Message from Brent and Susan

Dear Colleagues,

We are pleased to share November’s edition of Intermountain Med Staff News, a news brief with a goal of keeping Intermountain credentialed practitioners informed. This edition includes updates on various Intermountain initiatives including information about contact isolation for physicians and caregivers, SelectHealth preauthorization requirements for selected surgical procedures, and updates from various clinical programs. Click on any title in the list below and go directly to that article, or read the entire newsletter in PDF format on Intermountain’s Physician Portal. If you have questions, comments, or suggestions, please reach out to the contacts noted at the end of each article, or to either of us. If you have an article to submit or an idea for a story, please send it to us.

Thank you for all that you do in support of Intermountain Healthcare and the patients and communities we serve as we all help people live the healthiest lives possible.

Sincerely,

Brent Wallace, MD & Susan DuBois

Focus on pain and opioid management at Intermountain’s first Integrated Pain Symposium December 1-2 in Park City

Intermountain Healthcare is hosting our first multidisciplinary educational activity for caregivers involved in providing pain management for patients. The Integrated Pain Symposium — which will be Friday and Saturday, December 1 and 2, at Park City Hospital — will help caregivers learn how to effectively manage their patients' pain in light of our goal to reduce the amount of prescribe opioid tablets.
The agenda includes a panel discussion about the Opioid Community Collaborative, safe prescribing training, pain management for inpatients and outpatients, and new laws that relate to opioid prescribing practices. Pain management options and other issues will also be discussed.

"The discussion lately has been around opioid management, but what I don't want people to forget is we have patients who have pain," says Bridget Shears, RN, Intermountain's director of pain management clinical services. "We have to make sure we're appropriately managing that pain. We don't want caregivers to be afraid to use opioids as a tool for managing their patients' pain when needed, but we also want to provide you with information about what else you can do to help patients."

The cost for the event is $150 for physicians, $115 for advanced practice clinicians, and $80 for other caregivers. Sign up online at www.intermountainphysician.org/PainSymposium.

For more information, please contact Bridget Shears at bridget.shears@imail.org.

JAMA study shows opioids are no better than Advil or Tylenol for extremity pain

The United States is facing an opioid epidemic with nearly 100 deaths a day from overdoses. Despite the epidemic, opioid analgesics remain a first-line treatment for moderate to severe acute pain in the emergency department. A blinded and randomized study published in the Journal of the American Medical Association (JAMA) this month provides further rationale against this opioid prescribing. The study, involving 416 adult patients coming into an emergency department with arm or leg pain from sprain, strain, or fracture—demonstrated no difference in pain reduction after two hours with ibuprofen-acetaminophen compared to opioid-acetaminophen combinations.

Intermountain has pledged to reduce the average number of opioids prescribed per acute pain prescription by 40 percent across the system, by the end of 2018. Paul
Krakovitz, MD, Associate Chief Medical Officer, says, “This study provides important evidence that nonopioid alternatives can be as effective as opioids in the management of acute pain, supporting the reduction of opioid prescribing during and after urgent treatment and therefore supporting our goal at Intermountain.”

“Changing the prescribing habit away from opioids in the acute or other settings could reduce patients' initial exposure to opioids and the subsequent risk for developing tolerance, dependence, and addiction, or diversion to friends and family members,” says David Hasleton, MD, Associate Chief Medical Officer.

Jay Bishoff, MD, Director of the Intermountain Urological Institute, relayed his own measured experience for post-operative urology patients. “Since January 2017, our urology patients have been given nonopioid or nonnarcotic alternatives for postsurgical pain along with only six narcotic tablets,” he says. “More than 90 percent of our patients don't use more than the six narcotic tablets and many don't take any narcotics at all. Increasing evidence of the value of and preference for nonopioids supports our efforts to reduce opioid prescribing and risks.”


**Controlled Substance Database update**

Effective November 16th, 2017, Utah's Controlled Substance Database (CSD) went live with a new Patient Dashboard that captures four metrics:

1. Total active daily morphine milligram equivalents
2. The number of prescribers in 6 months
3. The number of pharmacies in 6 months
4. Active benzodiazepine-opioid combos

These metrics are displayed predominantly in the dashboard and represented by color for prescribers to easily identify high-risk patients and also to influence their future prescribing patterns.

For more information and to access and search the CSD, visit csd.utah.gov and log in to or create your new Utah ID account.

**Safety Story: An SBAR on Contact Isolation for Physicians and Caregivers**

Sometimes events/practices have the potential to harm our patients and/or, our caregivers. As a physician, please read the SBAR below and be aware of potential issues with non-compliance in the scenario.

**Situation:** Recently an inpatient in an Intermountain hospital was colonized with a Carbapenem Resistant Acinetobacter (CRAB). The care team (including physicians) were advised to wear contact precautions in the patient's room. Some physicians refused, stating they would not touch the patient and would only be in the room working on the computer.
**Background:** There is no cure for some infections that are present in our hospitals. CRAB implies bowel colonization, and likely colonization of the room and its contents. CRAB is an organism that lingers in the environment, on hands, and objects. It is important to note that the computer's wheels, if rolled into the room, are now contaminated; they should be cleaned before it is taken to another area. The physicians' clothes are likely contaminated—as well as their hands—after touching their clothes after washing.

In another health system, the National Institute of Health (NIH) demolished the walls of an entire unit to try to eradicate this organism. That's how serious CRAB can be.

**Assessment:** This organism is not something we want on our clothes, our computer, our hands, or transmitted to patients. As a high reliability zero harm institution we must be accountable to wear personal protective equipment to prevent spread of these organisms. There are no exceptions to contact isolation. Failure to follow the appropriate precautions puts patients, caregivers, physicians, and family members at risk.

**Required Actions:**

- Do not ignore isolation warnings and precautionary warnings.
- Use ARCC.
- Discuss this scenario in multiple physician venues.
- Ask questions of Infection Preventionists.

**Think about it:**

Could this happen in the areas you work?

As a physician, are you receptive to caregivers who ask you to comply with isolation precautions?

Could this or similar instances of non-compliance be discussed with your peers or in the department huddle?

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**Contact Jeanne Nelson at jeanne.nelson@imail.org with any questions.**

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**RESEARCH UPDATE**

**Designing, deploying, and operationalizing evidence-based best practices**

Intermountain is reorganizing to serve our patients and communities better. As part of this reorganization the Clinical Programs will now design, deploy, and operationalize our evidence-based best practices across the system. This change expands the Clinical Programs' accountability to include operational areas previously managed by regional and hospital service lines.
Applying the knowledge gained from research to our patient care is critical for the promotion of consistent treatment throughout our system, improving patient outcomes, helping establish care delivery standards in patient care, and setting criteria to measure medical and cost outcomes.

A focus on conducting research that will have a rapid impact on care delivery helps Intermountain excel at its vision to be a model health system. The following research studies show how research at Intermountain is improving patient care locally and abroad.

**Study finds pharmacist and primary care collaboration can improve diabetes and high blood pressure care**

In a joint effort between Pharmacy Services, Primary Care Clinical Program, and the Institute for Healthcare Delivery Research, researchers at Intermountain demonstrated that adding an ambulatory care clinical pharmacist to the primary care team helped more patients achieve their blood pressure and diabetes goals. Their research, entitled “Pharming out support: a promising approach to integrating clinical pharmacists into established primary care medical home practices,” was recently published in *The Journal of International Medical Research*. [Read more >](#)

**Pain management study designed to help patients reduce opioid use receives $8.8 million funding**

Intermountain Healthcare is working with Stanford Medicine, the Phoenix VA, and the Dr. Stieg pain clinic in Colorado to test pain management strategies that help patients with chronic pain reduce their use of opioids. Stanford's Beth Darnall, PhD, Clinical Professor of Anesthesiology, Perioperative and Pain Medicine will be the lead investigator of the study, which is funded by a generous award of $8.8 million from the Patient-Centered Outcomes Research Institute. Dr. Darnall will coordinate with Intermountain's Site Director Joel G. Porter, MD, a family practice physician. [Read more >](#)

**Study shows MRIs are safe for patients with a wide variety of pacemakers and defibrillators**

Magnetic resonance imaging appears to be safe for patients with cardiac implantable electronic devices, even for chest imaging, according to a new study by researchers from the Intermountain Medical Center Heart Institute. The study, recently published in the *Journal of Clinical Electrophysiology* found that MRI imaging can be safely performed on patients with devices. [Read more >](#)

**$3.8 million awarded to Intermountain and U. of U. cancer researchers for an advanced cancer screening tool**

Researchers from Intermountain Healthcare, University of Utah Health Care, and Huntsman Cancer Institute are teaming up to develop a new tool designed to help clinicians better identify patients who are at higher risk of developing cancer — with the help of a $3.8 million grant from the National Cancer Institute. The new tool will use data from electronic health records to screen patients for several types of cancer. It will help providers identify and manage high-risk patients in primary care settings. [Learn more >](#)

**Six research teams receive seed funding from Intermountain and Stanford for projects aimed at transforming healthcare**

Stanford Medicine and Intermountain Healthcare recently announced the recipients of more than $400,000 in seed grants focused on transforming healthcare. The six research projects will receive seed grants of up to $75,000 each and will be jointly led by principal investigators from Intermountain and Stanford. The Intermountain-Stanford grant program is part of a collaboration focused on advancing clinical care best practices, education and training, and clinical research in heart disease, cancer, and other conditions. [Read More >](#)

Over the years, Intermountain has been involved in thousands of studies across dozens of clinical specialties. Currently, more than 1,500 studies, in over 20 clinical areas are open and actively underway at Intermountain. The discoveries that come out of our studies improve Intermountain’s care delivery performance, as well as advance medical knowledge throughout the world.

If you have questions, please reach out to Sue Gagnier at susan.gagnier@imail.org.
Lower Back Pain Clinic Update
by Vikas Garg, MD, MSA, Fellowship trained, Board certified pain management specialist

One percent of the US population is disabled due to low back pain. Low back pain is the second most frequent reason that patients visit a physician. The etiology of low back is usually multi-factorial. The most common pain generators being: a) discogenic pain b) facet joint disease c) radiculopathy due to disc protrusion d) failed back surgery syndrome e) myofascial and piriformis muscle pain f) sacroiliac joint syndrome.

History, physical examination and MRI findings do not provide adequate diagnostic information in all patients. Making a right diagnosis is necessary for successful treatment.

Over the last decade, minimally invasive treatments for low back pain have gained in popularity. Some of the most important features of these treatment options are their extremely favorable risk/benefit ratio, improved outcome data, and diagnostic value not achievable by MRI or any other imaging.

Usage of opioid medication has gone up significantly for chronic low back pain in recent years. Research has shown that chances of becoming addicted to opioids are lower if used under the guidance of a trained professional. Intensive physical therapy, weight loss, and a home exercise regimen may be needed for improving quality of life in chronic low back pain patients.

In our pain clinic, we generally try to do a multi-disciplinary approach to treat pain conditions, which means using a variety of specialists to help patients feel better quicker. Some of these may include physical therapy, medications and non-surgical interventional approaches. That includes injections like epidural injections, nerve blocks, facet joint injections and radiofrequency ablation, or rhizotomy—where a nerve can be killed to help with pain. Newer techniques like spinal cord stimulators, an electronic device to mask pain can be tried. A fluoroscope should be used to do all interventional therapy due to significantly lower risk.

For more information please visit www.utahpaincenter.com or call 801-262-7246

Pediatric Urine Drug Screen Update

An accurate mass spectroscopy (MS) test exists to analyze a child's urine for the presence of drugs/toxins. This test, while accurate, could delay clinical care as the turnaround time can be several hours to days. The typical urine drug screen is an immunoassay that is rapid and inexpensive, but also is limited with false positive and false negative results and cut-off values that may not be appropriate for children. Positive results on the immunoassay are sent for mass spectroscopy but procedures for follow up on these tests are unclear. In 2016, 510 urine drug screens were sent from Intermountain ED's for children 0 – 12 years of age, with ½ (257) sent on children ages 10 – 12. Only 80/510 (16%) were positive requiring confirmatory testing. A review of 194 urine drug screens found that 46% were sent for patients with behavioral health diagnoses. The data show that we may be able to decrease the number of pediatric urine drug screens sent from the ED.
Guidelines are needed indicating when to send a urine drug screen on a pediatric emergency patient.

We reviewed published indications for drug screening in pediatric emergency patients, and developed the following recommendations, which were reviewed and approved by the Intermountain Pediatric Emergency Collaborative (IPEC).

Indications for Pediatric Urine Drug Screens in the Emergency Department:

1. Ingestion (intentional or unintentional) *
2. Altered Mental Status (includes hallucinations and acute psychosis)
3. Unexplained Seizures
4. Clinical evidence for Toxidrome
5. Unexplained Arrhythmia
6. Trauma or Abuse (when there is a suspicion of toxin)
7. Selective testing for Behavioral Health evaluation (not routinely required, not always required for admission)

*Most pediatric non-teenage accidental ingestions are straightforward and the concerning agent is clear. In these instances, toxicologic testing is often not necessary.

Please contact Carolyn Reynolds at Carolyn.Reynolds@imail.org with any questions.

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**Pharmacy Services**

**Pharming Out Support: Ambulatory Care Pharmacists Achieve DM and HTN Goals**

In a joint effort between Pharmacy Services, Primary Care Clinical Program, and the Institute for Healthcare Delivery Research, researchers at Intermountain demonstrated that adding an ambulatory care clinical pharmacist to the primary care team helped more patients achieve their blood pressure and diabetes goals. Their research, entitled “Pharming Out Support: A Promising Approach to Integrating Clinical Pharmacists into Established Primary Care Medical Home Practices,” was recently published in *The Journal of International Medical Research*.

This study examined the effectiveness of a team of ambulatory care clinical pharmacists embedded in Medical Group Primary Care clinics from 2012-2015 working under collaborative practice with adults diagnosed with diabetes mellitus and/or high blood pressure. Patients working with a clinical pharmacist to initiate and adjust medications related to these disease states, in addition to offering counseling on lifestyle modifications, were 93% more likely to achieve a blood pressure goal of < 140/90 mmHg and 57% more likely to achieve HbA1c values < 8% compared with a reference group that did not include pharmacist support. Additionally, patients co-managed by a pharmacist also showed significant improvement in time to goal achievement for both diabetes and high blood pressure as well as increased ambulatory encounters compared with the reference group.

“What was so critical about this study, was that the program was able to show a marked improvement for patients even when layered over a team-based care structure that has already demonstrated improved quality outcomes and decreased annual cost as published earlier in 2016”, says Kim Brunisholz, PhD, Senior Scientist in the Institute.

“Not only do patients benefit by enrolling, but this study also highlights the positive role and impact our ambulatory care clinical pharmacists have on the primary care teams within our clinics,” says Dr. Greg Parkin, MD, Salt Lake Clinic.
Pharmacy services currently employees 7 ambulatory care clinical pharmacists within 13 Primary Care Medical Group clinics. Jeff Olson, PharmD, MBA, BCPS, BCACP, Director of Ambulatory Care Pharmacy Services for Intermountain highlighted that “pharmacists embedded within primary care clinics play a valuable role in helping patients become more adherent to their medications and achieve better control of their chronic disease.” In addition to the services highlighted in the research, clinic-based pharmacists work to ensure the safe and effective use of medications in the outpatient setting. Some of their additional responsibilities include following-up with patients to review medications after a recent hospitalization, consulting with providers to optimize medication therapy, assisting in de-prescribing potentially dangerous medications such as opioids and benzodiazepines, and helping patients lower drug costs by switching to equivalent generic or lower-tier medications.

“As we look to increase patient access to healthcare,” Sharon Hamilton, Director of the Primary Care Clinical Program stated, “leveraging the clinical pharmacist embedded within primary care clinics increases patient access to timely treatment for chronic disease management and also improves patient clinical outcomes.”

Please contact Jeff Olson at Jeff.Olson@imail.org with any questions.

Reference:

OB Severe Hypertension Safety Bundle

The Women and Newborns clinical program will be implementing the Alliance for Innovation on Maternal Heath (AIm) Severe Hypertension/Preeclampsia Safety Bundle. The goals of this bundle is to accurately evaluate blood pressure, timely notification of provider with treatment of severe pressures within 60 minutes, and developing protocols to allow for streamlined evaluation and treatment. Patients presenting with severe hypertension (>160 systolic or >110 diastolic) will have a second blood pressure check documented within 15 minutes. A confirmed severe range blood pressure should have treatment with Labetalol, Apresoline, or Nifedipine within 60 minutes. There will be flip charts available as well as the Emergency Checklist for Management of Severe Intrapartum or Postpartum Hypertension.

Women with Severe Hypertension should continue to be treated with Magnesium Sulfate as a seizure prophylactic while treating the blood pressure.

The W&N clinical program will be measuring compliance to this safety bundle. The ultimate goal is to prevent adverse events by recognizing maternal warning signs and treating them in a timely manner.

If you have any questions, please contact Kristi Nelson at Kristi.Nelson@imail.org.
Newborn TeleHealth Resuscitation Simulations

TeleHealth will offer resuscitation simulations in 2018. Pediatric providers and nurses are encouraged to participate in these simulations to obtain first-hand experience with this tool and interactions with neonatology. TeleHealth technology is used to assist with resuscitations and consults between providers and level 3 nurseries.

If you have any questions, please contact Lory Maddox at lory.maddox@imail.org.

Episiotomy – Time for Restricted Use

Traditional obstetric wisdom held that the routine use of episiotomy would lessen the likelihood of severe (3rd and 4th degree) perineal lacerations associated with vaginal delivery. This, however, has proven not to be true. In fact, midline episiotomy is associated with a significant increase risk of 3rd and 4th degree perineal lacerations indicative of maternal anal sphincter injury! According to the most recent American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin on the topic, restrictive episiotomy practice is associated with a lower risk of severe perineal trauma (RR 0.67! 95% CI, 0.49-0.91).
Recognizing this, the Leapfrog Group, a patient safety organization comprised of employers and other purchasers of employee health coverage, now reports a hospital's rate of episiotomy for public consumption (http://www.leapfroggroup.org/ratings-reports). Routine episiotomies as reflected by a facility's high rate of episiotomy are viewed in a negative light by payers and consumers. A Google search of episiotomy finds numerous sites that point out why patients should not have routine episiotomies. Perhaps, because of patient safety organizations and public pressure, the rate of episiotomy has steadily decreased in the US since 2006. In 2012, hospital discharge data indicated a rate of 12%. Focused institutional efforts have lowered facility rates to less than 6%, and the Leapfrog Group has called for a rate of 5%. The ACOG now recommends restrictive use of episiotomy.

Against this background, it's disappointing that the rate of episiotomy in many Intermountain facilities exceeds 25%. Individual provider data indicate that some providers have episiotomy rates in excess of 50%! The vast majority of these procedures are "routine" and not clinically indicated.

If you have any questions, please contact Ware Branch at ware.branch@imail.org

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**SELECTHEALTH UPDATE**

**2018 Preauthorization Requirement for Spine, Joints, Hysterectomy, T&A**
In evaluating SelectHealth utilization data against national benchmarks, we have learned that use rates for spine surgeries (lumbar and cervical), joint surgeries (shoulder, hip, knee, and ankle), tonsillectomies/adenoidectomies, and hysterectomies are among the highest in the country. Therefore, effective January 1, 2018, preauthorization will be required for selected surgical procedures, including spine (lumbar and cervical), joint (shoulder, hip, knee, ankle), tonsillectomy/adenoidectomy, and hysterectomy. The preauthorization requirement will apply in Utah for the following product lines: SelectHealth® commercial plans, SelectHealth Advantage®, SelectHealth Community Care®, and the Children's Health Insurance Program (CHIP). The requirements will not apply to Federal Employees Health Benefits (FEHB) at this time. The current prior authorization requirements for any inpatient stay will remain effective.

SelectHealth is implementing this change to support appropriate utilization of services and adherence with evidence-based care process models developed through the Intermountain Healthcare Clinical Programs. SelectHealth and Intermountain Healthcare are dedicated to a programmatic approach of continuous improvement to support the use of evidence-based care process models, promote appropriate utilization of services, and reduce costs of unnecessary care. The Intermountain Clinical Program Development Teams (that include physicians from the Intermountain Medical Group, affiliated practices, and SelectHealth) are responsible for establishing the clinical criteria used to evaluate medical necessity and appropriateness of the preauthorization requests for the surgeries.

Providers can request preauthorization by submitting a Request for Preauthorization Form with all relevant clinical information. The form is available from selecthealthphysician.org. Click on “Provider Reference Manual,” on “Preauthorization,” and then on the “Request for Medical Preauthorization Form” link. Additionally, we are pleased to announce that we are in the process of rolling out an electronic preauthorization platform, CareAffiliate®. Clinics interested in this option can request access through their Provider Relations representative. Online training is available through the CareAffiliate tool.

SelectHealth will only pay for procedures that meet clinical criteria established through the Intermountain Healthcare Clinical Programs. Claims for services that are not preauthorized will be denied. These can be reviewed post-service through the SelectHealth Medical Review department.

If documentation supports the medical necessity/clinical appropriateness of the procedure, provider, and facility payments will be reduced 25% for failure to preauthorize the services.

The member will continue to be responsible to pay his or her cost-sharing amounts, but will not be responsible for payment of provider penalties.

Preauthorization is not required for emergency surgery. Operative reports may be requested to validate the emergent nature of the procedure.

If you have any questions, please contact your regional Select Health Provider representative.