

# medical staff NEWSLETTER

December 2013



volume 51, issue 12

## From the **President**

***“The more man meditates upon good thoughts, the better will be his world and the world at large.”***

- Confucius (551 BC - 479 BC)

The stability in finances to enhance innovation and reinvestment is the key factor for excelling in the healthcare industry. There are some result oriented strategies used by top health care industries which should be followed as well. These strategies are beneficial for improving quality and efficiency in terms of healthcare. Let's have a look at what are the basic or major strategies implemented by the best health care industries across the globe.

- Enhancing infrastructure of data reporting and IT
- Standardizing processes
- Creating right accountability for the overall improvement of performance
- Engaging physicians and clinicians
- Implementing and identifying result oriented practices throughout the organization

In order to acquire financial stability for the innovation and betterment of the organization, it is essential to fix present service offerings and management structure.

Due to numerous safety and quality initiatives taken by health care industries, partnering with the payers plays crucial role in enhancing quality. There are certain contractual agreements created by organizations in order to reduce the risk involved in payment systems and new projects.

The organizations must work directly with clinical staff during the negotiation process. It can work amazingly to control cost and improve the quality of an organization. As it

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## 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 November 4, 2013, by the Governing Board Subcommittee on November 6, 2013 and by the Governing Board on December 19, 2013.

**Don't forget to get  
your flu shot!!**

 Huntington Hospital

## Medical Staff Appointments



**Coward, Christine, MD**  
**Ophthalmology (Fellow)**  
 630 Raymond Avenue  
 Suite 330  
 Pasadena, CA 91105  
 626-577-1115 (office)



**Daneshvari, Ali, MD**  
**Internal Medicine**  
 HealthCare Partners  
 450 East Huntington Drive  
 Suite 200  
 Arcadia, CA 91006  
 626-462-1884 (office)  
 626-254-8258 (fax)



**Emmons, Lawrence, MD**  
**Diagnostic Radiology**  
 Diversified Radiology  
 1746 Cole Blvd.  
 Suite 150  
 Lakewood, CO 80401  
 303-914-8800 (office)  
 303-716-3777 (fax)



**Gaglia, Michael, MD**  
**Interventional Cardiology**  
 1520 San Pablo Street  
 Suite 1000  
 Los Angeles, CA 90033  
 323-442-5100 (office)



**Jacobi, Joshua, MD**  
**Cardiovascular Disease**  
 301 South Fair Oaks Avenue  
 Suite 404  
 Pasadena, CA 91105  
 626-716-9206 (office)



**McAndrews, Paul, MD**  
**Dermatology**  
 50 Alessandro Place  
 Suite 115  
 Pasadena, CA 91105  
 626-405-1155 (office)  
 626-577-5606 (fax)



**Stewart, Daphne, MD**  
**Hematology**  
 209 Fair Oaks Avenue  
 South Pasadena, CA 91030



**Whang, Stephanie, MD**  
**Pediatrics**  
 55 East California Blvd.  
 Suite 200  
 Pasadena, CA 91105  
 626-795-8811 (office)  
 626-795-0953 (fax)

## Allied Health Professional Appointments

- Mikael, Mona, PhD - Psychology

## Resignations

### Medical Staff Resignations

- Barstis, John, MD – Hematology/Oncology – effective 12/31/13
- Davis, Michael, MD – Ophthalmology – effective 12/31/13
- Doorly, Michael, MD – General Surgery – effective 12/19/13
- Hovsepian, Paul G., MD – Cardiovascular Disease – effective 12/31/13
- Rake, Alyssa, MD – Pediatric Critical Care – effective 12/19/13
- Recasens, Marta, MD – Ophthalmology – effective 12/31/13

### Allied Health Resignations

- Chung, Tyson, PhD – Psychology – effective 12/31/13

## From the **President** continued from page 1

is a well known fact that an organization can achieve success by implementing scenario based strategies, operational skills and planning. The healthcare industries must follow the futuristic strategic planning as it is the only way to get prepared for facing challenging situations. Scanning the market environment, identifying the unknown, developing key scenarios, analyzing internal capabilities, and implementing important strategies are the few factors to elevating the organization to the next level.

By following the above strategies, healthcare organizations noticed a reduction in the number of patients with chronic diseases. The transparency in the system is not only liked by patients but by clinicians and staff members as well. Apart from all, healthcare organizations also succeed in delivering physician and employee satisfaction which is essential for the overall growth.

'Triple Aim', which refers to the analysis of population health, cost reduction, and good quality, is the name given by top most health care organizations under which they strive to reduce a range of diseases among people. By using the available resources effectively, they can achieve success in improving the overall health of people. With the result of such a new healthcare system, cost per patient reduces drastically but it increases the number of patients which is a motivational factor for clinicians and physicians.

### Core Organizational Competencies

#### Development and implementation of patient-centered, integrated care

Hospitals need the competency to develop a plain and convincing approach for clinician integration and alignment. This will require formulating a shared culture among previous

independent practices, investing in training and development of physicians and nurses, and putting patients at the core of all care plans in order to motivate them for healthy lifestyle changes and to follow suggested treatments.

#### Developing accountable leadership and governance

Hospitals and care systems need boards and leadership teams to drive the organizational strategy in the changing environment while assessing the balance of rewards as well as risks. Successful boards will enjoy explicit succession in terms of the process of planning in place to ensure the selection and development of leaders with the required attributes. The affiliation of governance teams and management will bring together appropriate competencies for executing the must-do strategies.

#### Strategic planning when the environment is not stable

A strategic planning process must be continuous to reflect ongoing changes in the operating environment. Planning based on a scenario will be needed to observe vital changes in assumptions and making necessary adjustments. This will enable hospitals to operate more efficiently in times of financial crisis. Community health needs assessments should be conducted to study the health oriented needs and characteristics of a community and link those outcomes with forecasting activities.

#### Facilitating both internal as well as external collaboration

Collaboration is listed at the top of every core competency list in the health care systems of the future. It requires trust, communication, mutually beneficial relationships, common goals, integrating mechanisms, shared economic

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## From the **President** continued from page 3

incentives, and a performance-based evaluation. True collaboration will be seen as a valuable partner to physicians as well as other organizations existing in the community and require significant investment in data analysis techniques, technology, and infrastructure.

### Exercising financial stewardship & enterprise risk management

Hospitals and health systems need exact financial and operational information, including cost accounting systems, which enable them to evaluate revenues and expenses by each and every clinical service. They need to adopt improved methodologies such as Lean/Six Sigma and apply best practices for testing strategic activities in health management strategies and yearly assessment of enterprise risk management.

### Engaging employees' full potential

Hospitals and care systems must deploy a strategy for physician and employee partner commitment, and make sure that the physician and employee employment and retention systems are aligned with the strategic direction and expected culture. Physicians and other health care professionals must be trained in leadership skills and team-based care to develop proper understanding and skills for increased collaboration.

### Collection and utilization of electronic data for performance enhancement

Hospitals and health systems need to achieve digital connectivity so that information systems pass all relevant data to the point of care. This will facilitate improved decision-making although care must be taken to continuously review the data retrieved from the information systems for enhanced planning and evaluation.

### Conclusion

Utilizing the strategies to develop the core competencies will be critical for hospitals to excel in an environment that requires delivery systems to provide economic value, quality outcomes, service management, information transparency, performance accountability, and greater patient accessibility. Hospitals are urged to think about each of the core competencies as a means to evaluate the institution's current capabilities and to identify areas for potential development. I hope this report will enable us, the medical staff, to start thinking about and engaging in the hospital's implementation of its future strategies in which greater value and quality to be delivered.

**Edmund Tse, MD**  
*President*

## Partnership With Shriners Hospital

**Huntington Hospital is proud** to announce that it has entered into an agreement with Shriners Hospitals for Children – Southern California to provide inpatient surgical services for its pediatric patients; this is the first time Shriners Hospital – Southern California has engaged in such an arrangement. As a result of this arrangement, inpatient surgeries for Shriners Hospital for Children patients will be performed at Huntington Hospital by members of the Shriners Hospital's medical staff, all of whom have been granted privileges at Huntington. It is anticipated that the hospital could treat as many as 300 additional pediatric patients each year.

From the **Health Science Library**

**JAMA Journals Now Freely Available**

JAMA network journals can now be accessed by anyone from anywhere! All JAMA network journal content published during the past 12 months is now freely available via the JAMA Network Reader (<http://jnreader.com>). The JAMA Network Reader can be downloaded to a desktop computer, iOS or Android device, free registration is required.



What's more, selected content is freely available on the JAMA website (<http://jamanetwork.com/>), for issues older than 12 months. Free content includes all Original Research, Research Letters and Review articles. Sections still requiring a subscription to read include: Editorials, Invited Commentary, Editor's Note, Editor's Correspondence and Commentary.

JN Reader features include:

- An Offline Library (save whole issues to your device/desktop for offline reading)
- Bookmark individual articles for later reference
- Email the link for an article to yourself or a colleague
- Increase/decrease text size for ease of reading
- Article Features button displays a list of figures, tables and/or supplemental content for each article

The JAMA Network journals include the following titles:

- JAMA
- JAMA Neurology
- JAMA Facial Plastic Surgery
- JAMA Surgery
- JAMA Dermatology
- JAMA Ophthalmology
- JAMA Psychiatry
- JAMA Internal Medicine
- JAMA Pediatrics
- JAMA Otolaryngology – Head & Neck Surgery

The library will continue its print and online subscription only for JAMA. For more information or questions, contact the library at: [library@huntingtonhospital.com](mailto:library@huntingtonhospital.com), x5161 or text us at 626-344-0542.

**Joint Commission Primary Stroke Program Recertification**

**We had our Joint Commission (TJC) Advanced Primary Stroke Center re-certification survey on October 11.** Dr. Arbi Ohanian and the stroke multidisciplinary team members participated in patient tracers and department tours of imaging, lab, ED, the Neurosciences Stroke Center and the Critical Care Unit. The surveyor acknowledged the great teamwork exemplified by the staff. TJC cited us with one survey finding related to consistent non use of stroke order sets. These order sets are evidenced-based, clinical practice guidelines, for the care and treatment of stroke patients. When order sets are not used, the stroke core measures and standards of care may not be met for all patients. Corrective plans of action are led by Dr. Ohanian and are being taken to the Neurology Section, Department of Medicine and MEC for approval. We will monitor the use of stroke order sets through March to ensure 90% or greater compliance. Once this compliance is achieved we will receive the official re-certification letter from TJC.

## From the **Medicine Committee**

**The Medicine Committee** would like to share with the Medical Staff the Core Measure requirements for Acute Myocardial Infarction and Congestive Heart Failure. These two measures are reported on a quarterly basis to the Joint Commission, Centers for Medicare and Medicaid Services, among others. After a thorough review by our cardiology team, common errors were found that alter our quality outcomes data. We are hoping that this review of our findings will help our physicians understand what is required. Most of these items are intuitive but simple changes to our system will lead to a big improvement in results. While we are moving into the CPOE arena we would like to remind you of the quality management dashboard that will guide you in ensuring these measures are met. We think you for continuing to provide the highest level of care to our patients.

### Acute Myocardial Infarction (AMI)

**This pertains to all patients with positive Troponin, STEMI, or documented as Acute Coronary Syndrome/Myocardial Infarction**

1. ASA within 24 hours prior or after arrival. If ordering ASA always write "first dose now, then daily"
2. ASA at discharge or document why it is not indicated
3. Beta blocker at discharge or document the reason it is not given
4. Always document LV function
5. If LVEF <40% then ACE-I/ARB **BOTH** must be documented
6. All patients must have LDL checked within first 24 hours
7. Statin at discharge in all patients
8. In STEMI documentation is urgent PCI for infarct related artery
9. **MUST DOCUMENT WHY ABOVE NOT COMPLETED AND LINK TO CONTRAINDICATION** (Example: ACE/ARB not given due to renal insufficiency)
10. All summaries for medication must match and the discharge medication list must be the most thorough (any discrepancy or omission will lead to medication mismatch and fall out. Best practice would be to, in summaries, write "see discharge medication list")

### Congestive Heart Failure (CHF)

1. All patients must have documentation of LVEF stated. If echo completed previously can use that and not repeat. Can also say diastolic CHF which then assumes LVEF >40%
2. ACE-I/ARB at D/C for all patients with LVEF <40%
  - a. Must always link BOTH medications to reason if not discharged  
e.g. ACE-I and ARB are not given due to renal insufficiency  
NOT: ACE-I not given for abnormal Cr.
3. Discharge instruction filled out completely
4. Ensure all medications are matched on discharge medication list
5. Again discharge medication list must be the most thorough
6. Follow up MUST be documented

## Outpatient Rehabilitation Services

**Effective December 2013**, the outpatient rehabilitation services that are currently provided in the LaVina building of Huntington Hospital are being relocated to the satellite facility located at 630 Raymond Ave. #120, in Pasadena. Consolidation of the outpatient rehabilitation services at a single site allows us to streamline the service and provides a critical mass of patients to develop specialty programs.

The satellite facility is 12,000 square-feet and can serve about 150 patients a day. The state-of-the-art facility includes an indoor heated pool, open gym and private treatment rooms. It offers a wide range of rehabilitation services: hand therapy, occupational therapy, speech and dysphagia services, physical therapy, neuropsychology, physiatry and audiology services. The latest technology includes the EKSO skeleton – a mechanized system for ambulating paraplegic patients and Saebo Rejoyce – a device for improving function using the principles of Neuroplasticity.

The facility offers comprehensive outpatient rehabilitation services to a wide spectrum of patients. These services include, but are not limited to:

- Patients with musculoskeletal issues such as soft tissue injuries, back pain and joint replacements
- Neurorehabilitation patients with traumatic brain injury, spinal cord injury and stroke
- Parkinson's disease
- Vestibular and balance issues
- Handicap driver evaluation services.

It is a one-stop facility for the rehabilitation needs of your patients. The contact number is 626-397-3801 and the fax number is 626-397-7150. Please contact Ilin Ohanessian or me at 626-397-3808 for any information or assistance to provide care to your patients.

**Sunil K. Hegde, MD**

*Medical Director*

*Rehabilitation Services*

## Celebrating Milestones

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

### 45 Years (on staff 12/1968)

Lionel Ng, MD  
– Pediatrics

### 25 Years (on staff 12/1988)

Gustavo Alza, MD  
– Internal Medicine

### 20 Years (on staff 12/1993)

Paul T. Liu, MD  
– Geriatrics

Richard Nickowitz, MD  
– Gastroenterology

Raymond Yen, MD  
– Cardiovascular Disease

### 15 Years (on staff 12/1998)

Syeda Ali, MD  
– Nephrology

### 10 Years (on staff 12/2003)

John Leung, MD  
– Emergency Medicine

Edward Mena, MD  
– Hepatology

Mark Yeh, MD  
– Diagnostic Radiology

## Physician's... You Are The Patients Experience!

**A monthly communication** to assist physicians in patient engagement and the patient experience.

*Reviewed by: Shant Kazazian, MD*

From the CMS.gov website the following information was posted and last modified on June 26, 2013:

"The Centers for Medicare and Medicaid Services (CMS) was required by the Patient Protection and Affordable Care Act (ACA) of 2010 to establish the Physician Compare website which launched on December 30, 2010. In its first iteration, Physician Compare utilized the existing Healthcare Provider Directory already part of www.medicare.gov. Since that time, CMS has been working continually to enhance the site. This effort, along with the eventual addition of quality measures on the site, will help it serve its two-fold purpose:

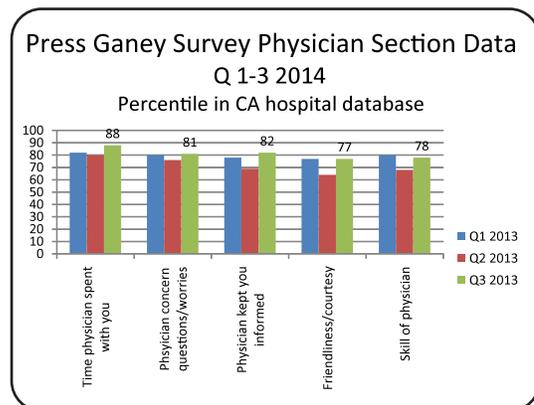
- Provide information for consumers to encourage informed healthcare decisions; and
- Create explicit incentives for physicians to maximize performance.

CMS has begun to implement a plan, established January 1, 2013, to make quality data available on Physician Compare. The plan for Physician Compare also includes publically reporting patient experience data from participating physicians on the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) measures."

The Rand Corporation has identified 11 of the top 40 highest rated physicians who are currently participating in the CG-CAHPS survey treating patients in a Midwest health plan. Rand interviewed the physicians and uncovered four behaviors most often mentioned by the physicians, which are captured in the survey:

- Spending enough time with patients
- Listening carefully
- Providing clear simple explanations
- Devising an action plan with each patient.

As discussed in previous Medical Staff Newsletter patient experience articles, our physician satisfaction data reflects these same behaviors as being highly correlated to our patients overall satisfaction. The following is data from Quarters 1-3 of 2013 from the Press Ganey Physician Section:



### Job Well Done!

"Great doctor, she takes time to explain and talk to you."

"My doctor was always checking on me and letting me know what to expect."

"Special thanks to my doctor. His bedside manner, communication and compassion for his patient was remarkable. TOP RATED."

*All patient comments are from the Press Ganey satisfaction survey.*

## Joint Commission Total Joint Replacement Recertification

**On October 18**, The Joint Commission (TJC) visited Huntington Hospital for the purpose of evaluating our orthopedic program for Total Joint, Disease Specific recertification. I am happy to report that we passed without any negative findings.

Cecelia Cayton, RN, is largely responsible for our success. Her leadership of 6 East, our Multidisciplinary Joint Team and the Knee and Hip Quality Team is the reason we not only passed recertification, but lead the hospital in earning recognition as a top hospital by *US News and World Report*. Orthopedics again ranked in the top 33 of the nation.

There are so many to thank. Alison Birnie, RN, has joined our team as Clinical Director and has proved a tremendous asset as well as advocate for the program. Janet Mayeda, RN, Susan D'Antuono, RN, CNS, and Jenny McFarlane, RN, CNS, have been with us for years now providing invaluable expertise. Jean Irizarry, Cynthia Yi, RN, and Marty Waskul were also instrumental in data collection.

Rida Selbak-Rivera, PT, Patricia Ellis, RN, Marie Firoozian, RN, Cathy Davis, RN and countless others on the Total Joint Multidisciplinary Team and those who work on the Orthopedic floor have made up our grass roots effort and are the foundation of our team. Many people in the OR contribute every day that we do surgery to ensure the best outcomes for our patients, as do those in pre-op testing and PACU.

At the end of our last review, we were advised to look at our transfusion rate. We contacted Dr. Hani Sami who is an expert in blood management. With his guidance, we have decreased our transfusion rate significantly.

This effort results in safer patient care and decreased costs to the hospital. It is a model for the rest of the hospital.

This reviewer was most impressed with our pain management. Drs. Jonathan Maskin, Leonard Kim and Brendon Katz are responsible. Anesthesiologists like Dr. Anthony Chang have taken a special interest in optimum care for our joint replacement patients. Their efforts so impressed the reviewer, that he told us we were well ahead of other institutions and should publish our results.

Finally, our orthopedic colleagues deserve recognition and thanks. Dr. Todd Dietrick, my co-champion, has chaired our Quality Team. Drs. Dan Laster, Greg Northrop, George Tang and Vahe Panossian, Stephen Riffenburg have donated their time and effort towards this team. They have guided us in efforts to decrease surgical site infections, advance technologies, provide minimally invasive techniques to both anterior and posterior approaches, rapid rehabilitation techniques and patient education. Our patients are made to feel that they are part of the team and their recovery and outcome is our primary concern.

Recertification validates the collaborative effort between medical staff and hospital staff toward the benefit of quality, cost effective orthopedic healthcare. We look to expand this to better coordination of the preoperative and post-operative process. It is this collaboration that will help us continue the best care possible in the ever changing economic climate. Thanks to all involved.

**Dr. Paul K. Gilbert**

## Editor's Note: Follow-Up on Reporting of Disciplinary Actions to the Medical Staff

**In the July 2013 issue, A Note From The Credentials Committee** was published regarding **Section 3.5 (5)** of the Medical Staff Bylaws, which discusses the obligation of members to report certain information to the Medical Staff. (The relevant Bylaws excerpt appears below) However, after editorial review of the newsletter had occurred, the following statement was added without authorization from either the Medical Staff or Administration, which was incorrect and misleading: "Failure to notify the Medical Staff or CEO of the said information will result in an automatic termination (of hospital privileges)." *Medical Staff members should be aware that no such automatic termination provision ever has been a part of the Bylaws or the Medical Staff Rules and Regulations, nor was any such "automatic" termination ever implemented in a situation where there was a failure to report information to the Medical Staff.*

The Bylaws language in question is:

Medical Staff members must promptly report any past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or privileges in any healthcare organizations [or] any licensure, certification or registration, and all related matters, within 30 days after the member becomes aware that such an action or a preliminary investigation has been initiated, or any significant development has occurred in the action, or the action has become final. For purposes of this Chapter, voluntary actions that must be reported to the Medical Staff Department shall only include those taken while under investigation for possible incompetence or improper professional conduct or breach of contract, or in return for an investigation not being conducted or action not being

taken; past or pending disciplinary actions include those taken by other healthcare organizations or by the Medical Board of California or a law enforcement agency or similar entity, including civil or criminal actions that call into question professional conduct and/or professional financial dealings[.]

Since we became aware of the misleading statement in the July newsletter, there have been discussions at the Orthopedic Section and the Medical Executive Committee (MEC). Publication of the present clarification is one step of our response. The other will be for the Bylaws Committee to revisit the language of this provision. The intent of the above-quoted paragraph is to require reporting to our Medical Staff of disciplinary action initiated against a Medical Staff member by the Medical Board of California or other government agency such as the federal Drug Enforcement Administration, or within another hospital or healthcare institution, which is based on serious quality concerns, ethical lapses, impairment, or other significant issues that might affect patient care. It is important for the Medical Staff to be aware of such matters so we can protect patients and also assist Medical Staff members who may need help with personal challenges. However, we recognize that our need to protect patients must be balanced with fairness to our members and protection of individual physicians from unnecessary burdens.

A failure of notification most commonly would come to our attention during our re-credentialing process, but whenever we discover such a failure, our process involves review by the pertinent Section Chair, Department Chair and Credentials Committee, and then by the MEC, before any final recommendation is made

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## Getting to Know Your Medical Staff Leaders

**Angela Hay, MD**, has been a member of the Department of Medicine, Pulmonary Section, since 2006 when she started working at Huntington on a part-time basis. She completed her postgraduate training at Cedars-Sinai Medical Center in Los Angeles, specializing in Pulmonary, Critical Care, and Sleep Disorders. Dr. Hay is responsible for monthly grand rounds for the IPA doctors. She has assisted with training rotating residents at Huntington in the past. She is the lead Health Care Partners hospitalist for Huntington.



Dr. Hay is the current Chair of Pulmonary Section for the term 2012 to 2014. In this role, she represents the Section at monthly Medicine Committee meetings. In addition, she is a member of the Critical Care Section and GME Committee.

Dr. Hay enjoys family time with her daughter. She is a basketball fan and attends UCLA games whenever she can. Dr. Hay loves jazz music and driving. If left to her devices she would be driving all the time.

### Editor's Note *continued from page 10*

about the consequences of failure to notify. (In some instances, more rapid action may be necessary to address the underlying concerns, albeit with the full range of established protections for any Medical Staff member charged with a serious breach of standards.)

**To the extent the paragraph quoted above was part of the consideration of any peer review decision at HMH, the consideration involved our normal multi-step process and nothing "automatic" in this situation ever has led to a loss of privileges.**

We welcome your input about this or any other Bylaws and/or Rules and Regulations issue that you think should be reviewed. An attorney is always part of the process of Bylaws language review before the recommendations go to the MEC, and Bylaws language changes are always submitted to a vote of the Active Staff. Whatever the final version of the paragraph above, we will publish the specific language in the newsletter as well, as a follow-up to the recent miscommunication.

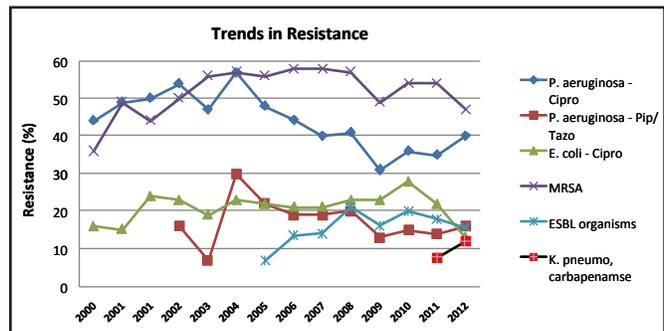
### Glenn Littenberg MD

*Editor, Newsletter*  
*Chair, Bylaws*  
 g.littenberg@scgahealth.com

## Huntington Hospital 2012 Antibigram Trends

Tuan Tran, PharmD, Annie Wong-Beringer, PharmD, and Paul Nieberg, MD  
 - June 2013

**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 Antibigram 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.** Similar to previous years, resistance of *Pseudomonas* to all anti-pseudomonal agents has been gradually increasing. Rates of resistance in descending order comparing 2012 to (2011) are: ciprofloxacin 40% (35%), meropenem 26% (21%), cefepime 24% (23%), gentamicin 25% (15%),

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## 2012 Antibigram Trends continued from page 11

piperacillin-tazobactam 16% (14%), and tobramycin 14% (10%). Thus, combination therapy with piperacillin-tazobactam plus tobramycin remains the empiric regimen of choice.

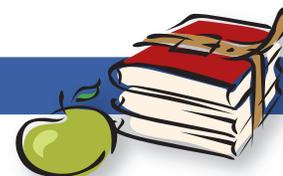
It is notable that the susceptibility of *Pseudomonas* to meropenem has continued its downward trend and is now at its lowest since we first began reporting meropenem susceptibilities in 2008. Additionally, the rate of KPC (*K. pneumoniae carbapenemase*) isolates are increasingly isolated from HH patients since 2011, and now accounts for 12% of all *K. pneumoniae* isolates. Among the KPC isolates tested against colistin and tigecycline (last resort agents), 21% and 27% are resistant to those agents respectively. Increased meropenem prescribing at HH over the past several years has no doubt contributed to the isolation of multidrug-resistant organisms such as *Pseudomonas* and KPC. In order to displace the use of meropenem for non-pseudomonal infections, a narrower-spectrum agent in the carbapenem class, ertapenem, was added to HH Formulary in April 2013. Note that ertapenem is NOT active against *Pseudomonas*, *Enterococcus*, and *Acinetobacter* species. 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. Meropenem has now replaced imipenem from HH Formulary as the anti-pseudomonal carbapenem.

It is important to recognize that even a modest decrease in susceptibility to ciprofloxacin (65% down to 60%) can negatively affect activity of other anti-pseudomonal agents due to the overexpression of bacterial efflux pumps, which have the capability to extrude other structurally-unrelated compounds. Continued restraint in ciprofloxacin use at HH is crucial in preserving utility of all anti-pseudomonal agents.

**Gram-positive organisms.** The rate of *S. aureus* (both methicillin-sensitive and methicillin-resistance) infections has declined from the previous year. Interestingly, a reversing trend is observed now with isolation rate of methicillin-sensitive *Staphylococcus aureus* (MSSA) exceeding that of methicillin-resistance *Staphylococcus aureus* (MRSA) infections. (Figure) 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 beta-lactam agents directed against streptococcal species be prescribed [Liu C, 2011]. Vancomycin remains the preferred anti-MRSA agent for patients needing parenteral therapy and do not have documented allergy or significant renal dysfunction. HH antibiotic use data from 2012 indicates that expensive alternative agents have been excessively prescribed in patients who could otherwise be given vancomycin and will need to be strictly curtailed; at least \$50,000 can be saved in drug cost alone if vancomycin was prescribed in those without renal insufficiency. Oral agents with excellent bioavailability and activity against MRSA such as doxycycline (96%) and Bactrim (100%) may be used to facilitate the transitioning of patients to outpatient therapy when appropriate.

The rate of *C. difficile* infections (CDI) continues to decrease since 2009. The mean rate of hospital acquired *C. difficile* infections for 2012 (vs 2011) was 35.3% (45.8%) with an incidence of 0.5 (0.66) 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

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**CME Corner**

**Medical Grand Rounds**

Topic: Colorectal Cancer:  
A Decade of Progress  
Speaker: Afsaneh Barzi, MD  
Date: December 6, 2013  
Time: Noon – 1 p.m.  
Place: Research Conference Hall  
Objectives: 1. Identify the goals of treatment in patients with colorectal cancer.  
2. Identify the aspects of multi-disciplinary care in selected patients.  
3. List the active treatment agents for metastatic colorectal cancer.  
Audience: Medical Oncologists and all other interested specialties  
Methods: Lecture  
Credit: 1.0 AMA PRA Category 1 Credits™

**Second Monday**

Topic: The Proper Applications of Robotic Surgery  
Speakers: Armen H. Dikranian, MD, Paul S. Lin, MD, & David J. Lourie, MD  
Date: December 9, 2013  
Time: Noon – 1 p.m.  
Place: Research Conference Hall  
Objectives: 1. Understand the applications of robotic surgery in different surgical specialties.  
2. Understand the economics of robotic surgery.  
Audience: Urology, Surgery, Gynecology, and all other interested specialties  
Methods: Lecture  
Credit: 1.0 AMA PRA Category 1 Credits™

**Reminders**

**Online Evaluations**

Please remember to fill out the online evaluation after you attend each CME Activity, it is **required to receive your CME credit**. Evaluations are critical for the hospital to retain accreditation and to improve our future programs. All of your survey answers will be anonymous.

To complete the survey, after you attend each CME approved activity a link should be sent to your email account. If you do not receive this email please contact Maricela Alvarez, CME Coordinator, at 626-397-3770 or via email at Maricela.Alvarez@huntingtonhospital.com.

**2012 Antibigram Trends** *continued from page 12*

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.

In summary, overprescribing of meropenem will need to be significantly curtailed; the rising resistance of Pseudomonas and increasing isolation of KPC render it no longer an effective agent for the empiric therapy of multi-drug resistant gram negative infections. The increasing isolation of carbapenem-resistant *K. pneumoniae* at HH is alarming, leaving clinicians with the highly nephrotoxic agent colistin and possibly tigecycline as the only viable treatment options. Vancomycin should be considered as first line for empiric therapy in suspected MRSA infections with discontinuation or de-escalation when appropriate; alternative agents should be considered in those with documented MRSA infections or known history of MRSA colonization/infection and have significant renal insufficiency or demonstrated lack of response.

December 2013 Medical Staff Meetings

monday	tuesday	wednesday	thursday	friday
-2-	-3-	-4-	-5-	-6-
- 12:15 p.m. OB/GYN Dept – CR 5&6  - 5:30 p.m. MEC – The Raymond		- 12:15 p.m. Endovascular Committee – CR-5	- 12:15 p.m. Pediatric Committee – East Room	<b>Holiday Party Langham Hotel (6–11 p.m.)</b>
-9-	-10-	-11-	-12-	-13-
- Newsletter Submission -			- Noon Medicine Committee – East Room	
-16-	-17-	-18-	-19-	-20-
			- 6:30 a.m. Anes Peer Rev – CR-7	
-23-	-24-	-25-	-26-	-27-
		<b>Merry Christmas!</b> 		
-30-	-31-			

December 2013 CME Calendar

monday	tuesday	wednesday	thursday	friday
-2-	-3-	-4-	-5-	-6--
	- 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 <b>Topic: Colorectal Cancer</b> - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-9-	-10-	-11-	-12-	-13-
- Noon - 1 p.m. Second Monday, RSH <b>Topic: Robotic Surgery</b>	- 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
-16-	-17-	-18-	-19-	-20-
	- 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 Conf., RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-23-	-24-	-25-	-26-	-27-
	- 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf, Conf. Room 11	<b>CHRISTMAS</b> 		
-30-	-31-			

**Medical Staff Administration**

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ADDRESS SERVICE REQUESTED

**Medical Staff Leadership**

K. Edmund Tse, MD, President  
James Shankwiler, MD, President-Elect  
Kalman Edelman, MD, Secretary/Treasurer  
James Recabaren, MD, Credentials Committee  
William Coburn, DO, Quality Management  
Peter Rosenberg, MD, Medicine Department  
Laura Sirott, MD, OB/GYN Department  
Ernie Maldonado, MD, Pediatrics Department  
Harry Bowles, MD, Surgery Department

**Newsletter Editor-in-Chief – Glenn Littenberg, MD**

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 13<sup>th</sup> of every month.

**Medical Staff Demographic Changes****Sevag Balikian, MD  
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Please notify the Medical Staff Office via email if there is a change in your demographic information.



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