medical staff NEWSLETTER

November 2014

volume 52, issue 11

From the President

"When you are content to be simply yourself and don't compare or compete, everybody will respect you."

"Kindness in words creates confidence. Kindness in thinking creates pro-foundness. Kindness in giving creates love."

– Lao Tzu

"Anger and hatred are two of our closest friends. When I was young I had quite a close relationship with anger. Then eventually I hound a lot of disagreement with anger. By using common sense, with the help of compassion and wisdom, I now have a more powerful argument with which to defeat anger."

– Dalai Lama

Physicians and Stress

Working in the ever rapid changing medical environment has posed a major stress to all health care providers. Physicians are among the ones that have suffered the most from these changes. Stress through various gradual changes could turn a productive, happy, and passionate doctor to an agitated and an intimidating person.

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Flu Season Has Begun!

November 1 is the official start of the influenza season. The Pasadena Public Health Department, under the authority of §120175 of the CA Health and Safety Code, has issued that healthcare workers must either be vaccinated or wear a mask in order to prevent the transmission of the influenza virus to patients; flu season is defined as November 1, 2014 – March 31, 2015. Healthcare workers who get vaccinated will be issued a sticker that will be placed on their badge identifying them as vaccinated. Those who decline the vaccination must wear a surgical mask when they are within three (3) feet of patients.

If you would like to get vaccinated, you can come to Employee Health/HACC, between the hours of 7 a.m. – 4:30 p.m., Monday – Friday, for a free vaccination (your sticker will be issued after being vaccinated).

If you have already been vaccinated, please complete the Seasonal Flu Vaccine Attestation or Declination Form and return it to the Medical Staff Office either via fax (626-397-2912) or email bianca.irizarry@huntingtonhosptial.com. If you have submitted the form you may obtain your sticker in the Medical Staff Office between the hours of 7 a.m. – 4:30 p.m., Monday – Friday.

Inside this issue:

Holiday Party is December 5. Remember to RSVP.

Huntington Hospital

Board Meeting

As provided by the Bylaws of the Governing Body and as the designated sub-committee of the Governing Board the following items were presented and approved by the Medical Executive Committee of October 6, 2014 and by the Governing Board on October 23, 2014.

Administrative Reports

Announcements

Meeting Attendance Rewards
The following raffle tickets were selected for the September 2014 meeting attendance awards:

- **Mehrangiz Mofid, MD** – Anesthesia Section
- **Douglas Willard, MD** – Emergency Medicine Section

Medical Staff Rules and Regulations

The following proposal was recommended for approval by the MEC and will be disseminated to the Medical Staff for comment prior to referral to the Board of Directors for approval:

- Every medicine patient in the CCU needs to be managed or co-managed by an intensivist. The attending physician may choose which intensivist or intensivist group they wish to consult – from the list of HMH credentialed intensivists.
- For every CCU medicine patient – the intensivist is responsible for triage into and out of the CCU.

Miscellaneous

Revised Sedation/Analgesia Privileging Criteria

A revised Sedation/Analgesia Self-Study guide and post test has been developed. Revised privileging criteria has been approved as follows:

a) ACLS/PALS certification will be required for all physicians requesting Sedation privileges, with the exception of the following specialties: Anesthesiology, Pulmonology, Critical Care Specialists (adult and pediatric), Cardiologists and Board Certified Emergency Medicine specialists. The effective date of the new requirement will be April 1, 2015.

b) All physician requesting Sedation privileges (except for anesthesiologists) will be required to complete an airway management course. The effective date of the new requirement will be April 1, 2015.

Privilege Sheets

Anesthesiology Privileges – Revision of the neonatal/pediatric anesthesia privilege criteria.

Please go to SharePoint → Medical Staff Services → Board Approved Items → 2014 and select October 2014 to see:

- Administrative Policies and Procedures
- Formulary Management
- Standardized Procedures
- Department Specific Policies and Procedures

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Medical Staff Services Corner

Physician Parking Space is at a Premium

Have you noticed that the parking spaces always seem to be full in the Doctors Lot? Be considerate of your colleagues who need to park while conducting hospital business. Please don't allow your staff or other non-physicians to park in the lot. Please also note that this lot is not meant for long-term parking.

Medical Staff Appointments

Albin, Michael, MD
General Surgery
800 South Fairmount Avenue
Suite 419
Pasadena, CA 91105
626-584-6116 (phone)

Sentovich, Stephen, MD
Colorectal Surgery
City of Hope
1500 East Duarte Road
Duarte, CA 91010
626-471-7100 (phone)
626-301-8113 (fax)

Yeh, Jennifer, MD
Dermatology
HealthCare Partners
50 Bellefontaine Street
Suite 104
Pasadena, CA 91105
626-304-6300 (office)

Medical Staff Resignations

- Alsoufiev, Alexander, MD – Internal Medicine
- Arya, Shashank, MD – Physical Medicine & Rehabilitation
- Brown, Warren, MD – Internal Medicine
- Bui, Kim Chi, MD – Neonatology
- Chen, Mike, MD – Neurosurgery
- Don, Debra, MD – Otolaryngology
- Ho, Frederick, MD – Allergy and Immunology
- Ke, Malcolm, MD – Internal Medicine
- Koetters, Peter, MD – Pediatrics
- Suzuki, Shuichi, MD – Neurology
- Urrea, Paul, MD – Ophthalmology
- Williams, Richard, MD, PhD – Internal Medicine

Allied Health Professional Appointments

- Leong, Deborah, PhD – Clinical Psychology
- Phan, Alexander, PA-C – Physician Assistant

Allied Health Resignations

- Fujimoto, Lisa, PA-C – Physician Assistant
- Sutherling, Jeri, NP – Nurse Practitioner
- Wheelock, Lesha – Perfusion Assistant
- Woolsey, Malia, NP – Nurse Practitioner

From the **President** continued from page 1

For example, Dr. X, a 50-year old physician, was proud and passionate on his role as a practitioner. He was energetic and ready to offer assistance when needed; however, over time, his behavior had changed drastically towards the employees at his office and hospitals and towards his peers. His productivity had dropped, and his job satisfaction plummeted. Some of the changes that had happened to Dr. X included (see if the followings ring a bell with you):

- From being jovial and easy to interrelate with to angry and irritable person
- Showing up late and showing no immediate response when consulted, and appearing stressed with no smile
- Negative perspective change on the feeling of medical career when approached (such as patients do not recognize what you do for them)
- Yelling and disrespecting other staff members
- Expressing temper with unprofessional behavior such as throwing medical tools or working equipment to the floor
- Making complains on minor changes such as schedules or questioning the competency of the junior staff
- Becoming more isolated with zero or minimal interest to intermingle with fellow peers or staff
- Appearance of being more depressed
- Relying on substances to get through a working day
- Developing churning attitude towards family, friends, and fellow workers who offer assistance

When the conditions become worse with Dr. X's efficiency, his expected quality medical care to his patients was poorly delivered. Immediate intervention from the medical staff was called upon to address the impact on the safety of patients. The Chief of Staff had to meet with him to respond to the change in attitude and behavior.

Research and surveys have established external and internal factors that may attribute to a

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change in attitude and behavior of a physician. The first objective of every physician, after completion of many intense years of study and training, is to offer quality services to patients, and to establish a successful, respectable, and rewarding career. This objective was subject to multiple challenges over the years due to many levels of medical reforms. Outside surveillance and regulations by various government agencies coupled with the demand in quick updating of the expanding medical knowledge, the decrease in reimbursement on services rendered, the call for perfect management from patients, and the constant scavenger hunt attitude of trial lawyers, makes the stress on physicians raised to an extremely high level. In 2000, many medical reforms took place upon the introduction of the IOM statement ("To Err Is Human"), which analyzed the high death rate caused by unintended medical result of medical intervention. This led to the emergence of the policies: pay for improved and quality services or do not pay for poor services, and making medicine a business that is based on external monitoring players. The emergence of these legislations had changed the Medicare reimbursement rate in which many physicians considered it to be inadequate in compensating the services that were rendered. These reforms exerted tremendous pressure on physicians in changing their thinking and the ways they practice medicine.

Analyses on physicians' level and response to stress

The changes in the health care have created stress in many health care providers. Many physicians may develop a few to many attributes that are similar to Dr. X. An article published in the 2009 Annals of Surgery indicated that 40% of surgeons reported being burned out and 30% showed positive depression symptoms. The burnout rating was attributed to be the greatest forecaster of career satisfaction. Some reports even revealed that the problem of career satisfaction can be traced back to the medical schools, with one of the report indicating a 50% burnout rate occurred in medical undergraduate with 10% undergoing certain limits of suicidal thoughts. In a survey carried out by the Global Physician's Foundation, 79% of physicians believed that medicine had changed to the point that it was minimally rewarding or not being rewarding at all. Many physicians expressed their opinion that "it does not pay" to practice medicine. Up to 49% of the physicians confessed that they planned on reducing the total number of patients in the coming years. Work satisfaction has been linked not only to affect the personal life of the physicians but also the quality of medical service. Stress, burnout, fatigue, and work dissatisfaction hinder effective staff relationship and performance efficiency, and contribute to the growing medical errors, and increase the possibility of legal proceedings. All these things create threats to the quality ultimately delivered to patients.

Managing stress

Helping physicians to deal with these challenges is not easy. First, it is necessary to get physicians to differentiate and understand that they have a problem. According to several research studies, many physicians do not even recognize a problem exists. Many of them think many problems naturally come with their job. This makes them become desensitized to specific sentimental components. Lack of recognition and denial of early situations will lead to the continuation of unresolved problems which could progress to be more difficult to resolve in the future. Secondly, there is difficulty in persuading physicians to allow others in participating in solving their problem. Stigma and thoughts of opening themselves to another person is one of the factors that hinder physicians to share their problems. Most of them feel they

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can manage the pressure themselves and need no external assistance. Others may fear opening up to others may lead to others questioning their integrity.

Denial and reluctance to allow others to intervene are the major hindrances towards successful stress management. Physicians should realize that failure to share severe problems can lead to burnout, hopelessness and even substance abuse. Ultimately, these problems can not only affect their patient care but will also affect their lives and families. Sharing a problem is an important step towards establishing a solution.

The earlier the physicians recognize that they are not invincible, the earlier for them to take steps towards dealing with the situations more effectively. The following techniques may offer assistance for physicians in overcoming some of their problems:

- Raising awareness on the toll of stress on mind and body such as physical symptoms (chest pain, headaches muscle pains or panic) or subtle symptoms (irritability, anger, apathy or isolation), after which they can be able to establish measures to curb them.
- Recognizing the impact of stress on self and others.
- Willingly accepting outside assistance.
- Overcoming barriers to seeking support and moving forward.
- Reaching out to family, friends and peers (stop isolating themselves), and trying to interact with them and share problems.
- Identifying self-help strategies such as life style, stress, and anger managements.
- Taking advantage of internal physician wellness program.
- Utilizing outside coaching and mentoring services.
- Utilizing professional counselors or therapists.
- Opting for careercounseling to re-energize, diversify, change model or profession, or even retire.

The strategies on the left are designed as ways to help physicians understand their environment and also provide tips that will enable them to adjust positively on their surroundings, increasing their satisfaction and productivity. In addition, various organizations offer different type of services in creating comprehensive therapy sessions especially if the condition is intense.

Moving forward

When the situation appears to be untamed, some physicians may consider making a turning point on their career path. After analyzing various reasons for their stress, physicians may opt to innovate and diversify their current model of practice such as:

- Switching current model of practice or integrating them
- Changing locations, such as, from large town to small
- Joining another practice within the medicine field
- Opting out of medical career when the condition worsens
- Continuation of mentoring process to avoid pitfalls
- Using medical skills in other ways such as writing other than practicing directly

Once the decision in making a major change in their career has been made, physicians should select the following evaluation process to enhance the success of their career goals:

- Creating a timeline to evaluate the career and what one wants from it e.g. setting goals and making adjustments
- Investigating and innovating new ideas e.g. researching on areas of interest and joining appropriate health care or business organization
- Spreading the word by updating CV, utilizing social media, establishing a website, creating networking opportunities, and enhancing exposure

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From the **President** continued from page 5

- Initiating a personal branding strategy such as focusing on experiences, interests and strengths

Conclusion

Stress can cause damages to a physician's personal life and career. The rapid changes in the field of medicine create many challenges to physicians and demand physicians in making major adjustments in not only their career but also their lives. Dealing with stress should be introduced at medical schools and continue with the residency training. Proactive support also needs to be enacted in dealing with the physician stress and burnout. Early intervention likely will yield positive results.

The combined efforts from a physician's family, friends and colleagues, is the key to offer early interventions which will provide better chances for success in the future.

The MEC and medical staff office at Huntington is committed to assist all the physicians at Huntington. We will utilize all our available resources to help our medical staff to have successful career at Huntington. Therefore, please feel free to contact me or any of our staff if you need assistance. Nothing is too small or too big for us to offer our service to you.

Edmund Tse, MD
President of the Medical Staff

From the **Health Science Library**

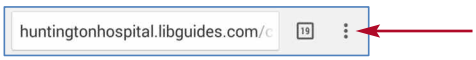
Add the Library's Resources to Your Mobile Device Home Screen

Adding the library's website and electronic resources to the home screen of your mobile device is a cinch and provides you with one tap access to a wealth of trusted medical information.

Here's how:
Step 1: Use your browser of choice to navigate to: http://huntingtonhospital.libguides.com
Step 2: Tap on the share icon (or menu icon in Android):

iPad using Safari Browser:

Android using Chrome Browser:



Step 3: Tap on the **Add to Home Screen** option
Step 4: Tap **Add**

To add library's resources individually, follow the above steps using the following URLs:

- OvidSP: http://ovidsp.ovid.com/autologin
- ClinicalKey: http://www.clinicalkey.com
- AccessMedicine: http://accessmedicine.mhmedical.com
- Natural Standard: http://huntington.naturalstandard.com
- R2 Library: http://www.r2library.com
- Gale Databases: http://go.galegroup.com/ps/start.do?p=HRCA&u=pasa63450&authCount=1

Users accessing the library's electronic resources from on-site via the hospital wi-fi are automatically logged in. For mobile access off-site, a username and password for each resource can be set up. Contact the library at (626) 397-5161 or library@huntingtonhospital.com, or submit a **Request Off-Site Access** form in the **ASK A LIBRARIAN** box on the library's website at: http://huntingtonhospital.libguides.com

Physicians Inspiring Donors: Dr. Mark Powell

Dr. Mark Powell seated with one of his young patients.

Grateful patients make generous donors and, according to nationwide data, physicians are overwhelmingly influential to a donor's decision to make a gift to the hospital. Each year, charitable support for Huntington Hospital fills the ever-widening gap between revenue and expenses, helping to pay for the critical programs, facilities and services that today's informed patients demand. The Office of Philanthropy at Huntington Hospital is grateful for the exceptional physicians who help us engage potential donors.

Recently, Dr. Mark Powell, former Chair and current Vice Chair of Pediatrics at Huntington Memorial Hospital, has assisted the Office of Philanthropy in a number of important and impactful ways. Dr. Powell strongly influenced SCRUBS donors – the hospital's dynamic group of young philanthropists – to launch a three-year Campaign for Pediatrics, which will be completed this year. In that time, Dr. Powell has attended numerous SCRUBS events as a passionate and forthright advocate for Huntington Hospital's young patients. Most recently, Dr. Powell helped facilitate a multi-million donation to Pediatrics from a grateful family whose children and grandchildren he cares for. This transformational gift would not have been possible without Dr. Powell's exceptional dedication to his patients and his willingness to partner with the Office of Philanthropy.

The Office of Philanthropy is exceedingly grateful to all our physician-partners – like Dr. Mark Powell – who go above and beyond the call of duty to engage donors in a meaningful way and help us transform grateful patients into generous donors. We look forward sharing more stories about physicians inspiring donors in future issues of this newsletter.

If you would like more information about working with potential donors, please contact Tracy Smith at (626) 397-3241 or tracy.smith@huntingtonhospital.com.

From **Physician Informatics**

Recent HANK Changes

The Medical Staff Task Forces have been busy working improving the HANK system and associated workflows. Below is a summary of the major accomplishments in the past month:

- The **Patient Name Search** has been enhanced to produce more results.
- A system change was made so that it will **not allow you to enter orders on discharged accounts**. However, prescriptions can still be placed on discharged accounts.
- **The NPO diet was modified to allow for exceptions** (ex: sips or ice chips).
- Under PowerNotes, a **Surgery folder** was added. Additionally, **changes were made to the Cancer Staging & Attestation** notes to make these easier to locate.
- The **Billing Worksheet** was modified so that you can preview it prior to printing.
- **Fetal Link** has been installed in the Maternal Child Health area and is available to all OB physicians remotely.
- The **Results Review quick view list is now sorted in alpha order**.
- The **clinical range for Lab and Vital Signs under Results Review displays 7 days**.
- The **Discharge Readiness** page has been **reorganized to move the required sections to the top of the screen (highlighted in yellow)**. If you have customized your Discharge Readiness page, you will need to reset or clear your preferences for this change to take affect.

Chart Search

A new feature has been implemented, which is called **Chart Search**. This provides the **capability to perform a 'search' of the patient chart and works similar to other**

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Physician Informatics continued

commercial search engines. This function enables you to search the chart for information that has been entered into Cerner on or after March 1, 2014. Some of the information available is clinical and physician documentation, transcribed reports, radiology and pathology reports, vital signs and laboratory results. There is a one-page handout on this new feature is available in the physician lounges, documentation rooms, and the physician informatics office.

Medication Reconciliation (Medicine Task Force)

The physician training guide on the medication reconciliation workflow has been finalized. If you haven't received a copy of the brochure, there are copies in the physician lounges, documentation rooms, as well as in the physician informatics office. In addition, nursing is in the process of completing their training on this workflow.

If you would like one-on-one assistance with the medication reconciliation workflow, Chart Search, or other HANK workflows or functionality, please contact physician informatics at ext. 2500.

From the **Clinical Documentation Specialists**

The surviving Sepsis Campaign of 2012 is recommending more frequent diagnosis of Sepsis with earlier intervention. Consider the diagnosis of "Suspected Sepsis" for all of your patients who have an infection and meet the SIRS criteria. Please document this diagnosis on the History and Physical and/or Progress Notes when appropriate.

SIRS (Systemic Inflammatory Response Syndrome) = Any 2 of the following 4:

Temperature >38C (100.4F) or <36C (<96.8F)

Respiratory rate >20 or PaCO2 <32mmHg

Heart Rate >90bpm

WBC >12,000/mm3, <4,000/mm3 or >10% bands

SEPSIS

* Any 2 of the 4 SIRS criteria PLUS a suspected source of infection (pneumonia, UTI, cellulitis, device, etc.) ALWAYS document the source, if known.

SEVERE SEPSIS

* Sepsis PLUS one/more organ dysfunction not considered chronic for the patient
* SBP <90mmHg or MAP <65mmHg
* Lactic acid > upper limits of normal
* Urine output <0.5mL/kg/hr for > 2 hours despite adequate fluid resuscitation or SCr >2
* Bilirubin > 2 mg/dl
* Platelet count <100,000
* Coagulopathy (INR > 1.5)
* Acute lung injury with PaO2/FiO2 <250 in the absence of pneumonia as the infectious source
* Acute lung injury with PaO2/FiO2 <200 in the presence of pneumonia as the infectious source.

SEPTIC SHOCK

* Severe Sepsis with hypotension despite adequate fluid therapy/requiring vaso-pressors, OR Lactic acid > 4.0

Documentation examples:

"Sepsis secondary to UTI" instead of Urosepsis. DO NOT DOCUMENT Urosepsis.

"SIRS from a non-infectious source" if SIRS without an infection (i.e. Pancreatitis or Lupus)

Man vs. Machine (Cerner Clash)

By: Charles F. Sharp, Jr. MD

Huntington Hospital abandoned paper records forever and entered the cyberspace entirely on March 1, 2014. Farewell to palpable paper charts, personalized medical archives and indecipherable written medical orders.

The Cerner system is cumbersome, tedious, and counterintuitive. The program seems to abandon common sense and demand adherence to an obtuse organizational matrix with a unique terminology; if the computer were a patient, one would suppose it was deficient in word-finding skills. Most physicians hate the system. Arbi Khodadadi, MD, summarized the distaste brilliantly by positing this scenario: Visualize the cockpit of an aircraft designed, not by pilots and engineers working in concert, but rather by the CEO of the airline who had never himself flown an airplane, but conceived a workflow situation based on his personal concept of how a pilot should fly an airplane.

There are certainly tangible advantages to the electronic health record (EHR). Records are neat, legible, organized, and readily accessed. Prescriptions can be sent at the speed of light to any pharmacy that has a computer (this works about 50% of the time, in my experience). Sharing information can usually be accomplished with a phone call or two, although there remains the nagging problem of integrating information from so many other computerized systems that simply cannot link together. Ironically, one of the major endorsements for computerizing medical documents was to prevent wasteful redundancy-having to reorder tests that had been performed elsewhere but were unavailable. President Obama stated in a famous speech in 2009 that the EHR would save taxpayers $8 billion a year, once implemented, eliminating duplication of laboratory and imaging studies. (Not going to happen.)

Another major goal of the EHR was to prevent errors and protect patients from medical interventions that might cause harm. Prescribing medications has subsequently become an exercise in engaging the computer and convincing the machine to accept a therapeutic strategy. Suppose, for example, I elect to prescribe intravenous potassium chloride for hypokalemia. Before I can do so, the machine warns me that my patient may experience an adverse reaction because she is currently taking Benadryl. I ask myself, what possible interactions exist between Benadryl and potassium? The computer informs me that there have been interactions between ORAL potassium chloride and oral Benadryl, which may result in delayed absorption or intestinal injury. But IV potassium? No data. The consequence of such redundant admonitions is a state of "alert fatigue." Studies have shown that over 90% of computer warnings are overruled by physicians. This raises an important issue: does the EHR help prevent errors, or does the system itself, by interrupting the physician's train of thought, serve as an annoying distraction?

Many physicians view the human/computer interaction as a deleterious one. Some evoke the scene in 2001: A Space Odyssey in which the astronaut Dave, after unsuccessfully attempting to rescue his colleague, asks the HAL 9000 computer to permit his re-entry into the spacecraft. "HAL" had earlier murdered all of the other members of the expedition.

> "Open the pod bay door, please, HAL."
>
> "I'm afraid I can't do that, Dave.
> This mission is too important to
> be jeopardized by humans."

How "smart" are computers, actually? Clearly, these machines have incredible powers to process and calculate, but can they "think"? IBM's Deep Blue edged Gary Kasparov in a chess match in 1997, although Kasparov complained

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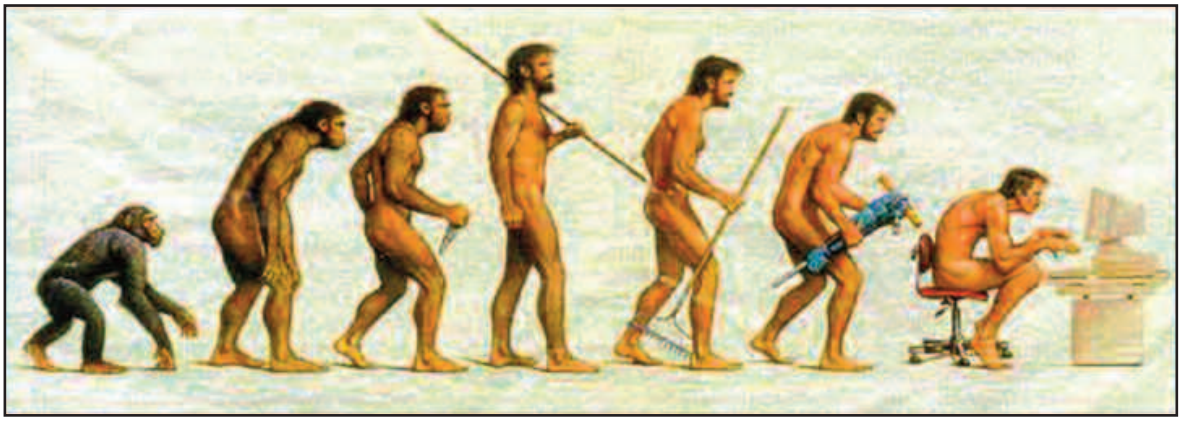
Man vs. Machine continued

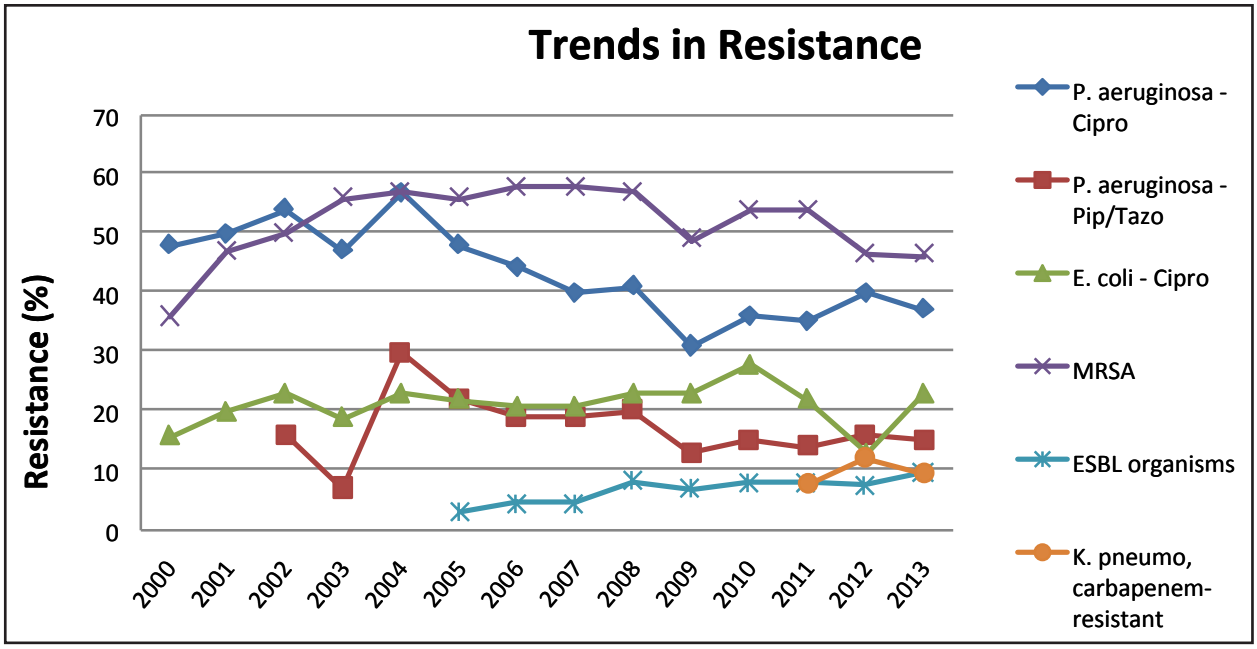
IBM cheated. IBM scientists now claim in their "5 in 5" strategy that their next generation of computers will be able to communicate telepathically with humans, making our interactions seamless. Mature readers, however, may recall the terrible fate of the Krell people in the movie, Forbidden Planet, in which computers amplified thought and emotion, resulting in "Monsters of the Id." Suppose one harbored availed distaste for a disagreeable patient: would the computer scheme to cause harm? (Isaac Asimov long ago addressed this concept in his novel, *I, Robot* and we all know what happened.) Not to be outdone by IBM, Google designed its own supercomputer using 16,000 computer processors hooked up to Google's secretive machine learning neural network and aspired to induce the machine to function like the human brain. Their scientists then offered this supercomputer access to a million videos on the internet. When I ask people to guess what it did, most answer either that it watched porn or it crashed. In fact, it did neither. This "monster" computer casually viewed *cat videos*! Google's computer network apparently put together a fuzzy image of a kitten because it began to recognize and identify cats from their frequent appearances on YouTube.

Most physicians have successfully developed a technique of incorporating the computer into the patient encounter. I like to spend some time talking with the patient, face to face, maintaining eye contact. Next, I "input" the necessary items into the computer. Lastly, I examine the patient. There can no replacement for hands on care. It's backwards, of necessity, but it can work, and most patients appreciate that these machines are ubiquitous in almost every business in America in this century. After all, nearly everyone, from checkout clerks in supermarkets to corporate CEOs, is forced to use computers; and outside the software industry, hardly anyone likes dealing with them. One of my patients informed me that the secret was just to "Surrender to the computer. Give it what it wants." And that is what most of us reluctantly end up doing. I have determinedly forced myself to stop grumbling about what I considered expensive and useless spyware, and, instead, when things get tedious, imagine the poor computer abandoning its monotonous robotic tasks and watching kittens frolicking on carpets, sleeping with puppies, chasing yarns of twine; exultant in its internal bliss. Perhaps they really do think like humans, or perhaps they are lazy and absurd machines – or both.



HUNTINGTON HOSPITAL 2013 ANTIBIOGRAM TRENDS

Pamela Ny, PharmD; Annie Wong-Beringer, PharmD; and Paul Nieberg, MD
September 2014



Huntington Hospital (HH) antibiogram is updated every year with antimicrobial susceptibility data on organisms isolated from patients at HH. The antibiogram can be accessed from Sharepoint by selecting Clinical Laboratory Information and the Antibiogram tab in the left column. Data obtained are used to monitor trends in antibiotic resistance and to make empiric antibiotic choices as well as formulary decisions.

Gram-negative pathogens – Rates of resistance have decreased overall for all agents against Pseudomonas, with the most notable decrease in resistance towards meropenem 16% (26%) and gentamicin 14% (25%) when comparing 2013 to (2012). Combination therapy with piperacillin-tazobactam plus tobramycin remains the empiric regimen of choice with resistance rates of 15% and 11%, respectively.

Notably, carbapenem-resistant *K. pneumoniae* (CRKP) isolates currently accounts for 9.4% of all *K. pneumoniae* isolates. The rates of resistance among the CRKP isolates tested against last resort agents, colistin and tigecycline, are 29% and 17%, respectively. Despite resistance to the carbapenems, published studies indicate that treatment with a carbapenem-containing regimen in combination with colistin, gentamicin and/or tigecycline for invasive CRKP infections yielded the best outcome. Increased meropenem prescribing at HH over the past several years has no doubt contributed to the isolation of multi-drug-resistant organisms such as *Pseudomonas* and CRKP. Ertapenem (a narrower-spectrum agent in the carbapenem class) was added to HH Formulary in April 2013 to displace the use of meropenem. Ertapenem is approved for the following: treatment of infections caused by ESBL+ organisms with documented sensitivity; mixed infections involving multidrug-resistant gram-negative organisms in patients who are ready for discharge and are expected to continue treatment in the outpatient setting. Note that ertapenem is NOT active against *Pseudomonas*,

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Antibiogram Trends continued

Enterococcus, and *Acinetobacter* species. Since the addition of ertapenem, there has been a decrease in meropenem use which in turn has led to a decrease in CR *Pseudomonas* and CRKP.

Of concern, *E. coli* resistance to ciprofloxacin has increased by 10% likely related to the use of ciprofloxacin for urological surgical prophylaxis. Cefazolin is the recommended antibiotic in this setting according to the 2013 Clinical Guidelines for Antimicrobial Prophylaxis in Surgery. It is important to recognize that overuse of the fluoroquinolones induces an over expression of broad-substrate efflux pump in *Pseudomonas* capable of extruding structurally-unrelated compounds, thereby selecting for strains with multidrug resistance. Thus, continued restraint in ciprofloxacin use at HH is crucial in preserving utility of all anti-pseudomonal agents.

Gram-positive organisms – The overall rate of *S. aureus* (both methicillin-sensitive, MSSA, and methicillin-resistant, MRSA) infections has declined from the previous year. Interestingly, a reversing trend is observed now with isolation rate of MSSA exceeding that of MRSA infections. While the increasing prevalence of MRSA has prompted clinicians to prescribe anti-MRSA empiric therapy for skin and soft tissue infection, a recent study showed no additional benefit when anti-MRSA agents were prescribed for non-purulent cellulitis [Pallin DJ, 2013] which is consistent with current guideline recommendations that a beta-lactam agent (i.e. cefazolin) directed against streptococcal species be prescribed [Liu C, 2011]. Vancomycin remains the preferred anti-MRSA agent for patients needing parenteral therapy who do not have documented allergy or significant renal dysfunction. If the patient has documented MRSA as a causative pathogen of skin and soft tissue infection and allergy to vancomycin or significant renal dysfunction, ceftaroline is an alternative parenteral therapy. Oral agents with excellent bioavailability and activity against MRSA such as doxycycline (99%) and Bactrim (98%) may be used to facilitate the transitioning of patients to outpatient therapy when appropriate.

The rate of *C. difficile* infections (CDI) has increased from 2012. Hospital acquired C. *difficile* occurred at 0.58 (0.50) per 1000 patient days. A clinical guideline for the management of *C. difficile* infections approved by PT&D at HH has been developed since March 2013 to assist clinicians in the diagnosis and management of CDI. The guideline can be accessed via the Pharmacy portal in Sharepoint and the Infectious Disease Corner tab located in the left column.

Summary – The increased use of ertapenem instead of meropenem for non-*Pseudomonas* ESBL infections has helped reduce the rate of CRKP and carbapenem-resistant *Pseudomonas*. Cefazolin (not fluoroquinolones) should be used for urosurgical prophylaxis to decrease selection of FQ resistance. Vancomycin should be considered as first line for empiric therapy in suspected MRSA infections with discontinuation or de-escalation when appropriate; alternatives such as ceftaroline should be considered in those with documented MRSA skin soft tissue infections or known history of MRSA colonization/infection and have significant renal insufficiency or demonstrated lack of response.

EPILEPSY DAY DISCUSSION

Date: Tuesday, November 4, 2014
Time: 10:30 a.m. – 1 p.m.
Location: Braun Auditorium

Dr. William Sutherling and Dr. Ian Ross will be discussing the Huntington Epilepsy and Brain Mapping Program.

The Medical Staff would like to send out a special thank you to Dr. David Man and Dr. Kimberly Shriner for all their time and effort in leading the Ebola Task Force and handling this time sensitive issue.

CME Corner

MEDICAL GRAND ROUNDS

Topic: Determining Brain Death via Neurological Guidelines
Speaker: Paul Vespa, MD
Date: November 7, 2014
Time: Noon - 1 p.m.
Place: Research Conference Hall
Audience: Primary Care, Neurology
Methods: Lecture
Credits: 1.0 *AMA PRA Category 1 Credits™*

SECOND MONDAY

Topic: Influenza, Pertussis, or Ebola: Which is Worse?
Speakers: Kimberly A. Shriner, MD
Date: November 10, 2014
Time: Noon - 1 p.m.
Place: Research Conference Hall
Objectives:
1. Have knowledge about the impact of influenza on the general population and the healthcare system.
2. Recognize clinical characteristics of influenza and differentiate from other infections such as Ebola.
3. Review the importance of vaccination in controlling influenza and pertusis.
4. Review biosafety measures and infection control with regard to all viral infections especially Ebola.

Audience: Primary Care Physicians, Internal Medicine
Methods: Lecture
Credits: 1.0 *AMA PRA Category 1 Credits™*

National Medical Staff Services Week

November 2 – 8, 2014

In 1992, President George Bush issued a proclamation designating the first week of November as "National Medical Staff Services Awareness Week," to acknowledge and thank medical services professionals (MSPs) for playing "an important role in our nation's healthcare system." When you visit a hospital, you see the doctors, the nurses, and other medical personnel. What you don't see are the people behind the scenes who make certain the credentials of all practitioners who are caring for you are correct and have been verified. MSPs are experts in provider credentialing and privileging, medical staff organization, accreditation and regulatory compliance, and provider relations in the diverse healthcare industry. They credential and monitor ongoing competence of the physicians and other practitioners who provide patient care services in hospitals, managed care organizations, and other healthcare settings. MSPs are a vital part in making certain that all patients receive care from practitioners who are properly educated, licensed and trained in their specialty.

Celebrating Milestones

The following physicians hit a service milestone in the month of November. The Medical Staff would like to recognize the following physicians for their service and dedication to Huntington Hospital.

35 Years (on staff 11/1979)

Neville Williams, MD – Urology

30 Years (on staff 11/1984)

Michele Montllor, MD – General Surgery
James Recabaren, MD – Surgical Critical Care

15 Years (on staff 11/1999)

Ihab Beblawi, MD – Gastroenterology
Steven Pavkovic, MD – Infectious Disease

10 Years (on staff 11/2004)

Stan Mathioulakis, MD – Internal Medicine
Waleed Shindy, MD – Gastroenterology

November 2014 **Medical Staff Meetings**

No Board Meeting this Month

monday	tuesday	wednesday	thursday	friday
-3-	-4-	-5-	-6-	-7-
- 12:15 p.m. OB/GYN Dept - CR 5&6 - 5:30 p.m. Medical Executive - Board Room		- Noon CME Committee - CR-8 - 12:15 p.m. OB/GYN Peer Review - CR 5&6 - 3 p.m. QMC Pre-agenda - CR-C - 5:30 p.m. Pediatric Dept. Cerner Task Force - CR-8	- Noon Medicine Committee - North/South Room - Noon Trauma Services - CR 5&6 - 12:15 p.m. Ob/Gyn Dept. Cerner Task Force - CR-10	- 7 a.m. Ortho Section - CR 5&6
-10-	-11-	-12-	-13-	-14-
- Newsletter Submission -	- Noon Critical Care Section - CR 5&6 - Noon Surgery Dept. Cerner Task Force Meeting - CR-10	- 7:30 a.m. Medicine Dept. Cerner Task Force - CR 5&6 - 10 a.m. PICU/Peds QI - CR 2 - 12:15 p.m. OB/GYN Committee - CR 5&6	- 6:30 a.m. Anesthesia Section - CR-7 - Noon QM Committee - East Room - 5:30 p.m. Neonatal/Pediatric Surgical Case Review - CR-10	
-17-	-18-	-19-	-20-	-21-
- 8 a.m. Emergency Medicine Section - ED Conf. Room - Noon GME Committee - East Room	- 12:15 p.m. Infection Control Committee - CR-10 - 12:15 p.m. Credentials Committee - CR-C	- 7:30 a.m. Cardiology Section - Cardiology Conf. Room - 5:30 p.m. Surgery Committee - CR 5&6	- 6:30 a.m. Anesthesia Peer - CR-7 - 8 a.m. Neurology - CR-5 - Noon PT&D Committee - CR 5&6 - 3 p.m. Neon QI - WT CR-10 - 5:30 p.m. Metabolic & Bariatric Surgery Committee - CR-10 - 6 p.m. Bioethics - CR 5&6	- 7:30 a.m. Spine Committee - CR-11
-24-	-25-	-26-	-27-	-28-
- Noon Radiology/Nuclear Med Section - CR-11	- 7:30 a.m. Interdisciplinary Practice - CR-C - Noon Pulmonary Section - CR-10 - Noon General Surgery Section - CR 5&6 - 5 p.m. Robotic Committee - CR 5&6	- 7:30 a.m. Medicine Dept. Cerner Task Force - CR 5&6 - 12:15 p.m. Endovascular Committee - CR-5	Happy Thanksgiving! 	Medical Staff Services CLOSED

November 2014 **CME Calendar**

monday	tuesday	wednesday	thursday	friday
-3-	-4-	-5-	-6-	-7-
- 12:15 - 1:15 p.m. OB/GYN Dept. Mtg, CR 5 & 6 **Topic: Antibiotics Update for the OB/GYN Influenza, Pertussis, or Ebola: Which is Worse?**	- 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11	- Noon - 1 p.m. Genitourinary Cancer Conf., Conf. Room 11 - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room	- 7 - 10 a.m. Trauma M&M, Conf. Room B - Noon - 1 p.m. Thoracic Cancer Conf., Conf. Room 11	- 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. Medical Grand Rounds, RSH **Topic: Determining Brain Death via Neurological Guidelines** - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-10-	-11-	-12-	-13-	-14-
- Noon - 1 p.m. Second Monday, RSH **Topic: Influenza, Pertussis or Ebola: Which is Worse?** Veterans Day	- 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf, Conf. Room 11	- Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room	- 8 - 9 a.m. Surgery M&M, Conf. Room B	- 7:30 - 9: a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-17-	-18-	-19-	-20-	-21-
	- 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf, Conf. Room 11	- Noon - 1 p.m. Genitourinary Cancer Conf., Conf. Room 11 - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room	- 7 - 8 a.m. Trauma Walk Rounds, Conf. Room B - 8 - 9 a.m. Surgery M&M, Conf. Room B - Noon - 1 p.m. Thoracic Cancer Conf, Conf. Room 11	- Noon - 1 p.m. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-24-	-25-	-26-	-27-	-28-
	- 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf, Conf. Room 11	- 7:30 - 8:30 a.m. Cardiac Cath Conf., Cardiology Conf. Room - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room	Thanksgiving 	- Noon - 1 p.m. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11

Huntington Hospital

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ADDRESS SERVICE REQUESTED

If you would like to submit an article to be published in the Medical Staff Newsletter please contact Bianca Irizarry at 626-397-3776. Articles must be submitted no later than the first Friday of every month.

Medical Staff Demographic Changes

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2013 – 2014
Best Hospitals Report

5 Hospital in the
Los Angeles metro area
10 Hospital in California
33 Nationally in Orthopedics
44 Nationally in Urology