INTERMOUNTAIN MED STAFF NEWS
THIRD QUARTER • SEPTEMBER 2016

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DEAR COLLEAGUES,

Welcome to the 12th installment of Intermountain Med Staff News, a news brief for our credentialed practitioners. Our focus with this newsletter is to keep you informed and up to date, and to continually develop strong relationships with you and your staffs.

To that end, beginning next month, this newsletter will see some changes, including moving to a monthly schedule, a shorter format, and the ability to read individual articles on the physician portal. Please let us know if you have other ideas for improving the readability and usefulness of this newsletter.

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

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

Sincerely,

Brent Wallace, MD
Chief Medical Officer
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Assistant Vice President
Physician Relations and Medical Affairs
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### 2016 BOARD GOALS – APRIL UPDATE

#### APRIL 2016 - BOARD GOALS PROGRESS

<table>
<thead>
<tr>
<th>Clinical Excellence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Zero Harm Error Prevention training in hospitals and leadership methods training in the Medical Group</td>
<td>Of Concern</td>
</tr>
<tr>
<td>Reduce hospital-acquired infection rate (CLABSI, CAUTI, SSI Colon, SSI Abd Hyst) by 20%</td>
<td>On Track</td>
</tr>
<tr>
<td>Reduce the system-wide rate of Adverse Drug Events with harm by 20%</td>
<td>Off Track</td>
</tr>
<tr>
<td>Reduce the incidence of patients with hospital-acquired pressure ulcers by 20%</td>
<td>Off Track</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Patient Engagement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Rating Hospital Stay 8-10</td>
</tr>
<tr>
<td>Medical Group</td>
<td>Rating Clinic Experience as Excellent</td>
</tr>
<tr>
<td>SelectHealth</td>
<td>Rating patient Health Plan 8-10</td>
</tr>
<tr>
<td>SelectHealth Share Members</td>
<td>40% Meeting Health Behaviors to be on track</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operational Effectiveness</th>
<th>Complete #1 plus 3 more of the following to be on track:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>iCentra will have at least three installations in 2016</td>
<td>On Track</td>
</tr>
<tr>
<td></td>
<td>iCentra will have at least four installations in 2016</td>
<td>On Track</td>
</tr>
<tr>
<td></td>
<td>At least 15 Care Process Models will be embedded into iCentra with a mechanism to track compliance</td>
<td>On Track</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Goal Area</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Engagement</td>
<td>Complete 3 of the following to be on track:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>75% of affiliated physician practices that request iCentra Physician Portal will have access to the application</td>
<td>On Track</td>
</tr>
<tr>
<td></td>
<td>Physicians in the “accountable” networks participate in performance-based incentives for SelectHealth Share, Advantage and Community Care products</td>
<td>On Track</td>
</tr>
<tr>
<td></td>
<td>Transparent quality reports will be available to individual physicians / clinics involved in SelectHealth accountable products</td>
<td>Of Concern</td>
</tr>
<tr>
<td></td>
<td>Geographic committees will demonstrate impact in key areas, which will be defined by the end of the first quarter</td>
<td>On Track</td>
</tr>
<tr>
<td>Community Stewardship</td>
<td>Achieve at least 95% of cashflow target AND:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All hospitals adopt a 3-year strategy to address prioritized community health needs; hospitals engage both community and internal partners in these needs (15 for entry, 22 for stretch)</td>
<td>On Track</td>
</tr>
<tr>
<td></td>
<td>Demonstrate normalized “trend” of total cost for SelectHealth large-group products (7.5% for entry, 5.5% for stretch)</td>
<td>Of Concern</td>
</tr>
<tr>
<td>Employee Engagement</td>
<td>Achieve at least two of the following to be on track:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase LiVeWell Index to 4.13</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Achieve a Gallup Accountability Index Score of 4.41</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Achieve a Gallup Grand Mean score of 4.15</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Increase the Extraordinary Employee Experience 2015 baseline index by 5%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

If you have questions, please contact Brent Wallace, MD, at Brent.Wallace@imail.org.
ON THE SET FOR CORE REVIEW 25TH ANNIVERSARY

This fall, Intermountain Healthcare will celebrate the silver anniversary of the Cardiovascular and Thoracic Core Curriculum Review and recognize those who helped create the course.

Donald B. Doty, MD, first started the course to address a concerning problem: University of Utah residents were failing their qualifying examinations.

“We have these young people coming through [the program],” Dr. Doty said. “We’re training and we’re teaching them and so on. When these people finish their training, they have to take a qualifying examination to become certified as a cardiovascular and thoracic surgeon. And half of our residents were flunking that test. Isn’t that disgraceful? I thought it was.”

Dr. Doty’s solution was to hold a 3½-day course with each topic on the examination broken down into highly-organized 20-minute lectures that cover the basic principles. A test question was given before and after each lecture to help students gauge their understanding, and detailed syllabus materials were provided as a study resource.

Schools held review courses of their own that met on a weekly basis. Factoring in vacation and holidays, they had 40 weeks of review sessions in the year to cover 75 topics appearing on the examination.

All the University of Utah residents passed after the first time the course was held. “None of them have flunked since,” Dr. Doty added. The course has become an impactful resource as it has grown during the 25 years since.

“We started with about 20 people in the first course, and it gradually grew to where we were getting almost all of the people that were coming up for that examination nationwide,” Dr. Doty said. “The advertising for it was essentially word of mouth. Now we have about a hundred people which is almost all of the ones who are going for the qualifying exams.

“I think it’s been a very good thing for the company as well as a benefit for the people,” Dr. Doty said. “We see these people at meetings and they come up [and say], ‘Thanks, I passed my boards. Really appreciate all you did for us.’”

Since the start of the Core Review, the course has been held in several countries including China, Australia, the United Kingdom, and Dubai.

CHANGES FOR CME
Intermountain Healthcare Continuing Medical Education will be adopting a new course catalog system called CME Tracker.

Searching for and registering for specific courses should become easier, conference applications and other forms will be paperless, and more robust data and analytics will be available.

CME Tracker will be gradually implemented throughout the fall with an anticipated complete adoption date of Jan. 1, 2017.

If you have any questions, please contact SarahAnn Whitbeck at SarahAnn.Whitbeck@imail.org.
## UPCOMING CME ACTIVITIES

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

- **Course Schedule**
  [https://intermountainphysician.org/intermountaincme/Pages/Course-Schedule.aspx](https://intermountainphysician.org/intermountaincme/Pages/Course-Schedule.aspx)

- **eCME Offerings**
  [https://intermountainphysician.org/intermountaincme/Pages/ecme.aspx](https://intermountainphysician.org/intermountaincme/Pages/ecme.aspx)

- **Transcripts**
  [https://intermountainhealthcare.org/pace-web/auth/classesList.html](https://intermountainhealthcare.org/pace-web/auth/classesList.html)

<table>
<thead>
<tr>
<th>Date</th>
<th>Title</th>
<th>Location</th>
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<tbody>
<tr>
<td><em>Wednesday, Sept. 7</em></td>
<td>Medical Group Clinician Forum</td>
<td>Marriott - City Creek</td>
</tr>
<tr>
<td><em>Thursday, Sept. 8</em></td>
<td>Medical Group Clinician Forum</td>
<td>Marriott - City Creek</td>
</tr>
<tr>
<td><em>Saturday, Sept. 10</em></td>
<td>Clinical Learning Day - South Region</td>
<td>Zermatt Resort</td>
</tr>
<tr>
<td><em>Saturday, Sept. 10 - Tuesday, Sept. 13</em></td>
<td>Cardiovascular and Thoracic Surgery Core Curriculum Review</td>
<td>Doty Family Education Center, Intermountain Medical Center</td>
</tr>
<tr>
<td><em>Tuesday, Sept. 13 - Friday, Sept. 16</em></td>
<td>Utah Certificate of Palliative Education</td>
<td>Ronald McDonald House</td>
</tr>
<tr>
<td><em>Wednesday, Sept. 14 - 17</em></td>
<td>Mindful Practice Retreat</td>
<td>Alta Lodge</td>
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<tr>
<td><em>Wednesday, Sept. 21</em></td>
<td>Intensive Medicine Clinical Program Conference</td>
<td>Thanksgiving Point</td>
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<tr>
<td><em>Wednesday, Sept. 21</em></td>
<td>Integrated Care Management Conference</td>
<td>The Falls at Trolley Square</td>
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<tr>
<td><em>Thursday, Sept. 22</em></td>
<td>Integrated Care Management Conference</td>
<td>The Falls at Trolley Square</td>
</tr>
<tr>
<td><em>Friday, Sept. 23</em></td>
<td>Integrated Care Management Conference-Southwest</td>
<td>Dixie Regional - River Road</td>
</tr>
<tr>
<td><em>Friday, Sept. 23 - Saturday, Sept. 24</em></td>
<td>Excellence in Trauma Care Conference</td>
<td>Canyons Resort</td>
</tr>
<tr>
<td><em>Tuesday, Sept. 27</em></td>
<td>Cardiac Stress Testing Conference</td>
<td>Doty Family Education Center, Intermountain Medical Center</td>
</tr>
<tr>
<td><em>Thursday, Sept. 29</em></td>
<td>Integrated Care Management Conference-Southwest</td>
<td>Dixie Regional - Foremaster Building</td>
</tr>
<tr>
<td><em>Friday, Sept. 30</em></td>
<td>Clinical Learning Day - North Region</td>
<td>McKay Auditorium</td>
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At a recent award ceremony at the University of Utah’s School of Medicine, Department of Pediatrics, Dr. Raj Srivastava received the coveted Excellence in Teaching award. Dr. Srivastava was chosen as a recipient by the residency house staff in the Department of Pediatrics.

Dr. Srivastava is a tenured professor of pediatrics at the University of Utah in the Division of Inpatient Medicine. He is a practicing hospitalist at Intermountain Primary Children’s Hospital in Salt Lake City, Utah and is currently employed by Intermountain Healthcare as the Assistant Vice President of Research. In addition to his various roles at Intermountain, he is also the Medical Director of the Office of Research and Vice Chair of Research, Department of Medicine, Intermountain Medical Center.

“This honor serves as a tangible example of how Intermountain Healthcare and the University of Utah collaborate in the best interest of those we serve in our community,” says Laura Kaiser, Intermountain Executive VP and COO. “We work together to provide excellent opportunities for training and mentorship of providers.”

If you have any questions, please contact Sue Gagnier at Susan.Gagnier@imail.org.
NEW RISK STRATIFIED LONGITUDINAL CARE MANAGEMENT LAUNCHED

Intermountain Medical Group launched a new Longitudinal Care Management process on July 13. Medical Group partnered with the Population Health and Integrated Care Management teams to begin screening high risk patients who have been identified through a new tool developed by population health analytics for longitudinal care management. This tool uses past medical utilization, quality, and cost data to determine the medical risk for all patients within the Intermountain system. The patient information from the top 1% of the high risk patients who have a Medical Group primary care provider is sent to the Medical Group care managers to screen them for longitudinal care management, which is a service provided by care managers to proactively and collaboratively develop an ongoing care plan to help those complex patients and their physician manage their medical conditions. This care management process is an important step for the Medical Group as they seek National Committee for Quality Assurance (NCQA) Patient Centered Medical Home recognition.

SelectHealth will launch a similar process, using the same risk stratification tool, for Intermountain patients with SelectHealth insurance (but without a Medical Group PCP) on September 13. Outcomes from this new program will be measured over time.

If you have any questions, please contact Catherine Hamilton at Catherine.Hamilton@imail.org or Dot Verbrugge, MD at dot.verbrugge@imail.org.

CLINICIANS LEARN ABOUT THEIR VITAL ROLE IN PHILANTHROPY

A patient who recently suffered a serious heart attack and was treated at Utah Valley Hospital told his caregivers, “the Intermountain system saved my life. It gave me incredible care in a way that not only addressed my physical health issues, it addressed my emotional and psychological issues. It was a continuum of care all the way through to my recovery. I’ll always be grateful. Thank you, Intermountain.”

In addition to his verbal expressions of gratitude, this patient decided to make a generous gift to the hospital. The contribution was conveyed via check, but for the patient this was much more than a financial transaction – it was transformative, and aided in his healing.

Gratitude is an emotion; generosity is a behavior. Research supports that expressions of gratitude can positively impact a person’s health and well-being. Among its benefits, it may contribute to quicker recovery from illness, lower blood pressure, and increase the ability to deal with stress. An article published by Harvard Health summarizes it well: “Expressing thanks may be one of the simplest ways to feel better.”

Recognizing the benefits of generosity, Intermountain Foundation is rolling out a “Clinician Engagement in Philanthropy” program. In partnership with national education and research firm Advancement Resources, the program demonstrates to physicians, nurses, and other caregivers that a patient’s gratitude is a direct response to the exceptional clinical care they’ve received during their health care experience. Through the program, caregivers are learning to increase their awareness around expressions of gratitude and encouraged to acknowledge, rather than dismiss, them. Upon recognizing patient gratitude, clinicians are able to direct grateful patients to Intermountain Foundation, where they are able to fulfill their intentions to make a difference.

Intermountain’s Clinician Engagement in Philanthropy program does not seek to turn clinicians into fundraisers; instead, it helps them understand their role in facilitating a grateful patient’s desire to give back. The program recently kicked off with system leaders, physicians, and others from the Central Region. In November, this pilot program is being introduced to select Central Region physicians and nurses through trainings designed to show the benefits of allowing patients to express gratitude.

In a video introducing the training, Kim Henrichsen, VP of

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Clinical Operations and Chief Nursing Officer, states, “I think it’s really important for all of us to be in tune with our patients and our visitors and our family members, because people really do want to give back.”

Dr. Donald Lappe, Medical Director of Intermountain’s Cardiovascular Clinical Program and Chief of Cardiology, attended the kickoff, and has since become passionate about receiving and responding to thanks. “Learning how to accept and return gratitude is not only creating a culture that more deeply values appreciation,” he said, “it also supports the programs and technology we rely on in order to continue to provide world-class care to our patients.”

If you would like more information, please contact Jason Befort, Donor Prospect and Research Manager, at Jason.Befort@imail.org, or Nancy Gregovich, Foundation Operations Officer, at Nancy.Gregovich@imail.org.

WHAT WORKS BETTER?

Studies at Kaiser Permanente have identified mindfulness as the best practice that ensures tech devices will enhance, not damage, your relationship with your patients. The studies advise against trying to pay attention to both the patient and the device at the same time. Multi-tasking is inefficient and prevents you from being connected with and attentive to your patients.

RULES OF THUMB: USING TECHNOLOGY WHEN YOU’RE WITH A PATIENT

1. Log in and explain what you’re doing:
   - “Let’s open up your chart so we have your history and results in front of us”

2. Alternate the focus of your attention, instead of trying to multi-task:
   - Be mindful to the patient and then mindful to the device and back and forth.
   - Attend fully to one and then the other instead of trying to attend to both at once.
   - When you ask a question, make eye contact. Don’t be out of eye contact for more than 10 seconds.
   - When the patient is discussing an emotional or critical issue, turn away from the device completely and tune into the patient.
   - When you’re entering information, explain: “Please give me a moment to jot some of this down while it’s fresh in our minds.”

3. Engage the patient with the device and the information on it:
   - Turn the screen toward the patient showing there’s no secret. Invite the patient to look with you: “Would you like to look with me? I’m reviewing your lab results.”
   - Share information like lab results. “Let’s take a look at what the specialist note recommends from your visit last month”

4. Log in and out in front of the patient:
   - Ease their concerns about confidentiality.

MED/SURG SUPPLIES STANDARDIZATION JUNE UPDATE

WE’RE OPTIMIZING! WHAT DOES OPTIMAL EXAM GLOVE UTILIZATION LOOK LIKE?
You’ve helped us get all the way to the “Optimization” step with exam gloves! What does this mean for you and your teams?

You may recall that “optimization”, in our standardization journey, is the state where a product is used for its intended purpose and we have appropriate quantities for our needs.

To reach optimization, our glove suppliers are visiting facilities during the next few months to simply observe our clinicians using exam gloves. The suppliers will watch to see how the glove is used and if the right glove is used in the right situation. For instance, suppliers will observe if a clinician is using the top quality glove for every procedure when the situation only requires the standard glove. The information collected will be used for improvement.

As with the original standardization project, the Supply Chain will coordinate every standardization step with the facility or clinic.

FEELING UNINFORMED? TRY THIS.
This piece is just one way to understand what’s happening with standardization. Consider these additional methods:

- Your huddle boards
- Staff meetings
- Your Materials Management team
- Medical Group has assistant clinical managers as well as a Supply Chain liaison, Kellen Boswell

WHAT’S COMING UP?
In 2016 we’ll be going through the rationalization* process of these products:

- Vacutainers
- Skin care
- Electrodes

*Rationalization is when we aggregate our purchases and identify an optimal number of clinically similar items.

June Supply Chain Organization Standardization

If you have any questions, please contact Trent Gee at Trent.Gee@imail.org.

MED/SURG SUPPLIES STANDARDIZATION AUGUST UPDATE

STANDARDIZATION IMPROVEMENTS
IV tubing, chemo tubing, and accessories
Under the direction of the Infusion Guidance Team, the SCO is helping to standardize to two primary suppliers for these items. This effort enables us to purchase directly from the manufacturer which reduces cost without negatively affecting patient care. This improvement will create fewer SKUs (item numbers), more items available in the Fulfillment Center, and result in fewer orders, less inventory, and reduced variation.

This standardization process will also produce a standard protocol and a standard product list for all chemo items for all facilities.

DR. CHARLES SORENSON
Shares his perspective on unnecessary variation

“I have found that almost all medical professionals become energized when they see the improved outcomes that result from decreasing unnecessary variation.”

*An excerpt from his 2016 University of Utah School of Medicine graduation speech

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Steri strips
In 2014, the cross-functional Packs Committee converted all the steri-strips in all the packs to a single supplier. To further standardize, the committee cooperatively decided that the single pull shelf items should be converted to the same steri-strips in order to reduce variation. The product is now available as single pull style and standardized to one supplier. Clinicians now have less variation. This modification also impacts waste because sometimes clinicians would dispose of the dispensing style that was not their first choice.

Standardization Success at Our LDS Hospital Pharmacy

Robb Dengg, Director of Pharmacy Services at LDS Hospital, recently shared his story with us:

“Federal regulation for compounding sterile hazardous drugs has been in constant flux. Because of this, hundreds of products have been purchased and utilized within the system. This has caused confusion on the correct products to use to safely compound hazardous drugs.”

“It was essential to standardize the products within our system to reduce variability, provide increased patient and employee safety and reduce cost. The sourcing group from the Supply Chain Organization guided our system in reducing the number of SKUs to a couple dozen and will be streamlining the ordering process to reduce variability and improve patient affordability.”

August Supply Chain Organization Standardization

If you have any questions, please contact Trent Gee at Trent.Gee@imail.org.
WHAT MAKES IRON MAN IRON MAN? A NEW WAY TO LOOK AT THE POWER OF iCENTRA

When you think about Iron Man — which I did last week in between my surgical practice and my administrative duties — you have to wonder: What makes him Iron Man?

He’s got suits of armor, a power source in his chest, great intelligence, passion for saving the world, and all the wealth of Tony Stark and Stark Enterprises — but here’s my theory: JARVIS makes Iron Man Iron Man. JARVIS is Tony Stark’s highly advanced (and often wisecracking) artificial intelligence-based computer system; it stands for Just A Rather Very Intelligent System.

You never see JARVIS; you just see Iron Man using it. You get the impression it’s built into the walls. He accesses the system and its gauges whirl and its lights flash and it gives him the information and the power he needs to do what he does.

Here’s one example of the power of JARVIS, from “The Avengers.” Iron Man confronts Loki, the bad guy, on the top floor of an office tower. He’s out of his suit; he’s just Tony Starks. Loki beats him up and throws him off the tower, but while he’s falling to his death, Tony uses a beacon in his watch to access JARVIS, which spits out a new suit and shoots it down to him. The suit wraps around him just in time, and right before he hits the ground, his suit powers up and he zooms back up to carry on the fight against the bad guys.

JARVIS, in other words, is iCentra. It says: Do this...Don’t do that...You might consider this. In Iron Man, ultimately Tony Stark chooses what he’ll do, but JARVIS gives him all the options and helps him make decisions — which is exactly how iCentra works, minus the British accent. iCentra isn’t just an electronic medical record; it’s a source of the evidence that helps us make evidence-based decisions.

iCentra addresses what I think is the Achilles heel of healthcare providers: Lack of information. The knowledge we need is always out there when we face a challenge or need to make a decision, but we don’t have access to it. We have a hard time getting water to the end of the row. All of us would do the right thing if we only knew what to do, but when we don’t, the result is uninformed decisions, poor outcomes, wasted resources, or — the ultimate enemy in healthcare — mistakes.

iCentra is a great and dreadful opportunity. It strips away our old way of doing things. It will totally shake up our world — that’s the dreadful. But it will give us the information, immediately, that will help us make better decisions. That’s the great. It’s the best communication system in the world, which will enable us to deliver the
best healthcare in the world. I hope that’s how you’ll look at it. Instead of being challenged by it, or resisting it, all of us need to embrace it. It’s the ultimate power source. It’s JARVI

So what makes Iron Man Iron Man? JARVIS does. Iron Man wouldn’t be himself — he wouldn’t even be alive — without it. It’s the ultimate resource for him, just like iCentra will be for us. And one day, maybe six months from now, after we’ve been trained and once we’re starting to be comfortable with it, I’m convinced iCentra will give us a reason to say what Tony Stark said in Iron Man 3: “You know, it’s times like these when I realize what a superhero I am.”

If you have any questions, please contact Mark Ott at Mark.Ott@imail.org.
ANTI-KICKBACK STATUTE FAQ

The Anti-Kickback Statute prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals of items or services reimbursable by a federal healthcare program. Intermountain Healthcare prohibits engaging in arrangements where any one purpose is to reward, compensate, or provide something of value in exchange for referrals.

1. **What is considered something of “value?”** Remuneration can be either direct, indirect, monetary, or in-kind.

2. **What is the “one purpose” test?** The intent element of the statute can be met if only one purpose of the remuneration was to induce a referral even if other, legitimate purposes exist.

3. **What are the penalties for violating the Anti-Kickback Statute?** Give feedback using the green highlighted order at the bottom of the order set to improve care and workflow of the orders.

4. **What are the key differences between the Anti-Kickback Statute and the Stark Law?**

<table>
<thead>
<tr>
<th></th>
<th>ANTI-KICKBACK STATUTE</th>
<th>STARK LAW</th>
</tr>
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<tbody>
<tr>
<td><strong>Prohibitions</strong></td>
<td>Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal healthcare program business</td>
<td>Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies</td>
</tr>
<tr>
<td><strong>Referrals</strong></td>
<td>Referrals from anyone</td>
<td>Referrals from a physician</td>
</tr>
<tr>
<td><strong>Intent</strong></td>
<td>Knowing and willful</td>
<td>Strict liability (unintentional violation can result in penalties)</td>
</tr>
<tr>
<td><strong>Penalties</strong></td>
<td>Criminal and Civil</td>
<td>Civil</td>
</tr>
</tbody>
</table>

5. **Is compliance with the Stark Law sufficient to comply with the Anti-kickback Statute?** Not always. For instance, under the Stark non-monetary compensation exception, a hospital or DHS entity may provide certain non-monetary compensation (“business courtesy”) to a referring physician that does not exceed $392 annually. However, if one purpose of the courtesy is to induce referrals from that physician, the hospital or DHS entity will likely have violated the Anti-Kickback Statute (as well as the Stark law).

If you have questions, please contact Wade Thornock at Wade.Thornock@imail.org. For more information, watch the video from the U.S. Health and Human Services Office of Inspector General titled, “Kickbacks to Physicians.”
IT HAPPENED HERE - MULTIPLE PATIENTS EVENTS

Sometimes events of harm occur that affect multiple patients. As a physician, these events may impact the care you provide. Recent examples include:

► CASE #1
Intermittent Breakdown in Computer Message Log Function- HELP 2
A patient service representative at an Intermountain clinic discovered lab results that were incorrect or were documented on the wrong patient’s chart. Upon further investigation, multiple issues were discovered across Intermountain clinics, including:

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

What Do You Think?
- What may have caused this event: A computer glitch.
- How was this recognized: This problem was identified by a Patient Service Representative (PSR) who recognized an error—then using STOP and RESOLVE,

spoke up in daily huddle to bring to the attention of her peers and leaders so that potential PHI issues can be resolved.

► CASE #2
Temperature Malfunction on Medication Refrigerator
Over the course of one month, 350 patients received vaccines that had been stored at a temperature lower than manufacture recommendations. The refrigerator temperature was checked and found to be out of range and therefore was adjusted and recalibrated to the correct temperature. Vaccines for Children (VCF) notified the clinic approximately one month later that there was a discrepancy in the clinic’s temperature log. The refrigerator was serviced and determined to be functioning properly. There was concern that the thermometers provided by VFC and the corporate vendor, Hi-Tek, vary significantly and alarms were not triggered. Manufacturers were contacted to determine viability of the vaccines at the low temperatures.

What Do You Think?
- What may have caused this event: Variability in the thermometers provided by two different vendors—(one was residential grade, other commercial or pharmaceutical grade).
- How was this recognized: Suggest that the facility request resolution using the SBAR format—Situation, Background, Assessment and Recommendation/Request. Determine one thermometer be the standard, continue to monitor and log the medication refrigerator and report variances.

► CASE #3
Courier Service Missed a Lab Pick-Up
The lab discovered that the specimen batches from two days prior were never picked up by the courier service (21 patients identified). Upon discovery, staff determined...
which specimens were no longer viable (8 patients identified) vs. those that were stable and could be sent to Central Lab for processing. A STAT courier was then called and the viable specimens were sent. Repercussions may include possible missed diagnoses and patient inconvenience resulting from the need to return for additional testing.

**What Do You Think?**

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

- **How was this recognized:** Some type of Hand-off should be used communicating to Courier Service regarding specimen pick-ups. Going forward Courier Service will use STOP and RESOLVE if questions arise.

**Think about it ...**

- As a physician, how are you informed when these events occur?
- Are you participating in daily or weekly huddles when possible?
- Have you seen huddle boards used in the areas where you work?

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**PHYSICIANS ARE USING ERROR PREVENTION TOOLS AND TECHNIQUES AND MAKING A DIFFERENCE**

**Recent examples from the regions include:**

**NORTH REGION:**

A surgeon in the OR stopped for the time out. He stated they were going to operate on the left side. Staff spoke up and said they had prepped the right side. The surgeon reviewed the chart and stated he was wrong and the surgery was supposed to be on the right side. He thanked the staff for “speaking up for safety” and using the Stop and Resolve Error Prevention technique.

**MEDICAL GROUP**

A child presented to the KidsCare (after being misdiagnosed in the ER) and was found to have new onset diabetes and be in severe DKA. When the paramedics arrived to transport the child, the physician requested the child be taken to PCH but the paramedics refused stating that they did not drive past a hospital (McKay Dee) to another hospital just because a physician requested it. They stated their policy is to take patients to the nearest hospital in proximity, not drive past hospitals. The doctor knew that this child needed to be seen by a pediatric intensivist ASAP and that service was not available at the closest hospital so the physician used ARCC (Ask a question, Request a change, voice a Concern, use the Chain of command) to get the paramedics to take the child directly to PCH.

**CENTRAL REGION**

Patient consented and prepped for urological surgery. However, the patient had consented to the wrong side. This incorrect side was confirmed by the OR staff. During the

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QUALITY & PATIENT SAFETY UPDATE, CONTINUED

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**For questions, please contact Jeanne Nelson at Jeanne.Nelson@imail.org.**
time-out process the surgeon said “Stop, that is the incorrect side.” Utilizing the Error Prevention technique of Stop and Resolve, he looked at his H & P and ordered an x-ray to confirm the correct side.

SOUTH REGION
A patient at UVH was scheduled for a major back surgery involving the use of spinal cage implants. Pre-operative prophylactic antibiotics were ordered, and the medical record indicated they had been infused. The operating room subsequently called the pre-op holding room to have the patient brought back to start the surgery. However, the anesthesiologist for the case had visited with the patient in the pre-op holding room shortly before the case was to begin, and remembered that he had not noticed any antibiotic hanging on the IV pole. Using Stop and Resolve, he promptly called a halt to bringing the patient back to the OR and thoroughly investigated the situation.

It was eventually determined that the pre-op antibiotic had, in fact, not been given. The case was then delayed until the antibiotic could be fully infused. The action of the anesthesiologist might very well have prevented a serious surgical infection, particularly since a significant surgical implant was to be used.

SOUTHWEST REGION
An orthopedic surgeon shared a story during Error Prevention Training where he went to do a knee surgery on a patient. The patient was already prepped and in the OR. They had prepped the right knee, and the physician initially assumed everything was correct until he glanced at the film which showed the left knee was the actual knee which needed surgery. They did a time-out, reviewed the patient history and films and realized it was the wrong knee which had been prepped. The physician used Stop and Resolve, and asked clarifying questions to prevent a wrong site surgery.

Questions? Please contact Jeanne Nelson, MSNEd, RN, at Jeanne.Nelson@imail.org or 801-442-307
The Centers for Disease Control and Prevention (CDC) released an alarming statistic... The suicide rate in the United States increased by 24% between 1999 and 2014. The report got the usual casual mention on the daily news and was sidelined by other news the next day.

In this June issue of Current Psychiatry, Dr. Henry A. Nasrallah, a neuropsychiatrist, calls attention to the neglect that society has towards the high risk of suicide and the needs of the mentally ill. He titled the editorial, The Scourge of Societal Anosognosia about the Mentally Ill, arguing that, similar to the lack of insight seen in stroke patients who overlook a paralyzed limb, society has forgotten that mental illness has deadly consequences. “Just as patients with anosognosia think they do not need help, a society that fails to attend to the mental illness of its citizens endangers their overall health and welfare.”

Dr. Nasrallah then identifies eleven hazards for persons with mental illness that have arisen from this societal neglect:

- Lack of compassion
- Lack of adequate, affordable health insurance
- Shortage of publicly funded programs and mental health practitioners
- Allowing the stigma to continue unabated
- Transforming the seriously mentally ill into felons
- Turning a blind eye to abuses by insurance companies
- Consent laws that restrict psychiatrists
- Failure to recognize that premature mortality (by approximately 25 years) is a devastating consequence of mental illness

Intermountain, and the Behavioral Health Clinical Program (BHCP), recognizes that timely access to psychiatric care is essential to the overall health and wellbeing of our patients. From the integration of mental health in Personalized Primary Care clinics, to acute crisis intervention in Behavioral Health Access Centers, Intermountain is actively adding resources to ensure these needs are not “forgotten”. State Legislative efforts have increased the ability to recruit new psychiatrists and psychiatric APRNs through refundable tax credits (HB 265), and the integrated, patient-centric, iCentra medical record will ensure that all providers will have access to, and be made aware of, the mental health needs of their patients.

As Dr. Nasrallah stated, “The tragic rise in the rate of death by suicide in men and women, among all age groups, year after year, is stunningly incongruent when juxtaposed against the elimination of smallpox and other communicable diseases through a concerted societal effort... Societal anosognosia appears to be selective: we have comprehensive insight about diseases of the body but not diseases of the mind.” The BHCP will continue to explore opportunities, and implores our providers, to break down social barriers and eliminate hazards to care for the behavioral health needs of our patients, helping them to live the healthiest lives possible.

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

Cardiovascular

CARDIOVASCULAR CLINICAL PROGRAM UPDATE

Our main focus this last quarter continues to be enhancing iCentra for CV use. We have nearly 100 PowerPlans (PP) and CV “orderables.” We appreciate the broad participation in our weekly leadership meetings. Some areas of improvement include standardized verbiage within our power plans. Additional PP have been created on request by the clinicians to embrace additional work processes. Many details within the PP have been improved. Our nurses have added much to facilitate the workflow for all caregivers. Our implementation in the South Region and Park City has gone well.

We also have significantly improved our intranet website which you can access by entering “CV” in the URL. There are updated contrast induced nephropathy prevention guidelines which we co-developed with radiology. We continue to work with Primary Care to refine the Hypertension and Lipid management guidelines. An updated guideline for managing dual antiplatelet therapy in post PCI patients undergoing non-cardiac surgery is now available. Finally, our reports on the same website are far more accurate, accessible and meaningful.

If you have any questions, please contact Donald Lappé, MD at Donald.Lappe@imail.org.

Intensive Medicine

PROVIDERS’ ROLE IN NEW CMS SEPSIS CORE MEASURES

On October 1, 2015 CMS established a new core measure for sepsis (SEP-1). Because of complexity and confusion in the definitions and timing of specified care delivery, good physician documentation is key in meeting established SEP-1 requirements. Quality abstractors need to have both date and time on all physician documentation for CMS data reporting. The definition of Time of Presentation (time zero) is critical to determining if care was delivered in compliance with the stipulated time frame. There are now two Times of Presentation: one for severe sepsis and one for septic shock. Septic shock can only be diagnosed after a fluid challenge of 30 mL/kg body weight is delivered. For this reason the two Times of Presentation frequently differ and accurately identifying these for SEP-1 documentation is one of the biggest obstacles.

PHYSICIAN ROLE #1

Early documentation of the diagnosis of Severe Sepsis and/or Septic Shock.

CMS allows Time of Presentation to be set contemporaneously by a physician/LIP in three ways:

1. By documenting the patient has “Severe Sepsis,” “Probable Severe Sepsis,” or “Septic Shock” in a dated/timed note,
2. By adding it as a new problem on the problem list, or
3. By noting a prior time at which one of the diagnoses was achieved.

If none of the contemporaneous methods occur, abstractors must retrospectively (following patient discharge) search the chart and find 3 criteria that all occur within a 6h time window, including:

1. Documented source of infection like pneumonia or cellulitis,
2. 2 or more SIRS criteria and
3. Organ failure.

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In this case the clinical team cannot know when Time of Presentation occurred or when the 3- and 6h time clocks started. Ultimately, CMS requirements necessitate increased clinician diligence to properly document care of severe sepsis and septic shock patients. Contemporaneous physician/LIP documentation is much more accurate and allows the care team to better coordinate care to meet goals.

**PHYSICIAN ROLE #2**

Reevaluation and documentation of patient’s status within 6h of the fluid bolus to assess effectiveness of the challenge and modification of plan of care as appropriate. The cardiopulmonary exam must be performed by the MD/LIP personally; other aspects need only physician review and documentation.

CMS requires that within 6h following fluid bolus and documentation of septic shock, a physician/LIP must document a reassessment of the patient. This can be done by evaluating and documenting two of the following: 1) CVP, 2) ScvO2, 3) Cardiac ultrasound, or 4) response to a Passive Leg Raise (PLR).

An alternative to these 2 of 4 is physician/LIP documentation of a sepsis “Focused Exam” consisting of capillary refill, peripheral pulse evaluation, skin examination, and vital signs review, plus documentation of a physician performed cardiopulmonary exam using precise options for terminology.

In order to assist physicians/LIPs with these tasks, we have embedded “PowerForm” tools into iCentra to remind, prompt, and facilitate providers’ engagement with sepsis documentation. The first is triggered by a preselected order in the sepsis and other related PowerPlans since order writing is usually done early in the admission/transfer work flow. The first PowerForm allows the clinician to check a box agreeing that the patient has severe sepsis and is accompanied with an automated time and date (see screenshot below); the time can be modified if the provider feels the criteria were met earlier than current time. The provider will also be prompted to indicate a source of infection to assure the first criteria for severe sepsis is documented. CMS criteria defining severe sepsis are on the PowerForm to give providers information needed to answer the question.

Septic shock is frequently confirmed at a later time since it must follow non-responsiveness to a fluid bolus of 30mL/kg body weight before confirmation. The septic shock PowerForm is thus triggered upon charting fluid bolus completion and will result in an alert to remind the nurse and physician to confirm “septic shock” and complete the mandatory documentation described above within 6h.

**PHYSICIAN ROLE #3**

Give feedback and suggestions to improve the process of documentation and evaluation on severe sepsis and septic shock.

We recognize current efforts are not perfect, and we are open to feedback and suggestions to improve them. CMS has received a lot of national feedback and has already made some modifications in SEP-1; we anticipate more changes in the future. Of particular note, CMS has not yet adopted sepsis-3 definitions.

Please respond to Terry.Clemmer@imail.org, Nancy.Nelson@imail.org, Russ.Miller@imail.org and/or Marni.Chandler@imail.org with suggestions and/or actionable feedback.
USE OF LEUKOREDUCTION TO PROVIDE CMV SAFE CELLULAR BLOOD COMPONENTS (RED BLOOD CELLS AND PLATELETS)

In a continued effort to improve blood product management and after careful review of the literature and review of current practices at other facilities, the Oncology Clinical Program and the Organ Transplant groups have agreed to utilize leukoreduced/leukodepleted blood products as a substitute for CMV seronegative tested cellular products. This will facilitate an expanded donor base for HLA matched/crossmatched platelet products and simplify inventory management at the facilities with a large hematology/oncology patient population.

The science behind the use of leukoreduced/leukodepleted products as a replacement for CMV seronegative tested cellular components is explained below in an article written by Dr. Walter E. Kelley, DO, FCAP, Medical Director for the American Red Cross. Dr. Kelley is an NIH trained physician and scientist who lives in Salt Lake City and practices throughout the intermountain west. He is board certified in Clinical Pathology and subspecialty board certified in Transfusion Medicine. He has published more than thirty papers, abstracts and book chapters in the fields of pathology and Transfusion Medicine. He currently serves as the American Red Cross representative to the US FDA Circular of Information task force.

"THE SAFETY OF LEUKOCYTE REDUCED BLOOD PRODUCTS IN THE PREVENTION OF TRANSFUSION TRANSMITTED CYTOMEGALOVIRUS” BY WALTER KELLEY, DO, FCAP

Cytomegalovirus (CMV) is an enveloped betaherpesvirus which is typically spread through personal contact, urine, and saliva, with intrauterine transmission by transfusion, organ, and tissue transplantation also documented. Most infections in immunocompetent individuals are asymptomatic, with some community acquired cases presenting as a non-specific mononucleosis like illness. Population studies show a prevalence rate between 40 and 100%. Viral persistence is seen in white blood cells, with reactivation occurrences documented, with resultant viral DNA detectable in the plasma as well as WBCs of immunocompetent individuals. Vertical transmission can adversely affect the fetus, resulting in serious developmental damage. Seronegative individuals undergoing hematopoietic stem cell (HSC) transplantation, solid organ transplantation, and those with congenital and acquired immune deficiency are at risk for serious illness if infected. Strategies to mitigate transfusion transmission risk for at risk immunocompromised patients have included transfusion from CMV antibody negative donors and WBC reduction by filtration or by apheresis. Mathematical modeling suggests a residual risk of CMV transmission when modern leukocyte reduction techniques are used is 1:13,575,000 (The Residual Risk of transfusion-transmitted cytomegalovirus infection associated with leukodepleted blood components, Vox Sanguinis, 2015). A cohort pilot study of 20 preterm low birth weight infants showed zero transfusion transmitted infections across 43 transfusions of all leukocyte reduced blood products (Postnatal cytomegalovirus infection: a pilot comparative effectiveness study of transfusion safety using leukoreduced-only transfusion Strategy, Transfusion 2016). To assess the risk of CMV transmission by transfusion in the modern era of universal WBC reduction, a group of 76 CMV Seronegative HSC transplant patients / CMV negative HSC donor pairs were evaluated by high sensitivity PCR for post-transplant CMV infection. Of the 76 HSC transplants, 59 received T-cell depleted grafts, which is a known risk factor for CMV infection. All blood products were produced by methods known to yield a 3-log reduction in WBCs in 99% of components with a 95% confidence interval. A total of 1442 transfusions were administered to the 76 patients [819 RBCs, 623 platelets (483 single donor platelets; 140 whole blood derived platelets pooled from four donors each)]. No cases of CMV transmission were detected, with 68/76 patients having ten or more negative results of high sensitivity PCR assays in the post-transplant period (Transfusion in CMV seronegative T-depleted allogeneic stem cell transplant recipients with CMV-unselected blood components results in zero CMV transmissions in the era of universal leukocyte reduction: a UK dual centre experience, Transfusion Medicine 2015). While no medical intervention is without risk, modern leukocyte reduction methods appear, by both mathematical modeling and clinical trial results, to appropriately mitigate the risk of transfusion transmitted CMV infections.”

If you have further questions, contact Terry Rees, Transfusion Service Supervisor, at Terry.Rees@imail.org or 801-507-5092
**Neurosciences**

The Neurosciences Clinical Program is working hard to publish new CPM’s this year including topics like dementia and concussion. In the meantime be sure to check out our updated CPM of **Emergency Management of Acute Ischemic Stroke**, which incorporates our latest Telestroke protocol (including inpatient), and the accompanying guideline for **Alteplase Standardization in Acute Ischemic Stroke**. Look for this publication soon on our Neurosciences Page.

Additionally, we are excited to bring you the expansion of TeleStroke services for our inpatients in acute care units: emergent 24-hour access to board certified neurologists that facilitates rapid, accurate, and appropriate treatment for patients with suspected strokes using TeleHealth technology. Under the new protocol, each inpatient TeleStroke will be activated and assisted by the rapid response team from each facility. They will follow an approved protocol ordering a CT scan and calling our neurologist for rapid assessment and necessary treatment. There are several benefits to expanding services to inpatients including: faster administration of thrombolytics, improved diagnosis and definitive stoke therapies, reduced variations in care, and reductions in unnecessary patient transfers to higher levels of care.

Finally, as part of the advancing of services we have standardized the use of Alteplase for Acute Ischemic Stroke. The dosing, compounding, and administration of Alteplase for patients presenting with acute ischemic stroke will now follow a uniform protocol throughout Intermountain Healthcare. This was done in accordance with best clinical practice and is an effort to help streamline practice, provide optimal patient care, and ultimately improve clinical outcomes. This initiative is especially important now that Intermountain Medical Center has gained Comprehensive Stroke Certification from the Joint Commission and we’ve implemented widespread use of our TeleStroke services.

For any questions, please contact Jeremy Fotheringham at Jeremy.Fotheringham@imail.org.

**Oncology**

**ADVANCING INTERMOUNTAIN’S ONCOLOGY INITIATIVES**

We held our first Oncology Clinical Program (OCP) and **Strategic Visions in Healthcare**. Our goal was to achieve a consistent level of comprehensive, high-quality cancer care at all our locations, an excellent experience for our patients across the cancer continuum, expansion of research, and strong alignment with our cancer specialty physicians. We’re excited to announce our first-ever Cancer Services Strategic Planning Retreat, which occurred on August 19, 2016. The retreat included central office, regional, and physician (affiliated and employed) administrative and physician leaders.

The Intermountain Precision Genomics Cancer Research Clinic is actively working to expand our industry-sponsored clinical trial program (including early phase trials). We recently submitted our application to join the Academic and Community Cancer Research United (ACCRU) network, which is a clinical research network that brings together leading scientific researchers from more than 65 academic institutions and community-based cancer treatment practices in the United States and Canada, committed to developing and conducting high quality cancer research that will improve the:

- Moroni Clinic – Bronze Level
- Mt Pleasant Clinic – Silver Level

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ACCRU’s Research Coordinating Center is based at Mayo Clinic Cancer Center in Rochester, MN. Our ACCRU application and subsequent review and hopefully acceptance is pending.

We are also very excited to officially announce the initiation of our Oncology Precision Network (OPeN), which will provide a forum for data sharing between Intermountain, Stanford, Providence, and Syapse. OPeN will advance cancer care through sharing of cancer genomics data, rapidly bringing the most promising treatment insights to cancer patients and physicians with the potential of increasing access to clinical trials. With its current membership, OPeN comprises data and physicians across 11 states, 79 hospitals and 800 clinics, and will impact 50,000 new cancer cases per year (Oncology Precision Network (OPeN) Announces Data Sharing Commitments at Vice President Biden’s Cancer Moonshot Summit).

We are also very pleased to announce the arrival of Dr. Terence Rhodes, who is certified by the American Board of Internal Medicine and is dedicated to cancer immunotherapies. According to Rhodes, “immunotherapy is therapy that helps the patient’s immune system in its fight against cancer. Immunotherapy can either take the breaks off the immune system or teach the immune system how to fight.” Rhodes will see patients at the Southwest Cancer Center in St. George, Utah. He will also conduct research and development (system-wide) in the field of Immunotherapy at Intermountain Healthcare.

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

Pain Management

ICENTRA UPDATE
Primary Care Clinical Program and Pain Management Clinical Services launched a new chronic pain workflow program for primary care providers. This pilot program is currently being evaluated, and we anticipate it will be available for all iCentra users soon. Some features include:

- Quick and easy access to pain management assessment forms found in the chronic pain care process model.
- Function and pain assessments can be tracked over time, so providers can compare assessments to treatments.
- Custom links are available to the state’s Controlled Substance database as well as the Washington State’s Opioid Dose Calculator.
- A pain management summary template is available to help summarize all assessments. This template will bring together the results from assessment tools in a note format and is called chronic pain management note. It includes items such as provider treatment orders, labs, etc.

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During the upcoming Clinical Learning days, presentations will include the new iCentra workflow as well as tools and tips for chronic pain management and opioid prescribing. Information will be provided on the new CDC guidelines and upcoming changes to the CPMs.

**TRAINERS NEEDED FOR LIVING WELL WITH CHRONIC PAIN SELF-MANAGEMENT PROGRAM**

As part of the chronic pain patient engagement strategy, Pain Management and Community Benefits is offering an education class called the Living Well with Chronic Pain Self-Management Program. The program was developed by Stanford University and is led by individuals with a chronic pain condition or someone that works or lives with someone with chronic pain. If you know of anyone interested in teaching the program, please contact Linda Caston at Linda.Caston@imail.org.

**PAIN MANAGEMENT CLINICAL SERVICE WEBSITE**

- Providers and staff can find all Intermountain pain assessment forms and tools, Care Process Models and Guidelines at the new updated site. Refer to:  
  [https://m.intermountain.net/pain/Pages/home.aspx](https://m.intermountain.net/pain/Pages/home.aspx)
- The new patient website can be found at:  
  [https://intermountainhealthcare.org/services/pain-management/](https://intermountainhealthcare.org/services/pain-management/)

**NALOXONE GUIDANCE**

Intermountain Healthcare and the CDC strongly recommend assessing risk and incorporate risk mitigation strategies that address the potential harms prior to initiating and periodically during opioid therapy. One strategy includes prescribing naloxone. Utah law allows the prescribing of naloxone to anyone at risk for—or who may be in a position to assist someone at risk such as a pharmacist for—opioid overdose, even without a provider-patient relationship. Intermountain pharmacists should refer to Intermountain Healthcare Pharmacy Services Naloxone Collaborative Agreement.

Intermountain providers should refer to Recommendations for Prescribing Naloxone in the Outpatient Setting Clinical Guideline 7/16 found at:  

For any questions, please contact Bridget Shears at Bridget.Shears@imail.org.

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**Primary Care**

**PRIMARY CARE CLINICAL PROGRAM**

**DIABETES PREVENTION**

The Primary Care Clinical Program (PCCP), the American Medical Association (AMA), and Omada Health are collaborating on an innovative new initiative aimed at reducing the alarming number of adults who develop type 2 diabetes. The new collaboration will create a roadmap for large health care organizations across the country to adopt proven online behavior change interventions for at-risk patients, and integrate those programs into provider referral and clinical workflow. The PCCP will be enrolling 200-250 patients from the Intermountain Medical Group North and Central Salt Lake Regions with commercial insurance through Select Health to evaluate this digital therapeutics approach along with our other diabetes prevention program tools.

People with prediabetes have higher than normal blood glucose levels, but not high enough yet to be considered type 2 diabetes. Research shows that 15%-30% of overweight people with prediabetes will develop type 2 diabetes within five years unless they lose weight through healthy eating and increased physical activity. Up to 90 percent of people with prediabetes are unaware that they have the condition. Within Intermountain’s service area, it’s estimated that 1 in 20 adults (more than 114,000 people) are living with prediabetes.

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In addition to the Omada pilot the PCCP is leading a system wide Diabetes Prevention Steering Committee with a mission to create a Diabetes Prevention Strategic Plan for 2017 & 2018 to include support for:

- Community Health Improvement
- LiVe Well
- Population Health

HIGH BLOOD PRESSURE
While PCCP continues work with providers on improving the number of patients with high blood pressure who meet their control targets, we are collaborating with the Medical Group to enlist specialists in this endeavor to support population health. We have learned:

- In a review of records in 2015, 14% of patients seen in the NSL InstaCares with a BP of 160/100 or higher, who didn’t have a diagnosis of high blood pressure, were diagnosed with high blood pressure in a primary care office within 6 months.

- In 2015, 363,000 patients were seen in IMG specialty clinics who didn’t have a visit with an IMG PCP. Blood pressure was only measured in 120,000 of those patients. Of the 120,000 patients, 33,000 patients had elevated blood pressure. It is estimated that if blood pressure was measured in all of these patients, approximately 100,000 would have had an elevated blood pressure.

- Extrapolating from these measures, by collaborating closely with specialty clinics who have identified previously undiagnosed patients with high blood pressure, and treating those targeted patients, we could prevent an estimated 340 CVD related events and 78 deaths each year.

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

Pharmacy Services

INTERMOUNTAIN HEALTHCARE COMMUNITY PHARMACIES AND MEDICAL GROUP ADDRESS UTAH’S OPIOID EPIDEMIC WITH NALOXONE

To help decrease opioid overdose and possible deaths from opioids, the Utah State Legislature passed a law to allow the prescribing of naloxone to anyone at risk for opioid overdose, even without a provider-patient relationship. To increase access to this opioid overdose reversal medication, Intermountain Healthcare Community Pharmacies and Medical Group expanded efforts by allowing community pharmacists to prescribe naloxone for at-risk patients, their caregivers, and those who request it according to a collaborative practice agreement (CPA) approved this past January and put into practice May, 2016.

To educate providers and the public on opioid safety and encourage the prescribing of naloxone, Intermountain Community Pharmacies and Medical Group collaborated to put into action:

- Educational materials for providers and patients on opioid abuse and naloxone.
- Standardized prescribing recommendations to ensure safer opioid prescribing methods.
Women & Newborns

CARING FOR PREGNANT WOMEN WITH POSSIBLE ZIKA VIRUS EXPOSURE

ABOUT ZIKA
The Zika virus spreads to people primarily through the bite of an infected Aedes species mosquito (Ae. Aegypti and Ae. Albopictus). People also can get Zika thorough sex with a man infected with Zika, and it can be spread from a pregnant woman to her fetus. (www.cdc.gov/zika)

DIAGNOSTIC TESTING FOR ZIKA
Testing for Zika virus infection is recommended for all pregnant women with possible exposure either (1) through travel to an area with active transmission of Zika virus (http://wwwnc.cdc.gov/travel/notices/) or (2) through sex without a condom with a man who traveled to, or resided in, an area with ongoing transmission of Zika virus regardless of symptoms. Symptoms only occur in about 1 in 5 people and include fever, rash, joint pain, conjunctivitis, muscle pain, and headache (http://www.cdc.gov/zika/symptoms/). Symptoms typically begin 2 to 7 days after being bitten by an infected mosquito. If blood testing for Zika is positive, equivocal, or inconclusive, then the clinician should follow the pregnancy with serial fetal ultrasounds and other tests to detect abnormalities. If the initial blood testing is equivocal, inconclusive, or negative, but a fetal ultrasound detects abnormalities suggestive of viral infection, then blood testing for Zika should be repeated.

REQUESTING LAB TESTING IN UTAH
Utah residents can receive Zika virus testing at the Utah Public Health Lab (UPHL) free of charge. However, testing capacity may be limited; therefore, UPHL and CDC are requesting that you discuss testing by contacting the UDOH, Bureau of Epidemiology at 801-538-6191 prior to testing (available 24/7). An Infectious Disease Test Request Form must accompany the sample. A copy of this form is available at here. Please include your NPI number along with your contact information in the space provided on the form to ensure that you will receive test results.

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SPECIMEN REQUIREMENTS FOR ZIKA TESTING:
Serum (preferred) or Cord Blood specimens:

- Collect serum (preferred) or cord blood (> 3 mL) in a large, red top, SST tube.
- Samples collected and shipped with expected arrival the same day can be shipped on cold packs (4°C); not frozen.
- If storage/transport will exceed 24 hours, serum should be frozen at -20°C or lower and shipped on dry ice to the Utah Public Health Laboratory (UPHL).

Information about additional specimen types (urine, tissue samples [placenta, umbilical cord]) can be found here.

If you have any questions, please contact Ware Branch at Ware.Branch@imail.org or Jean Millar at Jean.Millar@imail.org.


CHOOSING WISELY – MEDICATIONS, PPI’S: SAFETY RISKS ASSOCIATED WITH LONG TERM PROTON PUMP INHIBITOR THERAPY

Proton pump inhibitors (PPIs) play a crucial role in the therapy of disease associated with stomach acidity. Although neutralizing stomach acid can have a healing effect for disease, the inhibition of stomach acid can also alter functions such as the absorption of vitamins, minerals, and medication, as well as the destruction of ingested pathogenic bacteria, which could lead to further disease.¹

Several large studies have been performed to assess the risk of long term use of proton pump inhibitors. One meta-analysis found a measurable increase in hip fracture risk (OR, 1.2) in PPI users, but not in H2 receptor antagonist users.² Both the Nurses’ Health Study and other meta-analysis showed a 30% increase in hip fracture with prolonged PPI use. Also the FDA has modified the safety information on all PPIs and suggested healthcare professionals consider lowering or using PPIs for a shorter duration due to the association with fractures.¹⁰

One study showed an increased risk of Clostridium difficile infection (RR, 1.2-5.0) and other enteric infections with PPI use.³ It was noted, however, that elderly patients and patients with other significant comorbidities may already be at an increased risk of infection. Meta-analyses have shown mixed results for increased risk of community acquired pneumonia with short-term PPI use, and there has been no proven increased long-term risk.⁴

Based on in vitro data as well as initial retrospective studies, the FDA recommended against the use of PPIs in patients taking clopidogrel due to CYP2C19 inhibition leading to increased cardiovascular events. However, since this release, two randomized trials have failed to show an increased risk for adverse cardiovascular events. Meta-analyses have additionally shown that previous work was limited by heterogeneity.⁵ Current guidelines do not support a change in PPI therapy for patients initiating clopidogrel.

Recently, an article addressing an association between PPI use and dementia was published in JAMA Neurology 2016. A 40% relative increase in dementia was seen in 2,950 patients who used PPIs chronically compared with non-users. The implication of this finding is unknown and the authors suggest additional randomized controlled studies to examine the connection in more detail.⁹

Long-term side effects associated with PPI use and acid suppression will need to be weighed against the benefits of the medication. Current guidelines recommend long term acid suppression in patients with erosive disease, stricture, or Barrett esophagus. These conditions have nearly universal relapse by 6 months after cessation of therapy.⁷ In contrast, uncomplicated GERD patients whose symptoms recur after cessation of PPI therapy should consider maintenance therapy, but every attempt

continued on next page
should be made to attempt to taper off and minimize use of PPI medications. Studies have shown that most patients can be managed with intermittent or on-demand PPI therapy. H2 receptor antagonists can also be used as a “step-down” approach to control symptoms.

Contact Roy Gandalfi, MD at Roy.Gandolfi@selecthealth.org or 801-442-7928.


10. UptoDate. Overview and comparison of the proton pump inhibitors for the treatment of acid-related disorders

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>RXSELECT</th>
<th>RXCORE</th>
<th>COMMUNITY CARE</th>
<th>ADVANTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omeprazole*</td>
<td>1 (QL)</td>
<td>1 (QL)</td>
<td>1 (QL)</td>
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<tr>
<td>Pantoprazole</td>
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<td>1 (QL,ST)</td>
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<td>Dexlansoprazole (Dexilant)</td>
<td>3 (QL,ST)</td>
<td>3 (QL,ST)</td>
<td>3 (QL,ST)</td>
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<tr>
<td>Esomeprazole</td>
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<td>Rabeprazole</td>
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**PPI- ORAL CAPSULE**

**PPI- OTHER**

**H2RA**

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<thead>
<tr>
<th>MEDICATION</th>
<th>RXSELECT</th>
<th>RXCORE</th>
<th>COMMUNITY CARE</th>
<th>ADVANTAGE</th>
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<tbody>
<tr>
<td>Prevacid Solutab</td>
<td>3 (QL,ST,AL)</td>
<td>3 (QL,ST,AL)</td>
<td>2 (QL,AL)</td>
<td>4 (QL,ST)</td>
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<tr>
<td>First-Omeprazole</td>
<td>3 (QL,ST,AL)</td>
<td>3 (QL,ST,AL)</td>
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<td>NC</td>
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</table>

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<tr>
<th>MEDICATION</th>
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<th>RXCORE</th>
<th>COMMUNITY CARE</th>
<th>ADVANTAGE</th>
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</thead>
<tbody>
<tr>
<td>Ranitidine*</td>
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<td>1 (QL)</td>
<td>1 (QL)</td>
<td>1</td>
</tr>
<tr>
<td>Cimetidine*</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Famotidine*</td>
<td>1 (QL)</td>
<td>1 (QL)</td>
<td>1 (QL)</td>
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<tr>
<td>Nizatidine</td>
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</table>

* = Product available OTC  
ST = Step therapy  
QL = Quantity limit  
NC = Not Covered  
AL = Age Limit (<13 years old)
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](physician.intermountain.net/selecthealth/policies) and searching by policy number.

### NEW POLICIES

<table>
<thead>
<tr>
<th>POLICY NUMBER</th>
<th>POLICY NAME</th>
<th>EFFECTIVE DATE</th>
<th>SUMMARY OF CHANGES</th>
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</thead>
<tbody>
<tr>
<td>579</td>
<td>🏮 Ligament Sparing Knee Replacement</td>
<td>3/22/2016</td>
<td>Select Health does NOT cover ligament-sparing knee replacement surgery as it is considered not medically necessary.</td>
</tr>
<tr>
<td>578</td>
<td>🏮 Genetic Testing in Hereditary Cardiomyopathies (NEW)</td>
<td>5/4/2016</td>
<td>SelectHealth covers genetic testing for predisposition to inherited hypertrophic cardiomyopathy (HCM) and some cases of dilated cardiomyopathy (DCM) when determined to be medically necessary based on meeting medical criteria noted below. Coverage Criteria: Genetic Testing for inherited cardiomyopathy is covered if: 1. Testing is recommended by a medical geneticist, genetic counselor or cardiologist specializing in inheritable disorders and ANY one of the following: 2. Comprehensive or targeted (MYBPC3, MYH7, TNNI3, TNNT2, TPM1) HCM genetic testing for any patient in whom a cardiologist has established a clinical diagnosis of HCM based on examination of the patient’s clinical history, family history, and electrocardiographic/echocardiographic phenotype. a. Mutation-specific genetic testing is recommended for family members and appropriate relatives following the identification of the HCM-causative mutation in an index case 3. Comprehensive or targeted (LMNA and SCN5A) DCM genetic testing for patients with DCM AND significant cardiac conduction disease (i.e., first-, second-, or third-degree heart block) AND/OR a family history of premature unexpected sudden death. a. Mutation-specific genetic testing is recommended for family members and appropriate relatives following the identification of a DCM-causative mutation in the index case 4. Mutation-specific genetic testing for family members and appropriate relatives following the identification of a Left Ventricular Noncompaction (LVNC) causative mutation in the index case.</td>
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<td>POLICY NUMBER</td>
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<tr>
<td>577</td>
<td>Use of Chromosomal Microarray Analysis (CMA) in Pregnancy (NEW)</td>
<td>5/2/2016</td>
<td>SelectHealth covers use of chromosomal microarray analysis (CMA) in pregnancy when the following are met. A. Any one of the following: 1. Patients with a fetus with one or more major structural abnormalities identified on ultrasonographic examination and who are undergoing invasive prenatal diagnosis. 2. Patients with a structurally normal fetus undergoing invasive prenatal diagnostic testing 3. For fetal demise defined as greater than 20 weeks gestation is covered if autopsy shows dysmorphic features. In this situation CMA has greater sensitivity compared to karyotyping.</td>
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<td>POLICY NUMBER</td>
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</table>
| 584           | Chiropractic Services for Children *(NEW)* | 2/16/2016 | SelectHealth does NOT cover chiropractic care for children <7 years old as current evidence is insufficient to determine efficacy and safety of chiropractic care when provided to this age group. It meets the plan definition of investigational. SelectHealth covers chiropractic care for children ages 7 – 12 under limited circumstances. Criteria for coverage:  
- The child has a specific, chronic neuromusculoskeletal diagnosis causing significant and persistent disability  
- Other conservative therapies have been tried and have failed to relieve the patient’s symptoms  
- Improvement is documented with the initial 2 weeks of chiropractic care |
| 585           | Gastric Pacing/Gastric Electrical Stimulation (GES) *(NEW)* | 5/23/2016 | SelectHealth does NOT cover gastric pacing or gastric electrical stimulation (GES) for intractable nausea and vomiting secondary to gastroparesis as current evidence is insufficient to determine efficacy, durability and safety. This therapy meets the Plan’s definition of investigational/experimental.  
SelectHealth does NOT cover gastric pacing or gastric electrical stimulation (GES) for any other indication including obesity as it is considered experimental, investigational, or unproven. |
| 586           | Gastric Pacing/Gastric Electrical Stimulation (GES) *(NEW)* | 6/6/2016 | SelectHealth covers genetic testing for Rett syndrome in patients who phenotypically suggest the diagnosis.  
SelectHealth does NOT cover genetic testing for All other indications of Rett syndrome, including carrier testing (preconception or prenatal), and testing of asymptomatic family members to determine future risk of disease, are considered investigational.  
SelectHealth covers genetic testing when ordered or recommended by a medical geneticist or genetic counselor that is neither employed nor contracted to provide clinical services for the laboratory or the health system performed the requested genetic test when above criteria are met. |

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<tr>
<th>POLICY NUMBER</th>
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<th>EFFECTIVE DATE</th>
<th>SUMMARY OF CHANGES</th>
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<tbody>
<tr>
<td>587</td>
<td>OPPS (Hospital Outpatient Prospective Payment System) and ASC (Ambulatory Surgical Center) Services Only Covered Inpatient (NEW)</td>
<td>6/1/2016</td>
<td>SelectHealth does NOT cover procedures designated by CMS to only be covered as inpatient procedures when performed in an ambulatory surgical center or outpatient facility. Performance of these procedures in that environment whether it be in an ambulatory surgical center or outpatient is considered Investigational/Experimental.</td>
</tr>
<tr>
<td>588</td>
<td>Peroral Endoscopic Myotomy (POEM) for the Treatment of Esophageal Achalasia (NEW)</td>
<td>6/6/2016</td>
<td>SelectHealth does NOT cover Peroral Endoscopic Myotomy (POEM) for the treatment of esophageal achalasia as it is considered investigational/experimental.</td>
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**REVISED POLICIES**

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<tr>
<th>POLICY NUMBER</th>
<th>POLICY NAME</th>
<th>EFFECTIVE DATE</th>
<th>SUMMARY OF CHANGES</th>
</tr>
</thead>
</table>
| 172           | Reduction Mammoplasty (Breast Reduction) (Revised) | 3/18/2016 | SelectHealth Commercial Plan  
Phrase “Must meet ALL” has been added to under the Coverage Criteria  
Also clarified required of whom can submit documentation for consideration by changing practitioner” to “medical practitioner.” |
| 500           | Infertility Evaluation and Treatment (Revised) | 3/18/2016 | SelectHealth Commercial Plan  
Added:  
• Anti Muellerian hormone (AMH) to Laboratory tests covered as part of the infertility benefit in the evaluation of infertility under female. |
| 158           | Oxygen Coverage (Revised) | 3/24/2016 | SelectHealth Commercial Plan  
Added:  
• Section on portable oxygen concentrators to clarify when these devices are covered. |

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<tr>
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<tbody>
<tr>
<td>494</td>
<td>Cytoreductive Surgery (CRS) with Associated Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (Revised)</td>
<td>3/24/2016</td>
<td>SelectHealth Commercial Plan&lt;br&gt;Updated references and additional language was added to Summary of Medical Information.</td>
</tr>
<tr>
<td>506</td>
<td>Joint Replacement Using Makoplasty (Revised)</td>
<td>4/8/2016</td>
<td>SelectHealth Commercial Plan&lt;br&gt;Clarified exclusion to include not only total hip arthroplasty, but also unicompartmental knee arthroplasty</td>
</tr>
<tr>
<td>553</td>
<td>Urolift System for the Treatment of Benign Prostatic Hyperplasia (Revised)</td>
<td>4/22/2016</td>
<td>SelectHealth Commercial Plan&lt;br&gt;Modified coverage from not covered to covered with limitations which include:&lt;br&gt;• Coverage only for men ≥50 years old&lt;br&gt;• Limit number of implants per procedure to 6&lt;br&gt;• Limit one procedure per lifetime&lt;br&gt;<strong>SelectHealth Community Care:</strong>&lt;br&gt;Policy now reflects Urolift being covered under Community Care.</td>
</tr>
<tr>
<td>337</td>
<td>Cryoablation for Renal Cell Carcinoma (RCC) (Revised)</td>
<td>4/22/2016</td>
<td>SelectHealth Commercial Plan&lt;br&gt;Re-worded the policy for clarification:&lt;br&gt;Conditions for which coverage of cryoablation therapy in the treatment of renal cell carcinoma are allowed include (ANY One Criteria):&lt;br&gt;1. Patients who in the opinion of their surgeon and primary care provider could not tolerate a partial/total nephrectomy due to other underlying chronic medical conditions,&lt;br&gt;2. Patients with reduced renal function identified by a glomerular filtration rate ≤60 ml/min, serum creatinine ≥2.0, with a BUN to creatinine ratio &lt;20/1,&lt;br&gt;3. Patient who are symptomatic from the tumor and have a poor long-term predicted survival outcome due to metastatic renal cancer or other medical co-morbidities,&lt;br&gt;4. Patients renal mass is less than or equal to 3 cm.</td>
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<td>POLICY NUMBER</td>
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</table>
| 554 | Emergency Behavioral Health Services *(Revised)* | 5/5/2016 | SelectHealth Commercial Plan  
- Added language to clarify the definition of emergent state.  
“SelectHealth definition of emergent states - A condition of recent onset and sufficient severity, including severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect that failure to obtain immediate medical care could result in placing a Member’s health in serious jeopardy; placing the health of a pregnant woman or her unborn child in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.” |
| 264 | PET Scans in the Evaluation of Alzheimer’s Disease and Other Dementias *(Revised)* | 5/10/2016 | SelectHealth Commercial Plan  
“FDG” was added to the following:  
SelectHealth covers FDG-PET scans in the evaluation of dementia only when frontal temporal lobe dementia is suspected and other routine testing has failed to determine a definitive diagnosis as current evidence suggests clinical utility of this procedure in this circumstance.  
SelectHealth does not cover other types of PET scans, including FBP-PET, or PiB-PET for this indication based on very limited body of evidence pertaining to the comparative accuracy these tests relative to standard imaging procedures for AD (i.e., MRI, computed tomography) and the very limited evidence regarding the clinical utility for these indications. |
| 260 | DNA Analysis of Stool for Colon Cancer Screening *(Pregen, Pregen-Plus, Cologuard) (Revised)* | 5/17/2016 | Added: an update to summary of medical information was made after recently completed health technology assessment with new references.  
The coverage recommendation has not changed. |
| 514 | Whole Genomic Sequencing *(WGS)/ Whole Exome Sequencing *(WES) (Revised)* | 4/14/2016 | SelectHealth Commercial Plan:  
Coverage language updated:  
SelectHealth covers whole genome sequencing or whole exome sequencing in the evaluation of non-syndromic developmental delay, ataxia, or epilepsy when established criteria are met. |

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<tbody>
<tr>
<td>265</td>
<td>Radiofrequency Ablation (RFA) for Back or Neck Pain (Radiofrequency Neurolysis, Facet Joint Rhizotomy (Revised))</td>
<td>5/15/2015</td>
<td>SelectHealth Commercial Plan:                                                                                                               Added clarifying language under conditions for coverage #2:                                                                                                           Radiologic studies demonstrate no specific, focal deficit that would account for the patient’s chronic pain symptoms; e.g., clinically meaningful disc herniation, stenosis, spondylolysis or spondylolisthesis, instability, bony spur, tumor, fracture etc. that would suggest a competing explanation for the patient’s pain.</td>
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<tr>
<td>297</td>
<td>Genetic Testing: Comparative Genomic Hybridization (CGH)/Chromosomal Microarray (CMA) for Developmental Delay (Revised)</td>
<td>5/26/2016</td>
<td>SelectHealth Commercial Plan:                                                                                                               Extensively Revised coverage criteria. New criteria state:                                                                                                               Criteria for coverage: 1. The test is being ordered by a medical geneticist after receiving genetic counseling 2. The patient presents with a clinical diagnosis of developmental delay 3. Thorough history and physical has failed to establish a definitive diagnosis other than developmental delay 4. Chromosome Analysis has failed to provide a definitive diagnose in patients presenting with dysmorphic features suggestive of specific chromosome abnormality (e.g. Down syndrome, Prader Willi syndrome).</td>
</tr>
<tr>
<td>483</td>
<td>Transcatheter Pulmonary Valve Replacement (Revised)</td>
<td>5/21/2016</td>
<td>SelectHealth Commercial Plan:                                                                                                               Revised language to include Edward SAPIEN XT Transcatheter Heart Valve and also clarified criteria.                                                                                                 New Criteria state: Criteria for coverage: (Must meet 1 or 2 and either 3 a or 3 b) 1. Existence of a full (circumferential) RVOT conduit that was ≥16 mm in diameter when originally implanted 2. Failed Native pulmonic valve and justification for transcatheter valve implantation from a cardiovascular surgeon 3. Dysfunctional Right Ventricular Outflow Tract (RVOT) conduits with a clinical indication for intervention, and either: a. Regurgitation: &gt; moderate regurgitation b. Stenosis: mean RVOT gradient &gt; 35 mmHg.</td>
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<tr>
<td>118</td>
<td>Endoscopic Ultrasonography (EUS) (Revised)</td>
<td>5/31/2016</td>
<td>SelectHealth Commercial Plan:</td>
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<td><strong>Added additional circumstances in which EUS is covered to Criteria for Coverage:</strong></td>
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<td>c.5) Pancreatic pseudocyst drainage after attempt and traditional endoscopic approach</td>
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<td>f.) Non-small cell lung cancer (NCSLC)</td>
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<td>1) Staging of potential resectable known or suspected NSCLS</td>
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<td>g.) Celiac Plexus Neurolysis (when all of the following are met):</td>
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<td>1) Patient has a diagnosis of pancreatic cancer</td>
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<td>2) Pain that is intractable to maximally tolerate narcotic analgesics</td>
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<tr>
<td>561</td>
<td>Vectra DA Blood Test for Rheumatoid Arthritis (Revised)</td>
<td>7/19/2016</td>
<td>Policy updated to reflect recent technology assessment completed on 7/19/2016. Coverage position did not change.</td>
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<td><strong>For Commercial Plans:</strong></td>
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<td>SelectHealth does NOT cover Vectra® DA blood test in the management of rheumatoid arthritis as it is considered unproven and not medically necessary.</td>
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**ARCHIVED**

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<th>POLICY NUMBER</th>
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<th>SUMMARY OF CHANGES</th>
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<tbody>
<tr>
<td>338</td>
<td>Transient Elastography (Fibroscan) (Archived)</td>
<td>5/11/2016</td>
<td>Policy was archived as of 5/11/2016</td>
</tr>
<tr>
<td>236</td>
<td>Robotic Assisted Surgery (Archived)</td>
<td>6/1/2016</td>
<td>Policy was archived as of 6/1/2016</td>
</tr>
</tbody>
</table>

Please contact Ken Schaecher with questions, at Ken.Schaecher@selecthealth.org.
TECHNOLOGY ASSESSMENT ("M-TECH") NEWS AT SELECTHEALTH

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

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

<table>
<thead>
<tr>
<th>Technology</th>
<th>Date Reviewed*</th>
<th>Committee Decision</th>
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<tbody>
<tr>
<td>Cologuard® for Colon Cancer Screening</td>
<td>May 17, 2016</td>
<td>Not Covered for Commercial or Medicaid members. Current evidence suggests Cologuard has strong sensitivity in identifying colorectal cancer. Its sensitivity in detecting earlier adenomas, which is a major focus of colon cancer screening, is poor. Many other more cost-effective tests are available which meet the screening needs. See Medical Policy #260. Cologuard remains covered for SelectHealth Medicare Advantage members as required by the National Coverage Determination (NCD) CAG-00440N.</td>
</tr>
<tr>
<td>Posterior Tibial Nerve Stimulation for Urinary Incontinence</td>
<td>July 19, 2016</td>
<td>Covered for Commercial members. Current evidence has continued to evolve since the last technology assessment was completed in 2012. Though questions persist regarding the most efficacious clinical regimen/protocol for maintenance therapy, the literature has shown meaningful improvements OAB/UI symptoms. See Medical Policy #473. Coverage for SelectHealth Medicare Advantage members continues c/w criteria set forth in Noridian LCD L34226.</td>
</tr>
<tr>
<td>Vectra DA® for Rheumatoid Arthritis</td>
<td>July 19, 2016</td>
<td>Not Covered for Commercial and Medicaid members. Current evidence has demonstrated the clinical validity of Vectra DA/MBDA testing. However, little to no evidence of clinical utility has been published to date, particularly as it relates to alternative lab testing and clinical assessment, to illustrate an improvement in patient outcomes following Vectra testing. See Medical Policy #561. Coverage continues for SelectHealth Medicare Advantage members consistent with Noridian LCD L36255, L36249, L35160 and L36256.</td>
</tr>
</tbody>
</table>

*Date Reviewed does not necessarily reflect the date of implementation of coverage policy.
Other technologies currently under active assessment by the M-Tech Committee are scheduled to include the following. As the reviews are completed, notices will be sent to stakeholders accordingly to inform them as to SelectHealth’s coverage determinations:

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

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.

SELECTHEALTH SHARE SUPPORTS POPULATION HEALTH

Intermountain Healthcare providers are seeing more SelectHealth Share patients—accelerating our transition to the population health model and underscoring our commitment to more affordable healthcare costs.

SelectHealth Share is a commercial health plan product for large employers that is based on Intermountain’s Shared Accountability principles and population health model of care. The plan became available in January 2016 and currently covers more than 10,000 lives. Everyone in this plan shares accountability for maintaining the health of the plan’s members:

- Employers support and engage their employees in a culture of health
- Employees actively participate in making decisions that affect their health, their care, and its cost

Providers participate in a payment model in which compensation reflects productivity, quality, patient experience, and plan performance (total cost of care)

SelectHealth provides benefits that promote member health

Providers will continue to see more patients covered under Share and other similar plans based on population health principles (such as SelectHealth Advantage for Medicare-eligible members and SelectHealth Community Care for Medicaid eligible).

SelectHealth Share supports better health and better outcomes, as well as offering more affordable and predictable premiums.

For more information, visit SelectHealthShare.org or contact your SelectHealth provider relations representative.
THE COST OF PHYSICAL INACTIVITY

It is no surprise to anyone that physical activity is good for health, and physical inactivity detrimental to health. As it relates to healthcare, physically active people have lower rates of chronic disease, and utilize less healthcare than inactive people — and this translates into HUGE cost savings, for the system, for payers and for individuals.

Four years ago, The Lancet, published what was referred to as “The Physical Activity Series”, a series of articles examining the relationship between physical activity/inactivity and health. It was from one of those articles that the phrase, “sitting is the new smoking” came; after it was determined that global deaths/year from sedentary lifestyle exceeded global deaths/year from smoking.¹

The Lancet Physical Activity Series 2 was released August 1, 2016. In it, the article entitled, “The economic burden of physical inactivity: a global analysis of major non-communicable diseases”, estimated both direct healthcare and indirect costs (e.g. productivity losses, disability adjusted life years) of physical inactivity. It’s worth examining the details of how they calculated the costs of physical inactivity, because it is one aspect that makes this paper unique:

NINE STEPS TO ESTIMATE GLOBAL HEALTHCARE COSTS OF PHYSICAL INACTIVITY:

1. Identify major non-communicable diseases where physical inactivity is a recognized risk factor
2. For each disease, quantify the relative risk (RR) as a result of physical inactivity
3. Quantify prevalence of physical inactivity for each country
4. Calculate country-specific adjusted population attributable fractions (PAFs) to quantify the fraction of each disease (from Step 1) that is attributable to physical inactivity
5. Estimate the total number of cases for each disease in each country
6. Estimate the average annual costs per case of disease for each country
7. Calculate disease-specific and country-specific health-care costs attributable to physical inactivity based on estimates from Steps 4–6
8. For each country and globally, quantify the total health-care costs attributable to physical inactivity by summing across disease-specific estimates from Step 7, and subtracting potential double counting between diseases due to common comorbidity
9. Address the “who pays” question by estimating the health-care costs paid by the public sector, private sector or third party, and households within each country, and sum the costs for each sector across countries

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When all this was done, the estimated total (direct + indirect costs) global costs of physical inactivity in 2013 were more than $67 billion. Direct healthcare costs were estimated at $54 billion globally, of which nearly $26 billion was borne by the United States. While these numbers are extraordinarily high, they likely underestimate the total costs, as only 5 non-communicable diseases where physical inactivity is a recognized risk factor, were included in the analysis (Type 2 diabetes, CAD, stroke, colon cancer, and breast cancer).

As a healthcare system, and more importantly as a nation, we MUST get upstream of costly chronic disease. We can no longer afford to spend finite resources on treating conditions that could be avoided by healthier lifestyles. Stay tuned to efforts from Intermountain’s LiVe Well program to promote “11 Healthy Habits”. Topping the list of those habits is regular physical activity. Not only is exercise medicine, but it is money in the bank!

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