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DEAR COLLEAGUES,

In our continuing efforts to improve communication between Intermountain and credentialed practitioners, we are pleased to present the 4th 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,

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NORTHERN REGION IMPLEMENTATION

On August 22, Intermountain Healthcare leadership conducted another milestone review with all iCentra teams to assess progress with project goals and future tasks. This checkpoint determined iCentra is on track for implementation in the north region (north Davis, Weber, Cache, Box Elder, and Cassia counties) on December 1, and we will implement in a staged approach based on new ideas and feedback from region leadership and front-line teams.

Logan Regional Hospital, Bear River Valley Hospital, their associated ambulatory clinics, and Medical Group clinics in Cache and Box Elder counties will go live on iCentra on December 1, 2014. McKay-Dee Hospital, Cassia Regional Medical Center, their associated ambulatory clinics, and Medical Group clinics in North Davis and Weber counties are targeted to go live February 1, 2015.

This staged approach supports a guiding principle for the project that our patients will be safely and effectively cared for by clinicians, providers, and revenue cycle and business staff during the transition to iCentra, and offers the following benefits:

1. Focuses teams and resources on hospitals and clinics going live on December 1.
2. Provides more flexibility in training.
3. Further refines revenue cycle and clinical work flows and confirms that both clinical care and business operations are functioning appropriately.
4. Allows us to gather valuable information we can use to continue improving training experiences, staffing support models, implementation procedures, and workflow changes.

The August 22 milestone review meeting also indicated Intermountain is on track to complete the iCentra implementation by the fall of 2015, with project teams currently engaged in preparing hospitals, clinics, and revenue cycle teams in Utah, Millard, Sanpete, and Sevier counties for their transition to iCentra.

The north region hospital, clinic, and revenue cycle leadership will determine how the staged approach will change current plans for training schedules and staffing models. More information will be shared with those teams soon.

A vision for iCentra is that it will help enable a healthcare community that improves the quality of care for patients through better coordination.

PROVIDER WORKFLOW AND CONTENT
Provider content development, assessment, and testing for 52 specialties are also on track with 82% workflows built and in the process of being validated and tested. Workflows are developed and approved by Intermountain’s existing clinical content governance structure. Physicians may learn about workflows at roadshows or solutions galleries, or during simulation training or scheduled iCentra education classes by region.
BEST PRACTICE ORDER SETS AND APPROPRIATE VARIATION
Order sets help us deliver highly consistent, reliable, and excellent care. Intermountain’s vision for the iCentra order sets is that they will be used to promote best practices and measure and remove unnecessary variation for continuous improvement. iCentra order sets are developed and managed by Intermountain Healthcare’s Clinical Programs and iCentra teams. These Best Practice Order Sets are developed using peer-reviewed medical evidence, Intermountain Healthcare outcomes data, and cross-professional consensus. iCentra Best Practice Order Sets will offer individual clinicians the ability to make occasional thoughtful and appropriate variations to specific sections of an existing order set to accommodate for patients’ needs and other factors (e.g., the availability of regional services and consultants). iCentra teams will monitor these modifications and continuously reduce unnecessary variation.

AFFILIATED PHYSICIAN iCENTRA PRODUCT OFFERING
A vision for iCentra is that it will help enable a healthcare community that improves the quality of care for patients through better coordination. Concurrent with implementing iCentra in Intermountain’s hospitals and clinics by region will be the work to offer affiliated physicians and other medical staff access to iCentra (similar to what they have with HELP2). Data interoperability affords considerable benefits for all healthcare teams in our community, including improved patient safety, better-informed decision support, and better experiences for physicians. As such, iCentra will support HIPAA-compliant, secure connectivity for sharing relevant patient data with authorized affiliated physicians using EMR suppliers that support standard interface and exchange requirements.

Intermountain will offer the integrated iCentra electronic medical record (EMR), revenue cycle, and practice management system to affiliated physicians and will store their data separate from Intermountain’s patient data. Affiliated physicians will be able to purchase the complete iCentra system, which includes the EMR and practice management registration, scheduling, and billing solutions, or only the EMR and integrate to a third-party practice management solution. Regardless of what they purchase, each affiliated physicians’ patient data will always be stored separately. This approach is consistent with Intermountain’s policies regarding patients’ rights in authorizing data sharing and meets all HIPAA regulations for the responsible release of patient information.

Intermountain leaders, SelectHealth Provider Relations representatives, physician leaders, and technical teams will soon reach out to affiliated physicians by region to discuss product options, timelines, and training support.

CERNER ACQUIRES SIEMENS HEALTH SERVICES
Earlier in August, Cerner Corporation and Siemens AG announced Cerner’s acquisition of Siemens Health Services. Unlike when GE Healthcare acquired IDX in 2005, the Siemens acquisition will not affect Intermountain Healthcare’s current scope, configuration, and implementation of our next generation electronic medical record, iCentra. Cerner Millennium is core to iCentra and remains Cerner’s strategic EMR platform for their current and all future clients. This acquisition is expected to increase efforts in innovation, population health management, decision support, standards and interoperability, and device integration with big data.
DOZENS OF TEAMS MOVE SHARED ACCOUNTABILITY EFFORTS FORWARD

At Intermountain, we’re transforming care to stay ahead of changes in the healthcare marketplace, to improve the quality of care, and to reduce the unsustainable rise in costs in the current U.S. healthcare system. Dozens of teams across Intermountain are using three key strategies to help us reach our Shared Accountability goals:

1. Redesigning care through developing and consistently using best practices that are based on the best available evidence
2. Engaging patients in their health and care choices
3. Aligning financial incentives for everyone who has a stake in healthcare.

Here are current highlights:

**PERSONALIZED PRIMARY CARE/ADVANCED PRIMARY CARE**

Personalized Primary Care/Advanced Primary Care helps support effective and engaged relationships between patients and primary care providers. It also enhances the management of care among all of a patient’s care providers, supports a team-based approach to care, and increases focus on chronic and high-risk conditions. All Intermountain Medical Group primary care clinics are participating in the initiative, and its adoption by affiliated physician clinics should be complete in January 2016.

**SHARED DECISION-MAKING**

Pilot programs at select Intermountain Medical Group clinics are using web-based tools to help patients learn more about their conditions and treatment options. Currently, more than 2,100 patients have been invited to complete Shared Decision-Making education modules, and nearly 1,000, or 47 percent, have logged in and started their modules, which exceeds our goal of 30 percent. Intermountain is currently reviewing the effect these tools have on patient decisions.

**PATIENT EDUCATION**

Intermountain hospitals and clinics have a large and growing library of patient education content, including web content, patient instruction sheets, and videos. We’re also integrating patient education content into Intermountain’s websites, mobile apps, MyHealth portal, and iCentra applications. Physicians are helping develop and approve provider education resources.

**DIGITAL AND MOBILE TOOLS**

Digital and mobile tools are giving patients, health plan members, and consumers more choices in how they interact with Intermountain. The tools include mobile apps (such as Intermountain’s new Health Hub app), enhanced website access and content, social media, teleservices, and other resources. Visit Intermountain’s website to see all the free mobile apps Intermountain offers to connect patients with providers and improve their healthcare experience.

**CARE MANAGEMENT**

Intermountain has launched two care management pilots to better help patients with complicated health problems who use a lot of healthcare resources and often don’t have the economic or personal support to help them improve their health. These pilots include the Personalized Care Clinic, operated by the Intermountain Medical Group on the Intermountain Medical Center campus, and Community Care Management, which is offered by hospital case management teams in the Urban North and Southwest.
regions. Combined, these pilots are designed to serve about 1,600 patients. Caregivers help patients proactively meet their healthcare needs and overcome the social or economic challenges that make managing their health overwhelming.

**PHYSICIAN PAYMENT MODEL**

With input from participating physicians, Intermountain continues to evaluate a beta physician payment model that launched last fall. The beta includes a small number of patients at 15 Medical Group and affiliated clinics. The model pays for care provided and also includes payment for meeting quality, service, and total cost of care goals. Tools developed for the model give physicians data to support care decisions. Clinicians can see current performance and feedback on service, quality, and total cost of care goals. They can also see overall population health metrics, patient risk scores, and variances in how care is provided. We are evaluating these tools and will consider modifications based on experience as we prepare for future expansion.

**SELECTHEALTH**

SelectHealth is helping develop our Shared Accountability health plan product strategy and is the first payer through which this model will be available to the community. One of our key goals is to develop a SelectHealth commercial product, based on Shared Accountability principles, which we expect to be active in January 2016. The plan will have average premium increases that are close to the general inflation rate, which will be very attractive in the marketplace. That’s one way we’re striving to transform care and contain rising healthcare costs.

SelectHealth also continues to administer two government products based on the same principles:

1. SelectHealth Advantage, a Medicare Advantage plan; and
2. SelectHealth Community Care, a Utah Medicaid ACO plan.

**SHARED ACCOUNTABILITY NETWORK**

Intermountain/SelectHealth is developing a new physician network to support the new commercial Shared Accountability health plan product, which is based on Shared Accountability principles.

**HEALTH BENEFIT DESIGN**

SelectHealth is focusing on health plan benefit design that encourages plan members to become more engaged in their personal health and wellness. The design also supports members in becoming more involved in their personal healthcare decisions. In the future, we expect to offer this benefit design framework to other payers as well.

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*For more information about our Shared Accountability strategy, please contact Brent Wallace, MD, at brent.wallace@imail.org.*
IT HAPPENED HERE: COMPLICATIONS FROM PATIENT FALLS

Patients and families are educated about fall precautions in both inpatient and outpatient areas. Dependent on the patient status, a falls risk score is calculated and assigned to applicable patients. This score determines the level of assistance that a patient needs prior to ambulation.

INPATIENT SCENARIO
74-year-old female was admitted to cardiac care from the emergency department with heart failure. She was on fall precautions as a result of her falls risk score related to age, slight dementia, and current medications (on anticoagulation therapy). She and her family members were educated about falls precautions, but the patient did not follow this instruction and did not call for help when ambulating.

At 1:30 am on the first night of her hospitalization, she got up, unassisted, to go to the bathroom and fell at the bedside. There were no injuries noted and no further tests or x-rays were obtained after the fall. This fall was noted in the medical record but was not communicated verbally during the shift change hand-off by the nurses, between the physicians, or during rounding. The next afternoon, as the patient was ambulating in her room, she lost her balance and fell straight backwards to the floor, sustaining a second fall, striking her head on the bedside table. Initially, there was no change in level of consciousness and no external injury noted. However, that night, the patient became lethargic, had a change in mental status, and developed respiratory distress. She became increasingly unresponsive. A CT confirmed the diagnosis of a subdural hematoma, and the patient was transferred to the ICU. A repeat CT scan a few hours later revealed a large subdural bleed with some brain stem herniation. Palliative care measures were initiated after discussion with family and treatment was withdrawn.

OUTPATIENT SCENARIO
An 83-year-old male patient was being seen in an outpatient clinic for a bladder infection. The staff asked him for a urine sample. He declined help and went into the bathroom alone. The patient currently lives at an assisted care facility, and his son felt he should not be alone in the bathroom. The patient got light headed and fell in the bathroom, sustaining a large skin tear to his right upper arm, a hip injury, and a hematoma on his head. The patient is on Coumadin and required transfer to the Emergency Department.

As a provider, be aware of your patients’ falls risk score and the criteria used to obtain that score. Reinforce with patients the need to get help when indicated. Make applicable referrals for therapy services (PT, OT, and Balance).

Reminder: All information contained in the above scenarios is confidential, and physicians should not share outside of Intermountain facilities or with patients and/or families.

If you have questions, please contact Jeanne Nelson at jeanne.nelson@imail.org.
2014–2015 FLU SEASON

Although summer is not yet over, it is not too soon to be thinking about the upcoming flu season. The previous flu season demonstrated an interesting pattern with a predominance of H1N1 cases early in the season followed by a predominance of Influenza B cases later in the season. Reports from Australia indicate a busy flu season (H1N1 predominant) but it is not possible to predict the timing or pattern of the 2014–2015 season in the U.S.

VACCINE
The CDC recommends yearly flu vaccination for all individuals six months and older if they do not have contraindications. Vaccination of all healthcare workers is recommended by the CDC and is also Intermountain policy. This strategy has been proven to protect our vulnerable patients from iatrogenic cases of influenza. Individuals may apply for a medical or religious exemption.

Based on epidemiological data from the CDC, the components of the vaccine for the 2014–2015 season are identical to last year’s vaccine. Trivalent and quadrivalent inactivated injectable vaccines are widely available. A high-dose trivalent vaccine may be preferred for individuals over age 65 and is covered by Medicare Part B. A quadrivalent live attenuated intranasal influenza vaccine (LAIV) is available for healthy persons ages 2 through 49 years and is recommended for children ages 2 through 8 years. The vaccine will be administered to Intermountain employees and physicians beginning in October and must be received by November 30. The vaccine may be given to patients at an earlier date if the vaccine is available, and vaccination should continue through the spring until supply is gone for those not immunized in the fall. This year, for the first time, Influenza vaccine will be available at all Intermountain Community (retail) pharmacies without appointment.

TREATMENT
Oseltamivir (Tamiflu®) and zanamivir (Relenza®) are FDA-approved neuraminidase inhibitors with activity against both Influenza A and B viruses. To date there has been little antiviral resistance to either medication. These medications work best if started early in the course of illness and are particularly recommended for individuals who are hospitalized, have severe or complicated disease, or are at risk for influenza complications due to age (less than 2 or greater than 65 years), pregnancy, or underlying chronic medical illness. It is not necessary to wait for laboratory confirmation of influenza before starting antiviral treatment.

GENERAL PRECAUTIONS
Basic hand hygiene and cough etiquette are important tools in preventing transmission of influenza. Patients with a cough should be offered a standard face mask at the time of arrival to our hospitals and clinics, and tissues and hand sanitizer should also be made available. Individuals with flu symptoms should not enter our facilities as visitors, and healthcare workers should stay home if they are ill. Hand hygiene before and after every patient encounter will help to protect you and your patients from influenza and other pathogens.

If you have questions, please contact Douglas Smith, MD, at douglas.smith@imail.org.
TCC TEAM ENHANCES BEDSIDE PLAN OF CARE

On May 13th, 2014, the TeleCritical Care (TCC) team began rounding on ICU patients at LDS Hospital and Park City Medical Center. Since then, Logan Regional, Alta View, Riverton, American Fork, Valley View, Dixie Regional, and McKay ICUs have all gone live, and TCC is on track to be implemented at Utah Valley and Intermountain Medical Center in August and September. By the end of the year, all 263 intensive care beds will be connected to the TCC Support Center at Supply Chain. The primary objective of TCC is execution of the bedside plan of care with high reliability to reduce complications and, thereby, length of stay at the ICU.

THE TCC SUPPORT CENTER

The TCC Support Center is staffed by a team of experienced critical care nurses and the recent addition of Intensivists. Daytime (0700 – 1900) physician coverage through Telecritical Care started on Wednesday August 6, 2014. The primary role of the TCC physicians will be to consult on patients with no critical care attending physician among the bedside team. Research demonstrates that Intensivist review of the plan of care within one hour of admission reduces mortality and complications in the ICU setting. The TCC physicians will also support all critically ill patients through the following mechanisms:

- Support the TCC nurses with clinical decision making as they conduct their structured rounds
- Assist in the immediate response to patient instability when the bedside physician is delayed in responding
- Structured rounding on high-acuity patients
- Support the Intermountain Transfer Center to facilitate rapid and seamless transfer of ICU patients from outside and within Intermountain
- Support Life Flight, including Rural Ground Transport, as medical control physicians

Continuous MD coverage will commence this fall through support of intensivists at several Intermountain facilities. Until that time, we recognize that questions will arise during the 1900-0700 time period when TCC physician coverage is not available. In that situation, call the Intermountain Transfer Center at 801-321-3381 to be placed in contact with an on-call Intensivist at an Intermountain hospital with 24 hour in-hospital coverage.

Some frequently asked questions from physicians and staff include the following:

- **Will TCC physicians bill for this service?**
  No, this service will enhance patient care and essentially pays for itself.

- **Will this change the staffing model at the bedside?**
  No, TCC is an additional layer of support—a safety network that assists the bedside team and in no way replaces the primary caregivers.

As staff and patients experience the benefits of this important program, lessons learned are being collected in an effort to improve the ways we partner with the bedside team to support our most critical patients.

If you have questions, please contact Bill Beninati, MD, at bill.beninati@imail.org.
ACIP SPECIAL VOTE TO RECOMMEND PCV13 (PREVNAR 13®) IN SENIORS

The Advisory Committee on Immunization Practices (ACIP) met in a special session on August 13, 2014 and voted to recommend PCV13 (Prevnar 13®) in adults 65 years of age and older due to positive results of a large clinical efficacy trial showing 75% reduction in invasive pneumococcal disease and a 45% reduction in pneumococcal pneumonia. Also, unlike PPSV23 (Pneumovax®23), PCV13 appears to not have waning immunity, at least for five years, if not longer.

Immunity against pneumococcal disease develops best when the conjugate vaccine, PCV13, is given prior to the polysaccharide vaccine, PPSV23. Therefore, the current recommendation is as follows:

- Adults 65 years of age and older who have not previously received pneumococcal vaccine or whose previous vaccination history is unknown should receive a dose of PCV13 first, followed by a dose of PPSV23, 6 to 12 months after the PCV13 dose.

- If PPSV23 cannot be given during this time window, a dose of PPSV23 should be given during the next visit.

- The two vaccines should not be co-administered.

- Adults age 65 years of age and older who have previously received a dose of PPSV23 should receive one dose of PCV13 at least one year after the receipt of the most recent PPSV23 dose.

- For those whom an additional dose of PPSV23 is indicated (i.e., no PPSV23 since turning age 65 years) such dose should be given 6 to 12 months after PCV13 and at least five years after the most recent dose of PPSV23.

Please note that CMS (Medicare) only covers one pneumococcal vaccine dose, either PCV13 or PPSV23, for those age 65 and older. Patients will be responsible for the cost of the second vaccine. CMS is considering whether to cover more than one dose of pneumococcal vaccine, but that decision will not be final until January 2016 at the earliest.

If you have questions, please contact Tamara Sheffield, MD, at tamara.sheffield@imail.org.
RESOLUTIONMD

REMINDERS ABOUT RESMD

ResMD was successfully implemented across Intermountain in late 2013, and many clinicians are already accessing their images in this program, providing the following benefits:

- A simpler, faster, easy-to-use interface and streamlined process with tools available on-demand.
- The ability to view, in 3D, studies that were previously not available, such as Cardiology.
- A flexible, lightweight interface that can be viewed on computers, smart phones, and tablets.

Some clinicians still don’t know exactly what ResMD can do or how it can work seamlessly to improve their image viewing experience. To that end, we just want to remind you of three ways clinicians can learn more about ResMD and how it works:

1. Access documentation within the application or by e-mailing dave.anderson@imail.org for downloadable guides.

2. Watch the following training videos for more information:
   - Radial Menu
   - 2D Viewing
   - Layouts

3. Request a live demonstration and Q&A session at your facility or via WebEx from dave.anderson@imail.org.

We are dedicated to ensuring our clinicians have the tools they need to deliver extraordinary care to our patients. We are more than willing to meet with any clinical group or clinician to help answer questions concerning the ResMD medical image viewer. Please feel free to reach out to us at any time!

If you have questions, please contact Dave Anderson, at dave.anderson@imail.org.
The Behavioral Health Clinical Program continues to work on the Substance Abuse CPM and the Suicide Assessment and Prevention CPM. We anticipate the education and implementation of those CPMs during the 4th quarter. As part of the Suicide Assessment and prevention CPM, a new screening and assessment tool, the Columbia Suicide Severity Rating Scale (C-SSRS), will be used systemwide to improve the identification and management of this challenging population.

Additionally, the Clinical Program’s development team is focusing on identifying and making recommendations regarding which behavioral health services should be provided by Intermountain and when we should partner with community providers to offer services. Historically, behavioral health services provided by Intermountain have been limited to inpatient, outpatient, and emergency department care. Limitations have been related to payment resources and specific services offered. As we move forward with shared accountability and population management, it is very clear that our patients, based on clinical need and diagnoses (e.g., eating disorders, substance abuse treatment), frequently require additional levels of care, including education and prevention, outpatient, intensive outpatient, day treatment/partial hospitalization, observation/crisis stabilization, emergency, and inpatient care.

If you have questions, please contact Carolyn Tometich at carolyn.tometich@imail.org.
CARDIOVASCULAR CLINICAL PROGRAM UPDATE

➤ iCENTRA
The CV Program is very excited and pleased with our partnership with Cerner. We are producing common process order sets based by integrating order sets from throughout the system with physician input. Cerner has also been able to develop a solution to include our electronic discharge program components. Finally, we are working on a solution linked to Cerner to produce meaningful cardiac cath reports along with submitting to the ACC/AHA Cath PCI registry.

➤ SHARED ACCOUNTABILITY
The CV Program has worked closely with Joe Mott and his team to ensure our patients receive the highest value care with excellence in clinical and service quality. Our clinicians are embracing the use of the Appropriate Use procedure and testing documentation processes. We are also embarking on an effort with SAO to enhance outpatient heart failure care.

➤ COMPLIANCE
CV continues to adhere to many areas of compliance. Sheri Cosby, our CV compliance consultant, has worked closely with our team to be sure we meet all the CMS, licensing, and Joint Commission requirements.

➤ PATIENT SAFETY/QUALITY
We are focusing on reducing variation in our clinical processes of care by providing enhanced order sets and care process models. Most recently, we have produced guidelines and fact sheets for Hypertension Management and Lipid Management, which are available on our website.

➤ Visit our Heart & Vascular Services webpage
Our Heart Failure Board Goal continues to expand in scope and implementation. More details are also available on our website.

➤ SELECTHEALTH
We have partnered with SelectHealth to develop clinical guidelines in atrial fibrillation and other chronic disease management. Appropriate use and adequate insurance coverage has been an integrated effort with our two teams.

➤ FITNESS
We are strong advocates for wellness, fitness, and disease prevention. Many guidelines and resources are available from our program. We just completed our annual “My Heart Challenge,” this time involving firefighters from the Salt Lake Valley to inspire heart health in our community.

If you have questions, please contact Donald Lappe, MD, at donald.lappe@imail.org.
FOLLOW ESTABLISHED PROCESSES FOR ORDERING IMAGING EXAMS IN HOSPITALS

All hospital radiology orders must be requested or documented using one of the compliant methods listed below. The results of a recent hospital audit of compliance with documented imaging orders shows a need to clarify and communicate the expectation for ordering imaging examinations in hospitals.

**WRITTEN, FAXED OR SCANNED ORDERS**
Complete orders must be legible and include the date, time, and signature of the ordering physician/APC and demonstrate in the medical record that the order is medically reasonable and necessary. These orders can be written on scripts, exam order forms, etc.

**EMR/ELECTRONIC ORDERING SYSTEMS**
Any orders generated through an electronic medical record or computerized physician order entry method must be electronically signed by the ordering practitioner before the hospital imaging location will be able to perform the exam.

**HELP2-CLINICAL NOTES USING “RADIOLOGY COMMON ORDERS REPORT” NOTE TYPE**
All orders placed in HELP2 as a clinical note should follow the Hospital Radiology Ordering Process and must be electronically signed before the hospital imaging location will be able to perform the exam. This differs from our in-house ordering process as these orders are not considered verbal orders. The hospital will not schedule or perform the exam without the order being authenticated by the ordering provider.

**VERBAL ORDER**
Verbal orders for hospital imaging exams should only be used when a patient’s emergent needs make it unfeasible for the ordering LIP (licensed independent practitioner) to immediately communicate the order in written or electronic form. The LIP should call in the verbal order to hospital staff members according to their scope of practice. The order must be authenticated within 30 days.

**MESSAGE LOG**
Message log is a communication tool—not an ordering tool. There have been several incidents where the order has been requested through Message Log and the “order” was not considered valid. Message Log is not a recommended process for ordering imaging exams.

If you have questions, please contact Deanna Welch at deanna.welch@imail.org.

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**View Hospital Radiology Ordering Process Using HELP2**

**View Verbal Order Policy**

**View Medical Order Authentication Policy**
Cancer Services at Intermountain continues to demonstrate a commitment to cost-effective, high-quality care for our oncologic population. Recent and forthcoming articles in national publications provide a look into the care provided at Intermountain.

In the most recent edition of CAP Today, Drs. Melissa Cessna, Julie Asch and Ann Taylor are prominently featured on the front page. The article details how they collaborate and have produced a smart, cost-effective algorithm for molecular testing in acute myeloid leukemia patients. Bringing expertise from specialties including hematopathology and medical oncology, they are able to determine which testing should be done on which samples rather than the traditional “shotgun” approach to molecular testing.

The American Society of Clinical Oncologists (ASCO) recently authored a set of guidelines under the “Choosing Wisely” campaign. These guidelines are designed to draw attention to high-cost, low-value procedures that may be performed as part of cancer care. Intermountain is collaborating with Kaiser Permanente to examine how closely the Choosing Wisely guidelines are being followed in the two systems. At least three manuscripts will come out of this collaboration. The first abstract from the group is slated to be presented at the ASCO Quality Symposium this fall with a publication expected to follow.

If you have questions, please contact William Sause, MD, at william.sause@imail.org.
PAIN SERVICES UPDATES

DEA RULE IMPOSES STRICTEST CONTROLS ON HYDROCODONE COMBINATION PRODUCTS (HCPS)
Effective October 6, 2014, the Drug Enforcement Administration will move HCPs from Schedule III to Schedule II, which is for substances with the highest potential for harm and abuse.

The implications of moving hydrocodone-containing substances form Schedule III to Schedule II are as follows:

- Require patients to obtain new prescriptions every month
- Prohibit Fax or telephone prescriptions in non-emergency situations
- Prohibit nurse practitioners from prescribing these medications without physician supervision

For additional information click here.

LOW BACK PAIN CARE PROCESS MODEL REVISIONS

- Addition of recommendations for Red Flag evaluation and response for “suspected spondyloarthropathies.” Changes include indications for “ankylosing spondylitis.”
- Updates to the low back pain flashcard to reflect the above revisions.
- Spinal MRI Order Guidelines developed to support the Choosing Wisely campaign and iCentra integration. Guidelines include ICD-9 code recommendations and will replace the existing Spinal MRI Order Form.

CHRONIC PAIN REGISTRY/DASHBOARD

According to the IOM report published in 2011, pain affects more Americans than diabetes, heart disease, and cancer combined and is associated with many conditions including neuropathic pain, mechanical, injury, infection, surgery, headaches, and inflammatory/immune disorders. Over the last year, Pain Management Services developed a Chronic Pain Registry to assist with population management of chronic pain patients within Intermountain. Chronic pain is complex and costly; its treatment poses many challenges for patients and providers.

For additional information about pain click here.

The Registry and provider dashboards were developed to help providers understand their population better and to help the Pain Guidance Council identify gaps in current services systemwide, study trends, and determine best practice for the treatment of this complex health condition.

The Dashboard can be sorted by patient type to compare opiate vs. non-opiate treatment and includes data elements such as “is Chronic Pain listed on Problem List?”, utilization/cost data, opiate agreements (updated), medications, comorbidities, BMI, PHQ9 score, sleep apnea, tobacco use, surgeries, PCP visits, and MH visits. The trending of data over a period of several years will help determine if certain treatments are more beneficial than others.

For additional information about pain click here.

CHRONIC PAIN RESEARCH IN PRIMARY CARE CLINIC PILOT APPROVED

Pain Management Services, a Clinical Service, and Primary Care physicians at the Layton Clinic are working together to improve the care and coordination of chronic pain patients.

The purpose of the pilot is to facilitate care and interdisciplinary coordination through the use of Intermountain Healthcare’s Chronic Pain Care Process Model and a 10-week series of educational classes. All chronic pain patients will be invited to participate free of charge.

Dr. Joel Porter is the Principle Investigator and is working closely with Layton Clinic’s newly hired Nurse Practitioner, Jason Major, DNP, and Dennis Ahern, PhD, psychologist.

PAIN MANAGEMENT TREATMENT PLAN

Intermountain Healthcare’s Pain Management Treatment Plan (CPM034e-07/11) was developed and updated by the Functional Restoration Chronic Pain Development Team. Providers can obtain the updated form through Patient and Provider Publications as part of your care coordination and personalized treatment for chronic pain patients. Goals are developed with the patient and aim to improve quality of life. Care management staff can assist with interdisciplinary coordination, especially for those high-risk patients with multiple comorbidities.

If you have any questions, please contact Bridget Shears at bridget.shears@imail.org or Linda Caston at linda.caston@imail.org.
Some of these preparations provide an amount of marijuana up to five times that necessary to produce a CNS effect in adults. These products are not legal in the State of Utah but could be brought into the state.

Please be aware of the potential for these types of ingestions in any child that presents with alteration of mental status without a readily identified source. Urine drug screens will pick up the ingestion of these types of substances.

Please be aware of this possibility, particularly in the care of pediatric patients.

If you have questions, please contact Carolyn Reynolds at carolyn.reynolds@imail.org.
Earlier this year the Women and Newborns Clinical Program introduced a new “Early Onset Sepsis Risk Score” (EOS Score) calculated for all babies at the time of birth. This was based upon research conducted by the Kaiser-Permanente Hospitals in Northern California and several Boston-area academic hospitals. Since introduction of this EOS Score, we have:

1. Reduced the percent of newborns 34 weeks gestation and greater identified for early onset sepsis evaluation and treatment from 7.5% of all deliveries to 2.3%. (Significant reduction in the percent of babies identified as “ill” and separated from their mothers during a critical bonding period.)

2. Increased the percent of newborns identified for EOS evaluation and treatment who were started on antibiotics within 6 hours of birth from 50% to 70%. (Decreased the chance of harm for those babies at risk for sepsis, but not started on timely treatment.)

3. Despite reducing the number of newborns identified for evaluation and treatment of EOS from 7.5% to 2.3% of deliveries, the percent of newborns with positive blood cultures or identified as “clinical sepsis” and treated with 5 days or more of antibiotics has remained constant at just over 1%. (Despite less intervention, newborns who require treatment for sepsis are not being missed.)

Click here to learn more about neonatal sepsis

If you have questions, please contact Teri Kiehn at teri.kiehn@imail.org.
SELECTHEALTH ADVANTAGE IN-HOME HEALTH ASSESSMENTS

SelectHealth has partnered with a company called MedXM to provide an in-home comprehensive health assessment for selected members of SelectHealth Advantage. These assessments began in August 2014 and will be completed by a physician, nurse practitioner, or physician assistant working with SelectHealth Advantage. The objectives of these visits include:

- Improve the health and wellness of SelectHealth Advantage members by allowing SelectHealth to better understand their healthcare needs and coordinate their care accordingly.
- Assess the services our members are receiving under their SelectHealth Advantage coverage and determine whether they are eligible for additional healthcare screening services for improved member care and for HEDIS and/or Star Rating purposes.
- Determine whether the member qualifies for other services offered by SelectHealth, such as care management or chronic condition management.

As part of this program, a letter will be sent to selected SelectHealth Advantage members introducing the program, and a representative from MedXM will follow up with a phone call to schedule an appointment for an in-home comprehensive health assessment visit. Primary Care Physicians will be informed which patients are receiving visits prior to the call. Please encourage them to accept this invitation and schedule the visit at their convenience.

If a patient chooses to accept the invitation and schedule an in-home health assessment, they can expect the following:

- A licensed, credentialed healthcare provider will come to their home to review their current health status, medical history, and any current prescription medications.
- The visit is expected to take approximately 45 minutes to one hour.
- There will be no cost to the patient, and participation will in no way impact their premiums, benefits, or copayments.
- The results will be sent to their PCP upon request to be used at their discretion.

This visit is not meant to take the place of any existing doctor's appointments or any care provided, nor the payments that providers receive for any services, such as an Annual Wellness Visit. This program is voluntary and does not affect the patient’s healthcare coverage in any way.

For questions, please call MedXM Member Services at 888-306-0615, Monday through Friday, 8:30 a.m. to 5:30 p.m. or call SelectHealth Provider Relations at 800-538-5054 (toll-free), Monday through Friday, 8:00 a.m. to 5:00 p.m.
TECHNOLOGY ASSESSMENT (M-TECH) NEWS AT SELECTHEALTH

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

Following is a list of recent technologies reviewed and Committee recommendations:

**TOTAL ANKLE REPLACEMENT**
Reviewed March 18, 2014*

Cover in Select Circumstances
Current evidence has demonstrated durability out to approximately 10 years for some of the ankle implants. These survival statistics compare favorably with ankle arthrodesis. See Medical Policy #358

**UROLIFT FOR THE TREATMENT OF BPH**
Reviewed July 29, 2014*

Deny as Investigational and Not Medically Necessary
Current evidence has not demonstrated the durability of this procedure beyond 2 years, which is important given the numerous other procedures available that do have long-term durability data. See Medical Policy #553

*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:

- MDx Test for Prostate Cancer
- Prostate Cancer Classifier
- EpiFix Bioengineered Skin
- iStent for Glaucoma
- Knee Resurfacing
- MRgFUS for Bone Metastases
- MRgFUS for Essential Tremor
- MRgFUS for Prostate Cancer
- MRgFUS for Uterine Fibroids
- Negative Pressure Wound Therapy
- NeuroPace System for Treatment of Intractable Epilepsy
- Noninvasive Skin Imaging
- Oncotype DX for Colon Cancer
- Prosigna Breast Genetic Test
- TENS for Migraines
- Total Body Photography
- VEMP Testing
- Vermillion OVA1 Test for Ovarian Cancer

As the reviews are completed, notices will be sent to stakeholders accordingly to inform them as to SelectHealth’s coverage determinations.

If you have questions regarding coverage of these or any other technologies or procedures, or if you would like SelectHealth to consider coverage for an emerging technology, please email us at mtech@selecthealth.org or call Ken Schaecher, M.D. FACP, M-Tech Committee Chairman, at 801-442-7927.

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

1. Go to selecthealth.org
2. Click on the “Provider” tab (upper right corner)
3. Enter your log in information
4. Click on “Policies and Procedures” (left side of page)

*If you have questions, please contact Ken Schaecher, MD at ken.schaecher@selecthealth.org.*
FACT SHEET: MULTIPLE DOSE MEDICATIONS FOR PATIENT DISCHARGE

WHO IT APPLIES TO
Physicians, Licensed Independent Practitioners, Physician Assistants, Nurse Practitioners, Nursing, Pharmacy and Respiratory Clinical Staff

WHY IT’S IMPORTANT
This procedure describes how multiple dose medications are dispensed to patients, while in the hospital or emergency department, and are managed upon discharge.

THE KEY POINTS
Medications purchased by hospitals must be for inpatient use or for dispensing a limited take home supply as follows:

- Single medication dosing unit dispensed not to exceed a 30-day supply
- No refill requests will be processed through the hospital
- Expensive (as defined in the procedure) patient-specific medications are automatically provided at discharge unless otherwise noted
- Medications must be labeled
- The prescribing physician must indicate on the patient order that a medication is to be sent home with the patient at discharge.

Nursing/RT Responsibilities:
- Verifies the order
- Identifies the patient with two patient identifiers
- A licensed patient care provider provides medication education to the patient at discharge
- Ensures labeling is correct
- Adds documentation in patient record.

Pharmacy Responsibilities:
- The pharmacist entering the order into the MAR will ensure the medication is billed and that an ‘outpatient label’ is on the medication.

Medication dispensed in the emergency room:
- MD must indicate on the patient order that a medication is to be sent home upon discharge
- The nurse or RT must document in the patient chart that the medication being administered can be continued for home use
- The nurse or RT must fill in the patient name, physician name, patient encounter number or medical record number, directions and duration of use (if indicated) by the physician on the pre-printed label.

LINKS
View Multiple Dose Medications Discharge Procedure

CHECK YOURSELF
- Verify order
- Verify patient
- Ensure label is correct on medication
- Documentation is critical
NEW ID BADGES COMING SOON

Starting in October, we’ll be 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 new badges make it as easy as possible for patients and caregivers alike to identify names and roles of Intermountain employees, providers, volunteers, suppliers, etc. This enhances patient safety and helps us fulfill our Healing Commitment of helping patients feel safe, welcome, and at ease.

 WHAT’S DIFFERENT?
- Employee, provider, and volunteer badges will now be vertically oriented. Suppliers, 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.
- Badges will feature licenses but not certifications.

 WHEN AND WHERE WILL I GET A NEW Badge?
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 and many other buildings (like Homecare and Hospice, SelectHealth, etc.). We’ll also
have cameras and badge printers at large gatherings – like Medical Staff Meetings.

**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.

Stay tuned for more details on when, where, and how to get your new ID badge. If you have questions, please call Craig Allen at 801.442.3424 or email craig.allen@imail.org.
Incontroversible evidence demonstrates that a physically active lifestyle not only reduces the likelihood of developing chronic disease and premature mortality, but also improves the quality of life. Decades of reports and clinical guidelines have recommended that physicians advise their patients to engage in regular physical activity to promote health and prevent disease; however, for many reasons, healthcare has not effectively engaged in physical activity promotion in clinical settings. More recently, advances in technology—such as electronic health records (EHR) and payment reform efforts aimed at lowering healthcare expenditures, like population health management strategies—have made physical activity assessment and promotion both easier to perform and more relevant.

**PHYSICAL ACTIVITY VITAL SIGN (PAVS)**

Intermountain Healthcare integrated its physical activity vital sign (PAVS) into the HELP2 EHR in February 2013 and has integrated the PAVS into their new EHR, iCentra, which will be implemented in late 2014. These physical activity assessment tools are utilized at the point of care in ambulatory visits. Adult patients are asked three questions about their current physical activity level, typically by a medical assistant, at the start of the clinic visit, where it is recorded in the EHR for interpretation by the physician.

The PAVS is the first step in the exercise prescription. Without an understanding of current physical activity levels and activities, it is nearly impossible to advise the patient on how to optimize their physical activity to maintain health. The 2008 Physical Activity Guidelines for Americans recommend that adults should achieve 150 minutes per week of moderate intensity physical activity (brisk walking), or 75 minutes per week of vigorous physical activity (such as jogging), in addition to strength training for major muscle groups two times per week. Although the current versions of Intermountain Healthcare’s physical activity vital sign only assess aerobic type physical activity, it is important to discuss strength training as a component of the exercise prescription.

A major challenge and threat to physical activity promotion in the healthcare setting is time and competing demands in a typical 15-20 minute office visit. The brevity of the physical activity vital sign, along with the concept of team-based care, helps to “bring” physical activity prescription into the exam room. Each person on the healthcare team plays an important role in promoting physical activity. The medical assistant asks the PAVS questions and records answers in the EHR. The physician interprets the vital sign and advises the patient to start, increase, or maintain his or her physical activity.

Time permitting, the physician can delve deeper into the patient’s readiness for change as it relates to physical activity and use evidence-based behavior change principles to guide the patient toward a more physically active lifestyle. Intermountain Healthcare developed an integrated behavioral approach to physical activity.

There is some evidence that the more often a provider discusses physical activity with their patient, the more likely that person is to engage in regular physical activity.
promotion as part of its Lifestyle and Weight Management Care Process Model (LWM CPM). The LWM CPM provides guidance to physicians and their care team on why and how to address physical activity (along with healthy eating, adequate sleep, stress management, and weight loss) with adult patients. A LWM CPM aimed at children and adolescents is forthcoming.

Patients who suffer from musculoskeletal conditions may also benefit from further evaluation from a physical therapist that can prescribe exercises aimed at resolving or minimizing musculoskeletal symptoms that occur during, or as a result of, physical activity. Likewise, patients wishing to change their dietary intake may benefit from consultation with a registered dietitian—a service now mandated for coverage by commercial insurance payers through the Affordable Care Act.

If physicians, physical therapists, and dietitians all consistently assess and promote physical activity as a routine component of every clinical encounter, it is likely that we would start to see changes in patient self-reported physical activity. There is some evidence that the more often a provider discusses physical activity with their patient, the more likely that person is to engage in regular physical activity. Let me conclude by saying that the greatest predictor of physical activity counseling by physicians is, in fact, that physicians own personal physical activity habits. It is critical that clinicians not only talk the talk with patients, but also serve as “active” examples to their patients, colleagues, family, and community.

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