ratings and comments on Intermountainhealthcare.org provider search is June 1, 2015.

POTENTIAL BENEFITS OF TRANSPARENCY INITIATIVE – PHASE 1 PATIENT EXPERIENCE

- Support patient expectations of increased transparency of information.
- Provide patient feedback to individual physicians to validate or improve their service and clinical quality.
- Provide local and national benchmarking comparisons.
- Meet ABMS Maintenance of Certification requirements associated with patient experience.
- Provide information, tools, and education to physicians who want to improve.

We understand this change may raise questions for physicians. If you have questions or would like more information about the initiative, please contact Dr. Brent Wallace, Chief Medical Officer at 801-442-3866 or via email at brent.wallace@imail.org or Susan DuBois, AVP, Physician Relations and Medical Affairs at 801-442-2840 or via email at susan.dubois@imail.org.
MAKING ZERO HARM OUR CULTURE

Serious harm events are preventable and Intermountain’s goal is a continuous journey towards safety and ZERO Harm.

“As long as there is a single patient who doesn’t receive optimal care at Intermountain, we haven’t finished improving.” — Charles Sorenson, MD

As we begin our journey, we will be utilizing expertise in the science of high reliability as seen in the success of three industries: naval aviation, US commercial aviation, and nuclear power. These industries, like healthcare, operate under very trying conditions all of the time.

We will be supported by an external expert, Kerry Johnson, and his team at Healthcare Performance Improvement, LLC (HPI).

To embed safety in our culture it must be internally driven as well as owned, led, and sustained by physicians and leaders. You are the key to our success. No facility can achieve a state of high reliability without the full engagement of the medical staff:

- **Some of you** will be asked to participate in a diagnostic assessment of the serious safety events in your facility. During this process we will establish a facility serious safety event rate. You may also be involved in interviews.
- **Many of you** will participate in regional boot camp training and additional leadership training.
- **All of you** will complete a course in Error Prevention Techniques during 2016 where we will learn tools and techniques that will enable all of us to make error prevention strategies practice habits.

As physicians you have an unequalled impact on hospital/clinic morale through your influence on staff and leaders. We ask you to prioritize this important work.

*If you have questions, please contact Robin Betts at robin.betts@imail.org.*

---

INTERMOUNTAIN FOUNDRY REWARDS EMPLOYEE INNOVATION AT INAUGURAL EVENT

On January 26, the Doty Family Education Center auditorium was packed with a bevy of executives, physicians, clinicians, and members of the community for an inaugural Innovation and Growth Event. This event introduced the first four projects to complete an eight-week program through the Intermountain Foundry designed to support employees’ ideas for improving the quality of care while reducing costs.

Nina Nashif, Co-Founder and CEO of Healthbox—Intermountain’s partner in the Foundry—opened the meeting by describing the Foundry process and the number of submissions received in this first round: 40 applications that were reviewed for strategic fit, business need, and market opportunity. “In a world where 8 of 10 companies fail,” said Nina, “aligning ideas with these measures opens us to better success.” Bert Zimmerli, Executive Vice President and CFO, spoke about the drive for innovation initiatives, stating that “Innovation is really what Intermountain was founded on.” He was referring to the original mission given to Intermountain in 1975 by the LDS Church—to be a model healthcare system. “After all,” continued Bert, “There’s no way to be a model system without innovation.”

In a format similar to the television show Shark Tank, each project was presented before a panel of four experts in business, administration, medicine, and information technology.

The four “companies” presented were:

- **Wailua Magnetics:** Dr. John Doty, MD, presented a more effective and less expensive tool and care process for ablation, a technique used to treat atrial fibrillation.
- **GermWatch:** Dr. Per Gesteland, MD, MSc, gave details about future plans and expansion of GermWatch, a software tool that allows physicians, clinicians, and the community to track which infectious “bugs” are prevalent in their localities.
- **SmartPX:** Dr. Benjamin Horne, PhD, shared his project, SmartPX (short for smart prognosis), a predictive analytics score used to reduce readmission rates for patients with heart failure.

*continued on next page*
Micro Environ: Pravin Mishra, PhD, and Lincoln Nadauld, MD, PhD, spoke about a method for improving cancer cell studies through a new culture medium called ME-gel, which differs from traditional media because it is based on human cells rather than the cells of mice.

Along with these innovators, more than 50 other Intermountain employees were involved and dedicated to refining and rapidly testing these new products and ideas. “The Foundry is a great example of how Intermountain’s various Innovation and Growth programs, including the Transformation Lab, The Homer Warner Center for Informatics Research, Business Development, and others can work together to make great things happen,” said George Hamilton, Vice President of Business Development. The event concluded with a spontaneously composed ballad (accompanied by ukulele) that outlined the highlights of each project and a chance to view conference posters and demos of the projects.

Innovation and Growth at Intermountain Healthcare supports the ideation, creation, and adoption of new solutions that will improve quality and service while making care more affordable. We harness internal creativity and external disruption to continually improve outcomes, longevity, and overall wellbeing.

Intermountain partnered with Healthbox to bring its employees the Intermountain Foundry, one of the many avenues supporting employee innovation at Intermountain Healthcare. Through a structured eight-week process, employee innovators are supported to refine their business concept, assess the commercial viability, identify product development or service needs, and develop a plan to scale internally within Intermountain or beyond in the broader healthcare industry. The application process is open and Intermountain employees can submit ideas.

Submit Your Ideas Here

If you have any questions, please contact Jeremy Porter at Jeremy.Porter@imail.org.

INTERMOUNTAIN HEALTH ANSWERS COMING THIS MAY

Coming May 2015, a new 24-hour service called Intermountain Health Answers will be available at our call center to answer patient questions and provide follow up post-discharge. When people call Health Answers, our caring, experienced, registered nurses will listen to concerns, answer questions, and triage patients to the most appropriate care setting. We will use nationally standardized protocols to offer home-based remedies, recommend when to see a provider, and even save a place in line at InstaCare.

Our post-discharge calling service will call patients within 24 hours of discharge from a hospital or Emergency Department to ensure they’ve made a seamless transition back to a primary care provider. We’ll help find solutions to any barriers such as understanding discharge instructions, getting a prescription filled, or even finding a primary care provider.

The inbound advice service will be available to all SelectHealth members and the uninsured. Post-discharge calling will be for all patients, starting at Intermountain Medical Center and rolling out across the system throughout the year.

If you have any questions, please contact Teresa Garrett at Teresa.Garrett@imail.org.

NEW ID BADGES IN PRODUCTION

Starting in January in Intermountain’s North Region we began rolling out a new ID badge design for all employees, providers, volunteers, temp workers, visitors, and suppliers. We’ll re-shoot and update all photos on the badges as we change out the old badges for the new design.

WHY THE CHANGE?

The biggest reason for the new design is to ensure patient safety – the new badge makes photos, names, and required professional licensure bolder and easier to see. This helps patients and their families know who’s interacting with them, and what their role is.
The new badges use a different lanyard clasp, so they no longer require a hole punch (this was the part of the badge that broke the most in the past). They also have more secure encryption technology, and they better comply with a new state law around healthcare provider identification.

**WHAT’S DIFFERENT IN THE DESIGN?**

- Employee, provider, and volunteer badges will now be vertically oriented. Suppliers, temporary workers, school instructors, and students will have horizontal badges.
- Roles or departments are boldly printed in a colored box on top of the badge. Names will be larger beneath photos on the bottom of the badge.
- A new type of clasp that doesn’t require a card hole will firmly hold the badge.
- The new badges will continue to include your required professional licensure (as determined by state statute), but not certifications or educational credentials. Space on the ID badge is limited, and required professional licensure – along with the name and role / department – are the most important things to communicate to patients. Certifications and credentials are still very valued, and caregivers should consider sharing these with patients as appropriate to help them feel safe, comfortable, and at ease.

**WHEN AND WHERE WILL I GET A NEW BADGE?**

The transition began in January in Intermountain hospitals and clinics in the North Region (Ogden, Logan, and Box Elder areas, and Southern Idaho), and will start in April in most other Intermountain regions. We’ll provide detailed instructions about these times and locations in upcoming emails and other communications, but generally, badge printers will be located at all Intermountain hospitals. Those not working at hospitals will go to the nearest facility to get a badge.

To ensure there are no duplicate badges in circulation, we will require that your old badge be turned in when you get your new badge. If for some reason you no longer have your old badge, you will need to pay a small fee that is determined by your facility to obtain a new badge.

**WILL MY OLD BADGE STILL WORK?**

Yes! Your old badge will work until you get your new badge. The badge change will not affect access to clinical systems, computers, buildings, Kronos, Courier Services machines, etc. All old badges will be deactivated at the close of 2015.

If you have questions about name badge logistics (printing stations, effect on Kronos and other systems, etc.), please contact Craig Allen at craig.allen@imail.org or 801.442.3424. If you have other questions, please contact Karen Burnett at karen.burnett@imail.org or 801.442.2002.
CHANGES TO ONLINE PHYSICIAN RESOURCES

Intermountain is continually working to improve the online resources available to physicians. Here are two resources that can assist you with your work.

➤ NEW PHYSICIAN PORTAL SEARCH TOOL
The new search function on the Physician Portal is smarter, more accurate, and provides the ability to narrow search results with the use of “refiners.” These work much like filters on sites like Best Buy, where an initial search for “HDTV” can be refined by choosing a size, brand, and price range. Refiners on the Physician Portal include terms like “websites,” “clinical documents,” “people,” and “other resources.”

➤ Visit the Physician Portal

➤ UPTODATE
UpToDate is an evidence-based clinical resource available to all Intermountain and affiliated physicians through the Physician Portal. You can access it through “Clinical References” under the “Tools & Resources” tab or by going to the UpToDate website.

➤ Visit the UpToDate Website
UpToDate offers a comprehensive collection of continuously updated medical information as well as recommendations that can be used at the point of care. This service is also an accredited continuing education resource – login is required to track your CME credits. You must login to UpToDate at least once a month to keep your account from expiring.

If you have any questions, please contact Craig Kartchner at Craig.Kartchner@imail.org.
Intermountain Healthcare officially went live on iCentra at 3:30 a.m. on Saturday, February 21 at Logan Regional Hospital, Bear River Valley Hospital, and Medical Group clinics in Box Elder and Cache counties. The Intermountain and Cerner teams implemented a fully integrated electronic health record, practice management, and revenue cycle system.

Throughout the configuration of iCentra we have followed these principles:

- Patient care and safety always comes first for all of us.
- The experience of care is as important as the process of care for our patients.
- Physicians, advance practice clinicians, and nurses need training and support during a change like this so that they can focus on patient care and demonstrate professionalism.

**PREPARATION IS KEY TO SUCCESS**

The departments that had the most success during go-live were those who prepared for and practiced as a team prior to the transition. This key learning will be applied to our future implementations.

Also, education and training teams continue to refine physician training based on what we have learned at Logan and Bear River. We will work with all physicians to provide the initial training before treating patients using iCentra. This classroom training is designed to provide a common understanding of iCentra. Additional training, individual preferences, and creation of quick orders will

**MUTUAL EXPECTATIONS**

Intermountain Healthcare and physician leaders developed this list of mutual expectations that guide commitments for a successful joint partnership.

**Intermountain Commitments**

- Work collaboratively with integrity and good intent
- Provide an integrated system that is clinically efficient, reliable, and intuitive
- Provide education, training, Super Users, and Physician Coaches
- Accept, evaluate, and implement new functionality
- Support providers with learning and using cPOE and key functions that help them and our hospitals meet quality and regulatory metrics

**Provider Commitments**

- Work collaboratively with integrity and good intent
- Train, use, and optimize iCentra for my hospital and clinic work
- Meet with my coach and request support as needed
- Submit feedback and ideas to my coach, Clinical Program, Medical Director, or Chief Medical Officer
- Use cPOE and key functions of iCentra that support providers and hospitals meeting quality and regulatory metrics
occur as you meet with physician coaches before and during each go-live.

All physicians must complete the trainings and skills pass-off or clinical and admitting privileges will be inactivated.

Physicians and clinicians located in hospitals and clinics in Weber, North Davis, and Cassia counties have started training in preparation for the April 18 implementation of iCentra. Make sure you enroll early for the best selection of preferred dates and times.

**Here’s how you can register:**

- **Medical Group Providers in Weber and North Davis Counties** — Medical Group providers will be registered for learning labs and skill pass-offs by a Medical Group training coordinator. Shaunelle Page will be contacting your office to coordinate your registrations.

- **Other Employed or Affiliated Providers** — Follow step-by-step instructions on the iCentra Provider Learning website (link below) to self-register. You may also contact the Intermountain CME office at 801-442-3930 or cme@imail.org to register yourself or multiple providers.

**Register on iCentra Provider Learning website**

The North Region has more than 800 Super Users who have completed hours of additional training, parallel and simulation testing, and homework. During the transition to iCentra, these team members are wearing red vests for easy identification and are available to support all end-users. There are 41 Physician Coaches who met one-on-one with physicians to review iCentra and customize settings.

*If you have questions about iCentra, please contact your hospital, regional, or Medical Group leadership, or anyone involved in the iCentra project.*
Making Progress Towards New Commercial Health Plan Product

**Shared Accountability** is Intermountain’s mission-based approach to transforming healthcare as we move toward high-value healthcare. Here are current updates related to our Shared Accountability initiative.

**NEW SELECTHEALTH SHARED ACCOUNTABILITY HEALTH PLAN PRODUCT FOR LARGE EMPLOYERS WILL LAUNCH IN JANUARY 2016**

The new product is part of our effort to strengthen the integration of our healthcare system along with highly aligned affiliated physicians. This product gives greater emphasis to coordinated care, preventive services, engaging patients, healthier lifestyles, improving clinical outcomes, appropriate utilization, and sustainable costs. We’ll keep average annual premium rate increases on this product close to the general inflation rate. That will be a significant cost savings for all involved. Currently, SelectHealth offers two “fee-for-value” plans based on accountable care/population health management principles: SelectHealth AdvantageSM (a Medicare Advantage plan) and SelectHealth Community CareSM (a Utah Medicaid Accountable Care plan). SelectHealth will be the first payer to offer Intermountain’s Shared Accountability approach to the commercial market. For 2016, we’ll offer it to fully insured large employers that are purchasing health plans for their employees.

**SELECTHEALTH IS DESIGNING THE BENEFITS TO ENGAGE PLAN MEMBERS AND SUPPORT PHYSICIANS**

The plan benefit design will encourage and reward members for being more engaged in their personal health and wellness and more involved in their personal healthcare decisions.

**GEOGRAPHIC COMMITTEES ARE UP AND RUNNING**

Intermountain has established five Geographic Committees to manage the performance of these “fee-for-value” contracts. Each committee has two co-chairs: one physician and one administrative lead. In total, each team has eight physicians and four administrative leaders. The purpose of the committees is to ensure access, service, quality, and appropriate utilization costs for plan members and patients served by specific health plans.

For more information about our Shared Accountability strategy, please contact Brent Wallace, MD, at brent.wallace@imail.org.

Commitments that are required for network participation. Both Intermountain Medical Group and closely affiliated physicians will be involved in the governance of the physician payment model for this product.

Intermountain and SelectHealth launched the beta test in the fall of 2013 of a new physician payment model. The beta includes about 7,500 patients who are served by 383 physicians at 15 Medical Group and affiliated clinics. This beta has generated lots of dialogue, feedback, and learning from those involved. This process has helped us refine the model. Final details are now under review, with plans to have the 2016 payment model defined by this spring.

Intermountain and SelectHealth launched the beta test in the fall of 2013 of a new physician payment model. The beta includes about 7,500 patients who are served by 383 physicians at 15 Medical Group and affiliated clinics. This beta has generated lots of dialogue, feedback, and learning from those involved. This process has helped us refine the model. Final details are now under review, with plans to have the 2016 payment model defined by this spring.
INFORMED CONSENT POLICY UPDATE

Several recent Joint Commission surveys have been critical of our Intermountain Healthcare Informed Consent Policy for not explicitly stating that documentation of the informed consent discussion will be entered in the patient’s medical record. As a result of this concern, we have revised the system’s Informed Consent Policy to include an additional provision (in italics):

Existing Language

6.8 An opportunity to ask and have answered questions about the healthcare and its attendant risks, and

Additional New Language

6.9 Documentation of the informed consent discussion, entered in an appropriate location, such as in a form, the patient’s clinic note, progress note, history and physical note, or any update or addendum to the same.

WHAT THIS MEANS FOR YOU
You must document in the patient’s medical record that you have discussed with the patient, or the patient’s family or personal representative, the risks, benefits, and alternatives of the procedure. You can document this either in a clinic note, an H&P, a progress note, or another form electronically or on paper that is included in the patient’s medical record.

If you have questions, please contact Jeanne Nelson at jeanne.nelson@imail.org.
FACT SHEET: ISOLATION OF PATIENTS INFECTED WITH MULTIDRUG RESISTANT ORGANISMS (MDRO) SUCH AS CRE OR CRAB

This information regarding the care of patients infected with Multidrug Resistant Organisms (MCRO) applies to ALL facilities, clinical departments, and disciplines.

DEFINITION
Multidrug Resistant Organism (MDRO): Methicillin resistant Staphylococcus aureus (MRSA), Vancomycin resistant Enterococcus (VRE), extended-spectrum beta lactamase producing gram negative bacilli (ESBL), carbapenem resistant enterobacteriae (CRE) and carbapenem resistant Acinetobacter sp baumanii (CRAB), other gram negative organisms resistant to three or more classes of antibiotics (Pseudomonas aeruginosa, Burkholdaria cepacia, etc).

IMPORTANCE OF CARE
- Patients infected with CRE- or CRAB-positive organisms have been associated with high rates of morbidity and mortality, increased length of stay, high healthcare costs, and are difficult to treat.
- Although relatively new, these organisms have rapidly spread in the United States and throughout the world. In some areas, CRAB and CRE have become endemic and colonized patients can be found in both acute care and long-term care facilities.

KEY POINTS
- When these patients are reported to the Infection Preventionist the patient’s nurse will be given a checklist that includes a definition of these organisms and how the patient will be managed.
- Put the patient in a private room.
- Place the isolation sign on the patient’s room door.
- Contact precautions (gloves and gown) will be implemented.
- Notify the patient’s physician of isolation status and the organism. The physician may wish to consult with the local Infectious Diseases physician.
- In addition, for patients infected with CRE/CRAB, cohort staffing should be implemented. This means the nurse will only take care of the CRE/CRAB infected patient(s) during the shift. Example: one nurse to one patient or one nurse to two infected patients.
- Patients colonized with CRE/CRAB can be in nursing assignments with non CRE/CRAB patients. If needed, check with the hospital Infection Preventionist for clarification regarding your patient’s infection vs. colonization status.
- Nursing may cover some care functions, such as respiratory so that entry into the room can be limited.
- For cohort staffing issues, consult the facility director of nursing (CNOs have agreed to call in extra staff if necessary).
- Visitor restrictions might need to be implemented. Consult with your hospital Infection Preventionist, if needed.
- Family/visitors should wear gowns and gloves upon entering the patient room.

continued on next page
Patient should wear an isolation gown over their clothing when they are out of the room for any reason (ambulation needs, going to procedure or imaging room, etc.)

- Disinfect high-touch points in room each shift.
- If possible, dedicate equipment to patient room.
- Disinfect when equipment is removed from the room.
- If possible, limit procedures to patient room.
- If patient needs to go to a procedure room, disinfect the procedure room after use. Schedule procedures for end of day if possible.

- Educate staff, family, and visitors about the following infection control requirements:
  - Provide MDRO fact sheet for patient and family
  - Hand hygiene before room entry and when leaving the room
  - Family/visitors to wear gowns and gloves upon entering the patient room
- Daily CHG bath to decrease skin contamination (suggested; please discuss with patient’s physician as an order is required).

FACT SHEET: DISINFECTION OF NON-CRITICAL CARE PATIENT EQUIPMENT

This information regarding the disinfection of non-critical care patient equipment applies to ALL facilities, clinical departments, and disciplines.

**IMPORTANT OF CARE**
- Equipment in the patient environment is touched multiple times a day, which increases the likelihood of contamination by disease causing organisms.
- Devices such as cell phones, tablets, and communication devices, such as Vocera, are touched frequently.
- Organisms can be easily transmitted to the patient or to other patients causing infection.
- Infections can be serious and lead to death.

**KEY POINTS**
- Equipment added to the existing procedure includes: cell phones, tablets, and communication devices, such as Vocera.
- Below is the new verbiage and information which has been added:
  a. Non-critical patient care equipment/devices, as well as select items recommended by the facility Infection Preventionist, will be cleaned and disinfected when visibly soiled after each use in a patient’s environment.
  b. Any electronic device that comes into contact with the patient or the patient’s environment should be disinfected upon removal from that environment.
  i. If the device is placed in a plastic bag, throw away the bag or leave the device in the bag and wipe down the bag with an approved disinfectant or bleach in the case of C diff. Bags will be available through the Supply Chain.
  ii. If the device is not placed in a plastic bag, it is still expected to be wiped down with an approved disinfectant. Note: This can be harmful to the device.
  iii. If the device doesn’t leave the LIP’s or healthcare staff’s pocket, there is no need to disinfect the device upon exiting the patient environment.

**CHECK YOUR KNOWLEDGE**
- You may become aware of these patients by lab results and/or the Historical Encounter. The Infection Preventionist will notify you about these patients.
- What kind of isolation should be implemented for these patients?
- What is cohort staffing and which patients require it?
- If cohort staffing is an issue, who should you contact?

**OTHER RESOURCES**
- Centers for Disease Control and Prevention CRE Tool Kit
- CRAB and CRE check list
- MDRO Isolation Strategies
c. If a voice-activated communication device is used while in the patient’s environment, it should be wiped down with an approved disinfectant upon exiting the patient’s environment. It should also be wiped down at the end of the shift, prior to returning to its docking station.

- Clear bags are available from the Supply Chain Organization through the facilities materials management department.
- Bag size varies to accommodate the device.
- Communication devices may not be bagged depending on the device.
- Departments may choose to have the bags stored on the units.

**CHECK YOUR KNOWLEDGE**

- Do you know what disinfectant is approved in your environment of care? Check the Accountability Table in the Disinfection and Cleaning of Non-Critical Patient Care Equipment Procedure. The Accountability Table should be posted in a conspicuous location on the nursing unit.
- Do you know where to get device bags?

**OTHER RESOURCES**

- [2014 APIC Online Textbook, Chapter 31, Cleaning, Disinfection, and Sterilization](#)
- [2008 Guideline for Disinfection and Sterilization in Healthcare Facilities, CDC](#)
- [Breitkreuz, Lorna; Davies, Shauna; and Reed, Dina, “The safe integration of iPads into healthcare practices”, Canadian Healthcare Technologies Oct 2013, page 16](#)
- [IPAC Related to Electronic Devices in Healthcare Settings, FHQ Tribal Council: Health Services & All Nations’ Healing Hospital](#)

---

**FACT SHEET: RESTRAINT AND SECLUSION**

**Key Points for Medical Staff**

**INTRODUCTION**

Physicians and other licensed independent practitioners (LIP) must receive training prior to ordering restraints and seclusion. At a minimum, physicians and other LIPs authorized to order restraint or seclusion by hospital policy in accordance with state law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

**PHILOSOPHY OF USE**

Intermountain Healthcare’s philosophy on the use of restraint and seclusion highlights the following key points:

- Use only to protect the immediate safety of the patient, staff, or others.
- Use only as a last resort and when less restrictive alternative interventions have been ineffective.
- Should never be used as a means of coercion, discipline, convenience, or staff retaliation.
- The least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others is to be used.
- Discontinue restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.

The accountability to understand this philosophy, maintain a working knowledge of the appropriate procedure, and demonstrate compliance is the responsibility of the individual providers.

Restraint, as defined by CMS Regulation and Joint Commission Standard, “is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely; or a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.”

There are two main subsets of restraints:

a. Nonviolent/ Non Self-Destructive Restraints — an instrument or a means of restraint to prevent the infliction of harm to self or others during a medical procedure or treatment (i.e.: restraints used when a
patient is pulling at lines or catheters or disturbing dressings and wounds).

b. Restraint Seclusion Intervention / Violent, Self-Destructive Restraints — confinement or seclusion that is initiated because a patient is acting aggressively or threateningly. Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

**NONVIOLENT/NON SELF-DESTRUCTIVE (NV/NSD) RESTRAINT**

**MEDICAL STAFF ROLE: ORDERING**

**Obtaining a Medical Order:**

- The ordering physician should fill out the NV/NSD order sticker.
- The NV/NSD order will cover one restraint episode, from initiation to discontinuation.
- NV/NSD order sticker is available on the nursing units.
- iCentra will have an electronic process for restraint ordering.

**Completion of the NV/NSD order sticker:**

- The completion of the order is important for compliance with The Joint Commission Standards and CMS guidelines.
- Restraint indication, type, location, and initiation date/time are required.
- All required fields on the order sticker should be completed.

**Medical Reasons for NV/NSD Restraint:**

- Dislodgement of lifesaving equipment
- Picking at surgical/treatment site
- Pulling at tubes and lines

**Restraint Type:** CMS guidelines require the physician to choose the type of restraint used. The type of restraints are listed on the NV/NSD order sticker.

- Soft limb upper/lower
- Nylon limb upper/lower
- Mittens
- Immobilizers
PRN orders: Restraint orders cannot be written in a PRN format.

Violent Self-Destructive Restraint and Seclusion

Seclusion

The CMS Interpretive Guidelines state, “Seclusion is not just confining a patient to an area, but involuntarily confining the patient alone in a room or areas where the patient is physically prevented from leaving.”

If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether the door is actually locked or not. In this situation, the patient is being “secluded.”

Based on the definitions of seclusion, we conclude that preventing the patient from leaving a room for any period of time meets the definition of seclusion. Examples of this may include blocking the doorway, holding the door closed, or preventing the patient from leaving by intimidating them.

Physical Holds (for children and adolescents)

Effective January 1, 2011, the Joint Commission released new standards about physical or “therapeutic” holds in order to address safety concerns and decrease the risk of injury to patients. Physical holds are considered a method of restraint and should be treated as such.

Physical Holds (Joint Commission) are defined as, “A method of restraint in which a child’s or youth’s freedom of movement or normal access to his or her body is restricted by means of staff physically holding the child or youth for safety reasons.”

Medical Staff Role: Ordering and Assessment

Obtaining a Medical Order: An order for restraint and/or seclusion must be obtained during the process or within a few minutes of initiation. During emergency application periods a restraint or seclusion may be initiated without an order, but one must be obtained as soon as possible. Failure to do so is considered applying restraints without an order. Orders may not be written as a PRN order.

Renewing an Order: The order may be renewed up to a total of 24 hours, but may not exceed the allowable age specific maximum time limits. An order CANNOT be renewed if the intervention has been discontinued prior to the expiration of the order.

Medical Residents: If a medical student, resident, or fellow requires a co-signature, they are not considered “independent” and may not prescribe an order for restraint/seclusion.

One Hour Assessment: A patient assessment, both physical and behavioral, must be completed within one hour of the initiation of restraint/seclusion and MUST be completed by the LIP.

Required Physician/LIP Evaluation: If an order for the continued use of seclusion/restraint is required beyond 24 hours, the physician/LIP must evaluate the patient prior to giving a new order.

Amending the Treatment Plan: The use of restraint/seclusion requires an evaluation of the patient’s treatment plan. Any recommended changes require an update of the treatment plan.

The following are available resources/policies/protocols:

- Restraint Non-violent Non-self-destructive Pediatric Adult Protocol
- Restraint Seclusion Violent or Self Destructive Pediatric Adult Protocol
- Restraint Seclusion Policy
- Restraint Seclusion Violent or Self Destructive Order Time Frame

If you have questions, please contact Cindy Cook at cindy.cook@imail.org.

<table>
<thead>
<tr>
<th>Age</th>
<th>Max time limits for order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 9 and under</td>
<td>1 hour</td>
</tr>
<tr>
<td>Age 9-17</td>
<td>2 hours</td>
</tr>
<tr>
<td>Age 18 and adults</td>
<td>4 hours</td>
</tr>
</tbody>
</table>
IT HAPPENED HERE — PATIENT SUICIDE

Learning From Our Mistakes

Patient suicide often occurs after patients have been discharged from our facilities. Per regulatory requirements, Intermountain is required to investigate these cases.

CASE #1
A 28-year-old male voluntarily presented to the emergency department stating he felt extremely “uptight and anxious.” He indicated he had met with his outpatient psychiatrist and had some recent medication changes. He denied suicidal thoughts and intentions of self-harm. A crisis worker consult was obtained and the ED physician increased the prescribed anti-anxiety medications. The patient and his girlfriend stated he felt safe returning home and had appointments scheduled with his psychiatrist as well as his therapist. Discharge instructions were given and the patient agreed to return to the ED if his condition worsened. Twenty-four hours later the patient returned to the ED with increased anxiety and suicidal ideation. The crisis worker evaluated the patient and coordinated admission to the inpatient behavioral health unit. During the next 24 hours, the patient expressed no thoughts of self-harm and participated in care and medical treatment. He was discharged in the company of his girlfriend. Over the next two days, the patient kept his scheduled appointments with the crisis worker. On day three, the patient died by suicide.

What We Learned

It is difficult to predict which patients will die by suicide. Intermountain has recently adopted new screening tools and protocols. Use the screening tool at this link or contact your Behavioral Health resource.

CASE #2
A 43-year-old female admitted for opioid detoxification denied suicidal ideation during the social worker assessment. The patient did not tell staff she had been taking other controlled medication in addition to prescribed opiates. This was discovered in the urine drug screen and may have impacted the efficacy of the medication treatment plan. She refused her first dose of Seroquel as ordered as part of her detox plan. There was also a tandem-AcuDose mismatch resulting in delay of dispensing and administration of her 1st dose of Suboxone and Atarax. Six hours later, the patient was seen leaving her room and heading for the hospital entrance. The nurse followed the patient out of the entrance where the patient got into a waiting cab. The physician was notified and tried to call the patient’s cell phone. Two days after this AMA discharge, the physician was notified that the patient had died by suicide within an hour of leaving the facility.

What We Learned

Additional training on how to provide care for medical detox patients is needed. At Intermountain, nurses, techs, and social workers have been educated on how to care for this specific group. Also, a new procedure has been developed requiring a focused suicide assessment for all substance abuse patients.

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

M-Tech is SelectHealth’s formal process for reviewing emerging healthcare technologies (*procedures, devices, tests, and “biologics”*) for the purpose of establishing coverage benefits. Existing technologies are, at times, also examined through this process.

The following is a list of recent technologies reviewed by M-Tech Committee:

<table>
<thead>
<tr>
<th>TECHNOLOGY</th>
<th>DATE REVIEWED*</th>
<th>COMMITTEE DECISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRgFUS for Essential Tremor</td>
<td>12-16-14</td>
<td>Deny as investigational. Current evidence has yet to demonstrate the safety and efficacy of MRgFUS/HIFU for the treatment of essential tremor. <em>See Medical Policy #560</em></td>
</tr>
<tr>
<td>Endovenous Ablation of the Small Saphenous Veins in the Treatment of Varicose Veins</td>
<td>12-16-14</td>
<td>Cover. Current evidence has demonstrated that endovascular ablation of the accessory and short saphenous veins is safe and effective in the treatment of varicose veins. <em>See Medical Policy #193</em></td>
</tr>
<tr>
<td>Powered and Nonpowered Negative Pressure Wound Therapy</td>
<td>1-20-15</td>
<td>Cover in Certain Circumstances. Current evidence demonstrates the SNaP negative pressure wound system to have similar efficacy to standard NPWT systems in the treatment of chronic wounds. It is covered as being a proven therapy. Further, given the lack of evidence related to other nonmotorized and/or disposable wound therapy device effectiveness and safety, we recommend denial of coverage for the V.A.C. Via or PICO devices as unproven/ investigational. <em>See Medical Policy #185</em></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 include the following. As the reviews are completed, notices will be sent to stakeholders accordingly to inform them as to SelectHealth’s coverage determinations:

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

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

MEDICAL POLICY BULLETIN

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

NEW POLICIES

<table>
<thead>
<tr>
<th>POLICY NUMBER</th>
<th>POLICY NAME AND LINK</th>
<th>EFFECTIVE DATE</th>
<th>SUMMARY OF CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>556</td>
<td>Responsive Cortical Neurostimulation in the Treatment of Epilepsy (NEW)</td>
<td>9/16/14</td>
<td>New policy was developed following a M-Tech review for Neuropace. Commercial Plan covers responsive cortical neurostimulation in the treatment of epilepsy when criteria is met. SelectHealth Advantage follows commercial plan policy as there are no specific guidelines for responsive cortical neurostimulation in the treatment of epilepsy. SelectHealth Community Care may cover subject to the Utah Medicaid coverage status of codes that may be applied to the procedure. These codes will need to be found on the State of Utah Medicaid Look Up Tool to confirm coverage. For covered codes, since there are no specific Utah Medicaid criteria, commercial plan policy will apply.</td>
</tr>
<tr>
<td>POLICY NUMBER</td>
<td>POLICY NAME AND LINK</td>
<td>EFFECTIVE DATE</td>
<td>SUMMARY OF CHANGES</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>557</td>
<td>Radiofrequency Ablation of the Genicular Nerve (NEW)</td>
<td>9/1/14</td>
<td>New policy was developed for Radiofrequency Ablation of the Genicular Nerve. Commercial Plan, SelectHealth Advantage, and SelectHealth Community Care does NOT cover radiofrequency ablation of the genicular nerve in the treatment of osteoarthritis or any other indication as SelectHealth has found this procedure to be not medically reasonable and necessary since current evidence is insufficient to determine the efficacy and safety.</td>
</tr>
<tr>
<td>558</td>
<td>Interspinous Fixation (Fusion) Devices (NEW)</td>
<td>10/6/14</td>
<td>New policy was developed for Interspinous Fixation (Fusion) Devices. Commercial Plan does NOT cover interspinous fixation devices alone for decompression of spinal stenosis or in combination with spinal fusion as they are considered experimental and investigational. SelectHealth Advantage limits coverage of interspinous distraction devices/spacers to their FDA approved indications. Any other use of these devices are NOT covered as investigational. SelectHealth Community Care does NOT cover interspinous fixation devices. There are no specific guidelines for interspinous fixation (fusion) devices, commercial plan policy will apply.</td>
</tr>
<tr>
<td>559</td>
<td>Sphenopalatine Ganglion (SPG) Injection in the Management of Headaches (NEW)</td>
<td>11/5/14</td>
<td>New policy was developed for Sphenopalatine Ganglion (SPG) Injection in the Management of Headaches. Commercial Plan does NOT cover sphenopalatine ganglion (SPG) block for the treatment of acute and chronic headaches as current evidence is insufficient to determine efficacy and safety of this procedure. SelectHealth Advantage does NOT cover this procedure consistent with CMS (LCD) L34775 and L34779. CMS does not list headaches as a covered diagnosis for these procedures, commercial plan policy will apply. SelectHealth Community Care does NOT cover sphenopalatine ganglion (SPG) block for acute and chronic headaches.</td>
</tr>
<tr>
<td>560</td>
<td>Magnetic Resonance Guided Focused Ultrasound For Essential Tremor (NEW)</td>
<td>12/3/14</td>
<td>New policy was developed for Magnetic Resonance-Guided Focused Ultrasound for Essential Tremor. Commercial Plan Policy does NOT cover magnetic resonance guided focused ultrasound in the management of essential tremor as it is considered investigational. SelectHealth Advantage does NOT cover magnetic resonance guided focused ultrasound in the management of essential tremor as SelectHealth has determined to be not medically reasonable and necessary. SelectHealth Community Care does NOT cover the procedure as C9734 is a non-covered code with the State of Utah Medicaid Program.</td>
</tr>
<tr>
<td>POLICY NUMBER</td>
<td>POLICY NAME AND LINK</td>
<td>EFFECTIVE DATE</td>
<td>SUMMARY OF CHANGES</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------</td>
<td>----------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>561</td>
<td>Vectra DA for Management of Rheumatoid Arthritis (NEW)</td>
<td>1/9/15</td>
<td>New policy was developed for Vectra DA Blood Test for Rheumatoid Arthritis. Commercial Plan does NOT cover Vectra DA blood test for rheumatoid arthritis as it is considered investigational. SelectHealth Advantage does NOT cover Vectra DA blood test as there are no specific guidelines, commercial plan policy will apply. SelectHealth Community Care does NOT cover Vectra DA as there is no Utah Medicaid specific guidelines, commercial plan policy applies.</td>
</tr>
<tr>
<td>562</td>
<td>Corneal Hysteresis Testing (NEW)</td>
<td>1/12/15</td>
<td>New policy was developed for Corneal Hysteresis Testing. Commercial plan does NOT cover as the procedure is considered investigational. SelectHealth Advantage does NOT cover the procedure consistent with (LCD) L24473 and L27445. SelectHealth Community Care does NOT cover as code 0181T is a non-covered code with the State of Utah Medicaid program and code 92145 has no coverage status at this time of the review.</td>
</tr>
</tbody>
</table>

### REVISED POLICIES

<table>
<thead>
<tr>
<th>POLICY NUMBER</th>
<th>POLICY NAME AND LINK</th>
<th>EFFECTIVE DATE</th>
<th>SUMMARY OF CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>236</td>
<td>Robotic Assisted Surgery (REVISED)</td>
<td>9/29/14</td>
<td>The addition of the Heller myotomy was added to the covered procedures in the robotic policy.</td>
</tr>
<tr>
<td>246</td>
<td>Mechanical Insufflation-Exsufflation Therapy for the Clearance of Airway Secretions (Coughassist device) (REVISED)</td>
<td>9/29/14</td>
<td>An extensive revision was done on the Mechanical Insufflation-Exsufflation Therapy for the Clearance of Airway Secretions (Coughassist device). Commercial Plan covers mechanical insufflation-exsufflation devices as medically necessary for patients with neuromuscular disorders with significant impairment of chest wall and/or diaphragmatic movement resulting in difficulty clearing secretions, a demonstrated reduction in peak cough expiratory flow rate of &lt;3L per second and for whom standard treatments (e.g., chest percussion and postural drainage, etc.) have not been successful in adequately mobilizing retained secretions. SelectHealth Advantage covers mechanical insufflation-exsufflation device consistent with Medicare Local Coverage Determination L12744. Where Medicare policy does not explicitly outline coverage, commercial plan policy will apply. SelectHealth Community Care covers mechanical insufflation-exsufflation devices for Traditional Medicaid, subject to prior authorization, using criteria in the Medicaid Look up tool for code E0482. This device is not covered for Non-Traditional Medicaid. Code A7020 is covered up to every five years with quantity limit applied consistent with the State of Utah Medicaid Program.</td>
</tr>
<tr>
<td>POLICY NUMBER</td>
<td>POLICY NAME AND LINK</td>
<td>EFFECTIVE DATE</td>
<td>SUMMARY OF CHANGES</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>538</td>
<td>Gene Expression Testing for Indeterminate Thyroid Nodule Biopsy (REVISED)</td>
<td>10/13/14</td>
<td>A revision of Gene Expression Testing for Indeterminate Thyroid Nodule Biopsy with the criteria under the Commercial Plan Policy has been clarified.</td>
</tr>
<tr>
<td>357</td>
<td>Genetic Expression Profiling for Monitoring Acute Rejection in Cardiac Transplant Patients (Allomap) (REVISED)</td>
<td>8/28/14</td>
<td>A revision was made to the Gene Expression Profiling for Monitoring Acute Rejection in Cardiac Transplant Patients (ALLOMAP). The revision of the policy changed #2 under criteria for coverage from &gt;18 years to &gt;15 years and #11 exclusion criteria &lt;15 years was added.</td>
</tr>
<tr>
<td>260</td>
<td>DNA Analysis of Stool for Colon Cancer Screening (Pregen, Pregen-Plus and Cologuard) (REVISED)</td>
<td>10/15/14</td>
<td>A revision was made to the DNA Analysis of Stool for Colon Cancer Screening (Pregen, Pregen-Plus and Cologuard) policy. The addition of Cologuard was added to be covered by SelectHealth Advantage Plan and the coding for this test for Medicare is 81479, as Medicare does not cover HCPC S3890.</td>
</tr>
<tr>
<td>320</td>
<td>Interspinous Distraction Devices/Spacers (REVISED)</td>
<td>10/8/14</td>
<td>A revision was made to the Interspinous Distraction Devices/Spacers policy. The policy was revised to include other similar devices to X-Stop.</td>
</tr>
<tr>
<td>497</td>
<td>Genetic Testing: Lynch Syndrome Screening/Testing for Colorectal Cancer (REVISED)</td>
<td>10/20/14</td>
<td>A revision was made to the Genetic Testing: Lynch Syndrome Screening/Testing for Colorectal Cancer policy. The revision was made under the Commercial Plan Policy with the addition of the following language. *In instances where tissue specimen is not available, genetic testing for MLH1, MSH2, MSH6, and PMS2 will be allowed without first doing Immunohistochemistry.</td>
</tr>
<tr>
<td>493</td>
<td>Molecular Profiling of Tumors to Guide Cancer Therapy (REVISED)</td>
<td>11/14/14</td>
<td>A revision was made to the Molecular Profiling of Tumors to Guide Cancer Therapy policy. The addition of FoundationOne has been added to the policy as NOT covered.</td>
</tr>
<tr>
<td>POLICY NUMBER</td>
<td>POLICY NAME AND LINK</td>
<td>EFFECTIVE DATE</td>
<td>SUMMARY OF CHANGES</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>281</td>
<td>Gene Expression Profiling in the Management of Breast Cancer (REVISED)</td>
<td>1/1/15</td>
<td>A revision was made to the Gene Expression Profiling in the Management of Breast Cancer. The addition of MammaPrint has been added to the policy as covered if criteria is met.</td>
</tr>
</tbody>
</table>
| 142           | Liver Transplant (Adult, Cadaveric) (REVISED)                                         | 1/5/15         | A revision was made to the Liver Transplant (Adult, Cadaveric) policy. The revision is under “Criteria for Coverage” (Patient must meet A OR B).  
A. Procedure has been endorsed and recommended by Intermountain Healthcare Liver Transplant Services OR  
B. For Service being requested outside of Intermountain Healthcare (Criteria follows in the policy) |
| 415           | Breast Tomosynthesis (REVISED)                                                       | 1/9/15         | A revision was made to the move from noncovered to covered effective 1/1/15 as outlined in the policy. Updated codes were added to the policy.                                                                           |
| 185           | Negative Pressure Wound Therapy (Vacuum Assisted Wound Closure) (REVISED)             | 2/4/15         | A revision was made to the Negative Pressure Wound Therapy (Vacuum Assisted Wound Closure). The following information was added to the policy: Indications for Subsequent Approval:  
After initial one month approval, continued re-certification is mandatory for continued reimbursement. Each subsequent approval period is of a maximum of two months. |
Behavioral Health

IMPROVED PROCESS FOR PROVIDING CARE

The Behavioral Health Clinical Program (BHCP) continues to be busy. The implementation process for the Suicide Prevention CPM began in October. The Columbia Suicide Severity Rating Scale (C-SSRS) has a variety of tools that we are using. We are taking a three-part approach to impact the care of suicidal patients: use of the C-SSRS tools, a risk assessment to identify both modifiable and non-modifiable risk factors, and a safety plan for patients at risk who are going home.

The screening tool is currently being used by all of our ED Triage nurses when the patient presents a behavioral health concern. All crisis workers are using a longer version that assesses both ideation and behavior in more detail (Lifetime Version). The shorter screen, which focuses on the 12-hour period since the last nursing assessment was completed, is being used in inpatient behavioral health units and some inpatient medical units.

We recently began development of a plan to continue education and implementation of these tools in outpatient behavioral health clinics, as well as with the remaining inpatient medical nursing staff, Mental Health Integration providers (MHI), and primary care clinicians. Analytics are currently being developed to identify use rates, findings, and trends.

The BHCP is developing a systemwide strategic plan to direct Intermountain’s support of integrated behavioral healthcare. This integrated model will include care and clinical performance standards, an easily accessible network of services and provider offerings, and operational components ensuring connectivity and collaboration across the continuum of care. The plan should be completed by early 2nd quarter.

If you have any questions, please contact Carolyn Tometich at carolyn.tometich@imail.org.
RADIATION DOSE FOR ADULT CT HEAD PROCEDURES REDUCED

Imaging Services set a 2014 system goal to reduce the radiation effective dose for head CT scans to a level of two mSv or less. This goal was achieved at the extraordinary level. The main components of the goal were to:

- Collect and report accurate CT dose data
- Understand current state practice
- Develop standardized low-dose head CT protocols that meet image quality requirements
- Train staff

At the beginning of 2014 only 38.1% of adult head CT procedures had a radiation effective dose of two mSv or less. By January 2015, over 92% of adult head CT scans met this standard.

Achieving this goal was quite remarkable due to the significant impact to the system and the far-reaching change that was required to accomplish it. Within Intermountain Healthcare there are 41 CT scanners that are used for CT head imaging, which include three different brands of scanners and many different models of each brand. Protocols had to be developed and implemented for each of the different scanner brands and models. Dose reduction software was also added to the scanners to increase the benefit of the standardized, low-dose protocols in reducing radiation dose.

As seen in the graph below, the first eight months of the year were spent laying the groundwork and evaluating the current state, reviewing image quality, developing and testing low dose protocols, and working with staff and radiologists at all of Intermountain’s facilities. As implementation of the protocols took place, the number of patients with CT head radiation effective doses below the two mSv threshold increased.

Appropriate utilization criteria was also developed as part of the goal for the indication of headache.

If you have any questions, please contact Deanna Welch at deanna.welch@imail.org.
ENTERPRISE IMAGING ANNOUNCES UPGRADES TO RESMD

ResMD, the new imaging software rolled out in 2014, was upgraded on January 27 and now includes the following features and functionality:

1. Stacks of images are now in one group. In the old version, there were times when stacks of images were divided into two groups. (see Picture 1)

2. The “All Images” option loads all series into one large group, allowing for seamless scrolling from one series to the next. In the old version, each series had to be individually loaded with a double-click. (see Picture 2)

3. Quick and easy printing using the “Paper Print” icon in the lower left corner. The provider now has the option to remove patient demographics and choose what printer to use. (see Picture 3)

If you have questions, please contact Randy Tebbs at randy.tebbs@imail.org or Dave Anderson at dave.anderson@imail.org.

Picture 1

continued on next page
Old Version required a double click on each series to load it into the viewer.

New Version allows all series to be loaded at the same time and seamless scrolling from one series to the next.

Old Version, there was no easy way to “Paper Print”.

New Version, Provides a “Paper Print” Icon.

continued on next page
Picture 3, continued

You can then decide if you want Patient demographics on or off by clicking here.

Then you are given the choice of what printer to use.
In Intermountain Healthcare Sepsis Bundle Experience

Sepsis is the second leading cause of death in non-coronary ICU patients in the U.S. The range of mortality rate is from 20% for sepsis, 40% for severe sepsis, and over 60% for septic shock respectively worldwide. Quick identification and evidence-based early treatment is critical to best care and improved patient outcomes.

In 2005, the Intensive Medicine Clinical Program (IMCP) conducted a multi-year, longitudinal quality improvement initiative focused on patients with severe sepsis or septic shock. The goal was to significantly increase compliance with 11 elements identified in a sepsis bundle and to reduce in-hospital mortality in patients with severe sepsis or septic shock who were admitted to the Intensive Care Unit (ICU) from the emergency department (ED).

In 2004, Intermountain's systemwide compliance with the 11 elements of the sepsis bundle was 4.4% and mortality rate was 20.8%. The sepsis bundle was implemented as best practice in 2005 and was the IMCP Board Goal for three consecutive years beginning in 2008. Bundle compliance increased from 4.4% in 2004 to 74.7% at the end of 2010. Mortality rate for the same period decreased from 20.8% to 8.7%.

In 2014, IMCP once again chose Sepsis as the focus of a board goal implementing an updated version of the bundle and broadening the patient population to include patients that develop severe sepsis or septic shock at an acute inpatient setting. Mortality for patients who develop severe sepsis in the inpatient setting can be as high as 40%. The IMCP believes the greatest impact on hospital mortality can be made by providing education for early identification of sepsis and implementation of the sepsis bundle on acute care floors while continuing to improve compliance of the sepsis bundle for patients admitted from the ED to the ICU. See Figure 1 for the 2014 Board Goal results for compliance and mortality.

Additional Resources:

2015 Sepsis Bundle
Sepsis Flow Diagram

If you have any questions please contact Terry Clemmer, MD at terry.clemmer@imail.org or Nancy Nelson at nancy.nelson@imail.org.

If you have any questions please contact Terry Clemmer, MD at terry.clemmer@imail.org or Nancy Nelson at nancy.nelson@imail.org.
Musculoskeletal

NEW PROJECT MANAGEMENT PLAN TASK FORCE

Our Musculoskeletal Clinical Program (MSKCP) is organizing a task force to create a standardized Project Management Plan for Patient Reported Outcomes/Measures that will be implemented systemwide. Kim Henrichsen and Brent Wallace will be the executive sponsors of this task force. We will have representatives on the task force from such areas as Clinical Programs, Healthcare Delivery Research, eBusiness, My Health, Rehab Services, Application Development, Software Engineering, Homer Warner Center, EDW, Medical Informatics, Quality, and SCO. This task force will be co-chaired by Matt Peters (SSCP) and Ben Layne (MSKCP).

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

Neurosciences

A BOLD NEW START FOR THE NEUROSCIENCES CLINICAL PROGRAM

As the Neurosciences Clinical Program (NSCP) embarks on its inaugural year of operations, we have several ambitious goals. The NSCP Guidance Council will consist of multi-disciplinary representation from all Intermountain regions. Under the direction of the NSCP Guidance Council, the NSCP will have four development teams: two currently in operation (Stroke and Spine) and two new teams (Epilepsy and Neurosurgery). Stroke, led by Dr. Kevin Call, and Spine, led by Dr. Stephen Warner, will continue their disease state-specific focus. They will also expand to include patient care aspects in pre- and post-hospital settings and overall patient wellness. The two new teams, Epilepsy, led by Dr. Tawyna Constantino, and Neurosurgery (medical director to be named soon), will focus on establishing care processes and reducing variations in care in their respective areas.

Other initiatives for the year include:

- Telestroke services rollout for all Intermountain hospitals
- Designing a care process model for seizure treatment in the EDs
- Concussion management in primary care and sports medicine clinics
- Optimizing neuro critical care management across Intermountain

We look forward to working with all the disciplines who participate in neurosciences care to see what the new program will bring this year.

If you have questions, please contact Jeremy Fotheringham at Jeremy.fotheringham@imail.org.
OUR RECENT FOCUS

Over the past few months, our efforts have been focused on:

- Partnering with the Oncology Clinical Trials Office and Office of Research to alleviate our IRB suspension, which we have successfully accomplished by submitting a corrective and preventative action plan (CAPA) and creating various standard operating procedures (SOPs).
- Submitting main member applications to the National Cancer Institute (NCI) for national consortia group clinical trial participation (NRG and SWOG).
- Partnering with the Intermountain Cancer Genomics (ICG) program at Dixie Regional Medical Center (DRMC) to:
  - Obtain CLIA certification and provide next gen sequencing capabilities; CLIA certification obtained last fall, >200 specimens have been sequenced to date.
  - Post two Academic Medical Oncologist positions, to be placed at Intermountain Medical Center, who will be responsible for creating a phase I and cancer immunology program.
  - Partner with industry to expand our clinical trial portfolio and increase our accrual (access to targeted therapeutics).
- Reinvigorating our cancer-specific development teams to develop meaningful quality improvement and outcomes-based research projects.
- Partnering with the Intermountain BioRepository to consent and enroll our patients in our general specimen/tissue collection protocol (samples to be used for future research projects).
- Developing chemotherapy order sets as we prepare for iCentra; this effort has been led by Dr. Derrick Haslem (DRMC) and Dr. Kerry Rowe, Oncology Clinical Program Biomedical Informatics.
- Submitting our first successful CMS Meaningful Use submission for radiation oncology; the submission was for Q4, 2014 data.
- Supporting DRMC’s Susan Komen grant application for breast cancer patient navigation services; NOA’s will be announced in May 2015.

Going forward, we are also exploring options to restructure our Genetic Counseling and Cancer Registry service lines.

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

CANCER GENOMICS AND PERSONALIZED MEDICINE CLINIC

Genomic medicine is at the forefront of developing new strategies and methods for treating cancer. It is reassuring to know Intermountain is taking a lead in this field. Intermountain Cancer Genomics Program is offering in-house next generation genomics sequencing at the CLIA-certified genomics laboratory located at Dixie Regional Medical Center. This genomic sequencing test looks at a specifically selected panel of variants that are identified as driving tumor growth and are clinically actionable. In addition, every tumor is presented at the Molecular Tumor Board, which is comprised of national and international leaders in the field of genomics to determine the best treatment options.

Dr. Lincoln Nadauld helped develop the technologies at Stanford University that make personalized cancer medicine possible and now oversees Cancer Genomics and Personalized Medicine for Intermountain Healthcare. Dr. Nadauld is available for a one-time patient consultation or continuing personalized medical care at the Dixie Regional Medical Center’s Personalized Medicine Clinic. The Personalized Medicine Clinic accepts patient referrals from around the world. Dr. Nadauld currently participates in a number of national clinical trials looking at targeted therapies with additional trials that will be opening soon. The Personalized Medicine Clinic has financial eligibility counselors available to assist patients in obtaining targeted therapies. To schedule a patient consult or appointment with Dr. Nadauld in the Personalized Medicine Clinic call (435) 688-4900.

To submit tumor tissue for testing or for more information go to http://precisioncancer.org, call (435) 251-5780, or email genomics@imail.org.
NEW TOOLS TO DIAGNOSE AND TREAT NECK PAIN

Pain Management Clinical Services and the Functional Restoration Development team released the new Neck Pain Care Process Model (CPM) and Neck Pain Flashcard in February.

The CPM and associated tools were developed to assist primary care providers with the diagnosis and treatment of neck pain. National guidelines, expert opinion, and emerging evidence were used in the development of this CPM.

You can access the Care Process Model and additional resources at the links below:

- Neck Pain Care Process Model
- Patient Self History: Neck Pain
- Patient Exam: Cervical Spine Evaluation

If you have any questions, please contact Bridget Shears at bridget.shears@imail.org or Linda Caston at linda.caston@imail.org.

PEDIATRICS

FEBRILE INFANT CARE PROCESS MODEL

The evidence-based care process model of febrile infants ages 1 to 90 days old has been in use since 2008. Since the start of implementation of this care process model we have seen improvement in testing rates, better recognition of bacterial infections, appropriate admissions, and shorter lengths of stay. We achieved all of our board goals in 2010 and have been able to sustain a high level of compliance with the recommended care for more than five years. This really is an amazing achievement!

The care process model is not static, but rather dynamic. It is continuously improving based on feedback from providers, improvements in technology, and new evidence. In 2011 the Pediatric Clinical Program completed major updates to the care process with recommendations to improve management of infants with RSV, a common viral illness, and those infants at risk for herpes virus — a rare but potentially devastating infection.

In 2012, the BioFire™ FilmArray rapid PCR testing panels were approved by the FDA and have been included in the care process model, providing us with much more information about the viruses causing fever in these infants. The cost of PCR testing has caused some providers to question the added value of viral testing though.

Still, the febrile infant care process model continues to recommend viral respiratory testing for all febrile infants that are admitted. Test results have great value for infection control in the inpatient setting to identify infants with influenza who can benefit from antiviral treatment and help providers to identify infants with little risk for bacterial infection so that these infants can discontinue antibiotics and be discharged home. The cost of viral testing is warranted for admitted infants and saves costs overall. Viral respiratory testing for febrile infants that are low-risk and are not to be admitted is not necessary.

In addition to respiratory viral testing, enterovirus testing should be completed in season (June-November) and in any case of CSF pleocytosis. Please remember this test when appropriate.

The Pediatric Infectious Disease team is currently evaluating respiratory viral result data to determine if a further revision to the care process model can be recommended.

If you have questions, please contact Carolyn Reynolds at Carolyn.reynolds@imail.org.
2015 WORK PLAN

The Primary Care Clinical Program Work Plan includes:

- Defining clinical best practices for the configuration and implementation of iCentra with a focus on lipid management, high blood pressure, chronic kidney disease, and diabetes
- Continuing to expand the Choosing Wisely® initiatives
- Expanding the Diabetes Prevention Program

To date around 1,200 patients have been enrolled. Compared to the control group, these patients were 67% more likely to achieve 5% weight loss, 57% less likely to have incident diabetes, and were over five times more likely to have counseling on lifestyle and weight management.

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

Surgical Services

UNAPPROVED PRODUCT PROCESS

In an effort to ensure that new products used in the care of patients have evidence to support improved outcomes, Intermountain Healthcare has put in place an Unapproved Product Process with our facilities and suppliers. This has been approved by Intermountain Healthcare clinical leaders and became effective on February 9, 2015.

Products currently used at Intermountain Healthcare are considered approved and will not be affected. The target products for this initiative are first time use products introduced to the system. We expect our suppliers to follow our policies and procedures and introduce all new products via the supply chain for review by the appropriate clinical program.

Any physician is welcome to submit a new product they wish to trial to the appropriate clinical program for review. For example, a new surgical device for review would be submitted to the Surgical Services Clinical Program, whereas a new device used in labor and delivery would be submitted to the Women and Newborns Clinical Program.

The review process will generally be completed in a 30-day period. If the physician or supplier does not follow this process and the device is used in a procedure on a patient, Intermountain will not pay for the product nor will the patient be charged. The supplier will have in effect donated the device for free. It is the responsibility of the supplier, not the physician, to ensure their products are pre-approved for use.

The supplier will always need to have a physician champion within Intermountain Healthcare who is requesting the device and that physician will need to be willing to present to the clinical program why the new device is needed. Adherence to this policy will ensure that new technology is thoroughly vetted for safety and effectiveness prior to being used and that our patients are getting the best price possible.

To learn more about why this policy is being implemented:

Read the Supplier Relations Policy

If you have questions, please contact Shon Wettstein at shon.wettstein@imail.org.
YOU HAVE TO WALK THE WALK

Being physically active is one of the most important things Americans can do to improve their health. Regular physical activity is associated with a reduction in adverse health outcomes such as cancer, heart disease, depression, and all-cause mortality. For adults, the majority of these benefits occur with at least 150 minutes per week of moderate intensity (brisk walking) activity. Muscle strengthening activities performed twice a week can provide additional benefits.

Professional and governmental organizations, along with disease prevention and treatment guidelines, advise physicians to counsel patients about the importance of regular physical activity. The National Committee for Quality Assurance (NCQA) has endorsed two HEDIS quality measures regarding physical activity counseling by primary care physicians: one aimed at children and adolescents ages 2 through 17 and one for older adults 65 and older. These measures are among many others used to define the quality of healthcare delivery.

We have all heard the old adage, “you practice what you preach.” However, the converse of this statement, “you preach what you practice,” is equally true when it comes to physical activity promotion. There is an expanding body of literature demonstrating that physicians (and medical students) who engage in healthy lifestyle behaviors are more likely to discuss these behaviors with their patients. Similarly, patients are more likely to find their provider a credible and motivating source of information on physical activity if the physician discloses how active he or she is.

Dr. David Sabgir, a cardiologist in Ohio, started a program called, “Walk with a Doc,” to encourage physicians to actually walk with their patients. Walk with a Doc encourages physicians to organize regular walks with their patients and community members. The program has been adopted by physicians from all across the US, Canada, and now Europe.

Visit the Walk with a Doc website

I recall from my own medical student days a cardiologist who walked into a classroom with Marlboros in the pocket of his white coat. Frankly, I dismissed him out of hand as a trustworthy source of information. Thankfully, an extremely small percentage of US physicians smoke cigarettes (less than 5%), but in a 2013 Gallop poll, 42% of physicians reported not getting at least three days of moderate intensity physical activity each week – so there is certainly room for improvement.

If we want to achieve our mission of “helping people live the healthiest lives possible,” we need to help them move more. We’ll be more successful in that effort if we also move more. So keep talking the talk with your patients to increase their physical activity, and share your own efforts to increase your physical activity. Be a positive role model for your patients, your colleagues, and staff, and of course your family and community.

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