medical staff NEVVSLETTER



October 2013 volume 51, issue 10

From the **President**

"To practice five things under all circumstances constitutes perfect virtue; these five are gravity, generosity of soul, sincerity, earnestness, and kindness."

Confucius



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 September 9, 2013 and by the Governing Board on September 26, 2013.

HCAHPS

551 BC - 479 BC

In a hospital setting, patient care is addressed as a major priority due to the hospital's nature as a refuge for the sick. Doctors and hospital staff strive to cure their patients of any illnesses they may have, but oftentimes patient satisfaction is neglected at the cost of patient care. Being overwhelmed by the pressure and amount of patients, it may be easy for physicians to lose focus on areas of patient satisfaction such as effective communication in order to gain efficiency of the care that is delivered. Recent studies have shown that 65% of preventable deaths or serious injuries to patients are caused by ineffective communication. In order to address this issue, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey was initiated in 2006 as a means for patients to voice their satisfaction. Although hospitals had previously implemented surveys for their own purposes, HCAHPS is the first nationally standardized survey that publically reports its scores. As an incentive, the Enactment of the Deficit Reduction Act of 2005 required hospitals of the Inpatient Prospective

continued on page 4

Administrative Reports

Department/Section Rules and Regulations

Medical Staff Rules and Regulations

The following section has been added to the Emergency Medical Services (§2.20) portion of the Rules and Regulations:

Response time

For adult patient requiring a medical admission, the admitting physician or any physician acting as the patient's admitting physician, is required to call back the emergency Department within thirty (30) minutes of being called/paged by the Emergency Room physician. Failure to respond within thirty (30) minutes will result in the patient being admitted to the academic Hospitalist for the

continued on page 2

Inside this issue:

From the President	1, 4-6
Summary of the Minutes	1-4
Celebrating Milestones	6
PhysiciansYou are the Patient's Experience!	7
Bioethics Corner	8-10
Getting to Know Your Medical Staff Leaders	10
Telemetry	11
CME Corner	12
New Medical Director	12
Joint Commission Readine	ss 13
Physician Informatics	14
Medical Staff Meeting Calendar	14
CME Calendar	15

Don't forget to sign up for HANK training!



Medical Staff Rules and Regulations continued

duration of the admission or a specific time agreed upon by the Academic Hospitalist and the admitting physician.

It is the physician's responsibility to notify the Emergency Department in writing of any groups or the name of the physician admitting on their behalf. It is also the responsibility of the primary care physician to inform the Emergency Department immediately of any changes to these practices. Failure to do so may result in admitting the patient to the Academic Hospitalist by default.

Allied Health Professional Rules and Regulations

The following revisions have been recommended to Section 16 "RN-Evaluation for 5150 Status":

- 16.1.2 Must have a minimum of three (3) years of psychiatric experience.
- 16.3 Must successfully complete a minimum six (6) proctored assessments.

Privilege Delineation Forms

Revisions were approved to the following Privilege Delineation Forms:

- Cardiology
- Neurology
- Adult Nurse Practitioner
- Clinical Psychology

Please go to SharePoint → Medical Staff Services → Board Approved Items → 2013 and select September 2013 to see:

- Administrative/Clinical Policies and Procedures
- Order Sheets
- Formulary Management
- Standardized Procedures
- Departmental Policies and Procedures and Order Sets
- Ancillary/Nursing Policies and Procedures

Medical Staff Appointments



Bitar, Fahed, MD Interventional Cardiology Foothill Cardiology 315 North Third Avenue Suite 207 Covina, CA 91723 626-915-4700 (office) 626-214-7814 (fax)



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continued on page 3



Medical Staff Appointments continued



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continued on page 4



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Wittig, Kristina, MD Urology Fellow City of Hope 1500 East Duarte Road Duarte, CA 91010 626-471-7100 (office) 626-301-8285 (fax)



Zhumkhawala, Ali-Asghar, MD Urology Fellow City of Hope 1500 East Duarte Road Duarte, CA 91010 626-471-7100 (office) 626-301-8285 (fax)

Resignations

Medical Staff Resignations

- Chang, Andy, MD Urology effective 9/30/2013
- Nam, Howard, MD Otolaryngology effective 9/01/2013
- Samimi, David, MD Ophthalmology Fellow – effective 9/30/2013
- Sedrak, Michael, MD General Surgery effective 8/31/2013

From the President continued from page 1

Payment System (IPPS) to implement the HCAHPS Survey in order to receive their full annual payment. Other hospitals are also allowed to voluntarily use and report their results of the HCAHPS survey which are gathered on the hospital compare website.

The HCAHPS survey is given to adult patients at random who have been discharged between 48 hours to six weeks from a hospital. The survey is flexible for patients as it can be taken through mail or telephone, and is offered in English, Spanish, Chinese, Russian, and Vietnamese. Furthermore, the format of the

HCAHPS survey is simple yet effective. There are ten HCAHPS measures which are broken down into six summary measures, two individual measures, and two global measures. The summary measures encompass topics such as doctor and nurse communication with patients, hospital staff responsiveness towards patients, staff communication with patients about medicine, staff response to the patient's pain, and communication of important information at the time of discharge from the hospital. The two individual measures cover topics such as cleanliness and quietness of a patient's room, and the two global measures address the patient's

continued on page 5



From the President continued from page 4

overall satisfaction and whether or not they would recommend the hospital to a friend or relative. With all these ten measures, the HCAHPS survey gives a technical view of a patient's satisfaction and experience at a hospital.

Although the HCAHPS survey is broad, it does not always provide all aspects of patient satisfaction. Since the survey only gives a partial view of a hospital's performance and provides patient satisfaction with technical aspects of care, physicians and hospital staff need to actively pursue their role in patient satisfaction in order to help improve the survey results. There are three essential barriers that must be broken in order to satisfy the patient's idea of "great" care. These barriers are a lack of a shared mental model, lack of trust and compassion, and lack of effective communication.

The first barrier is often created because of varying approaches in discussing a patient's illness. The hospital staff usually informs their patients in a factual manner, whereas patients tend to be more focused in their own emotion and to seek more attention as they are often going through a troubling time. In order to share this mind set, health care providers must overcome these differences in mentality and provide patients with the assurance that they are both on the same side, overcoming the illness together. The second barrier is to earn a patient's trust by showing more compassion. It is essential to break this barrier because patients are more inclined to share information with their care givers if the physician shows kindness and concern to their patient. The third barrier is crucial for patient engagement; effective communication can also prevent many mistakes and can increase safety. If health care providers stay open to questions and do not

interrupt, patients will have a less intimidating impression of their physician. Even though these actions do not explicitly contribute to HCAHP scores, excelling in these areas will increase the "overall" and "would recommend" categories of the HCAHP scores and also give the patient a comforting experience.

There are a few pointers in order to build a stable relationship through communication with one's patients. In order to effectively establish this, clinicians must be confident, empathetic, humane, personal, frank, respectful, and thorough. These key traits are essential in building a patient's trust. By being confident but not arrogant, patients are given peace of mind and are also more likely to be confident in overcoming their illness. By being empathetic, humane, and personal, doctors show that they care for the patient by showing their interest in them as a person instead of a mere patient with an illness. By being frank, respectful, and thorough, doctors efficiently and effectively tell patients what they need to know and show that they are willing to work with patients. During the communication process, doctors should make a positive first impression by checking the patient's record, both past and current, before they meet. This will make the patient feel important and make the doctor appear genuine. During the interview, doctors should ask their questions in an open-ended manner in order to get the most information out of the patient. In response, they should also show concern and empathy when addressing the patient. These skills which all physicians were taught in medical school are sometimes forgotten and streamlined due to their busy practice, and yet, they are essential in building a strong patient-physician relationship.

continued on page 6

From the **President**

continued from page 5

There are benefits in doing the HCAHPS survey. First, it is a nationally public survey which allows hospitals around the country the ability to view how they stand in comparison to each other. This builds competition and creates an incentive for better health care. As for the patients, they are given information that allows them to choose a hospital that can offer them better experience. Secondly, the physician-patient relationship, which is closely related to HCAHPS scores, is beneficial because it can improve patient health. A recent study shows that better communication between doctor and patient results in better physical and mental health as well as better control of chronic diseases such as diabetes and hypertension. Furthermore, a strong relationship between physician and patient will greatly reduce the risk of malpractice. A past study showed that 71% of the requests to file malpractice claims against doctors resulted from problems with physicianpatient communication. Therefore, better communications with patients are only beneficial to patients but also to physicians themselves.

By treating patient with courtesy and respect, listening to patient carefully, and explaining things in a way that patient could understand, the HCAHPS scores on the physician side will certainly improve. Besides, this will improve the overall trust of patient on the care that is provided at Huntington.

Edmund Tse, MD

President

Celebrating Milestones

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

30 Years (on staff 10/1983)

Uma Deperalta, MD – Nephrology

25 Years (on staff 10/1988)

Edward Laurance, MD –
Pediatric Gastroenterology
Dean Noritake, MD – Rheumatology
Ronald Olah, MD – Internal Medicine
Luch Shih, MD – Otolaryngology

20 Years (on staff 10/1993)

David Miller, MD – Maternal & Fetal Medicine Christian Rutland, MD – Addiction Psychiatry

15 Years (on staff 10/1998)

Norman Chien, MD – Geriatrics
Luis Dimen, MD – Pulmonary Disease
Ramona Kyaw, MD –
Radiation Oncology
Carolyn Lamb, MD –
Internal Medicine
Khin Khin Oo, MD – Internal Medicine
Georgia Sotiropoulos, MD –
Emergency Medicine
Xuedong Wang, MD – Pathology

10 Years (on staff 10/2003)

Marlys Drange, MD – Endocrinology Cynthia Martel, MD – Hematology/Oncology

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

Empathy is the "capacity" to share and understand another's "state of mind" or emotion. It is often characterized as the ability to "put oneself into another's shoes," or in some way experience the outlook or emotions of another being within oneself. Empathy is a powerful communication skill that is often misunderstood and underused. Initially, empathy was referred to as "bedside manner"; now, it is considered a skill that has tangible benefits for both clinician and patient: Effective empathetic communication enhances the therapeutic effectiveness of the clinician-patient relationship. Appropriate use of empathy as a communication tool facilitates the clinical interview, increases the efficiency of gathering information, and honors the patient."*

Physicians who are expert empathetic communicators, especially in difficult situations, create the most positive and satisfying patient experiences. Patients respond positively to physicians who encourage the disclosure of feelings, elicit and respect concerns, and acknowledge patients' fears.

Physicians are encouraged to join the Huntington staff and volunteers who have watched an exceptional video created at the Cleveland Clinic which is located on You Tube titled: "If we could see inside other 's hearts" http://www.youtube.com/watch?v=IQtOgE2s2xl.

Physician Comments on empathy:

"As a graduate from the Jefferson Medical College, I fully adapt the definition from the Jefferson Scale of Empathy (JSE): "A cognitive attribute that involves an ability to understand the patient's experiences, pain, suffering, and perspective combined with a capability to communicate this understanding and an intention to help."

- K. Edmund Tse, MD

"Empathy and compassion are not just one extra thing you have to do in a patient visit. One of the best ways I have found to cope with the demands of my job is to connect with people, and feel the thrill of helping them. Too often, we underestimate the power of a smile, kind word, listening ear, the small acts of caring; as Teddy Roosevelt said, "No one cares how much you know until they know how much you care."

- Todd Dietrick, MD

"Empathy to me is understanding patients emotions. I strive to treat every patient as if they were my most important."

- Shant Kazazian, MD

Job Well Done!

"The cardiologist was so kind, comforting, and respectful that I really wanted that physician to be my heart doctor. I have an appointment with that physician this week."

"My doctor was beyond outstanding. I felt confidence after meeting the physician. The physician has great empathy for the patient as well as family members."

(Empathy and emotional intelligence: What is it really about? Ioannidou, F and Konstantikaki, V; International Journal of Caring Sciences, 1(3):118–123; Sept-Dec 2008)

Bioethics Corner

Talking Points for Consent and Informed Consent

By: Wendy Kohlhase, Ph.D. and Farnza Datomi, Director, Risk Management

General Issues Regarding Consent

- Informed consent is required for those procedures which are complex or involve material risks that are not commonly understood. The **patient's physician** is solely responsible for providing the information to the patient and or responsible party in order to make an informed decision.
- Sections 2.1 and 2.2 of Huntington Hospital's Medical Staff Rules and Regulations note that it is the responsibility of the physician to obtain an additional informed consent for complex procedures* and treatment as defined in Administrative Policy 113 "Consent, Obtaining and Documenting". Obtaining informed con sent is an active process in which each physician participating in the treatment of a patient provides all material information to enable the patient make an informed decision in regard to any proposed treatment or procedures.
- Section 2.3 of Huntington Hospital's Medical Staff Rules and Regulations notes that the physician shall document in the patient's medical record that a discussion was held with the patient that included discussion of all material information, that the patient indicated understanding of the material information and informed consent was obtained. Informed consent may be documented by the physician in any of the following areas of the medical record:
 - History and Physical/Consultation
 - Progress Note
 - Pre-printed and approved informed consent formats
 - Faxed copy from a physician's office

Content of the Informed Consent

- Section 2.2 of Huntington Hospital's Medical Staff Rules and Regulations defines material information as:
 - ◆ The nature of the procedure or treatment
 - The risks, complications, and expected benefits or effects of the procedure including potential problems related to recuperation.
 - Any alternatives to the treatment and their risks and benefits.
 - Likelihood of achieving treatment or care goals.
 - Any limitations on confidentiality of information learned from or about the patient.
 - Name of practitioners performing the procedure(s) or important aspects of the procedures.
 - The patient's physician is encourages, but not required to inform the patient who will be performing significant surgical tasks during the patient's operation and what each person will be doing.

Process

The physician will obtain informed consent and document that discussion in his/her notes.

Physician Responsibility

The patient's physician is responsible for providing the information the patient needs in order to make an informed decision; physician is responsible to obtain informed consent for the procedure and is responsible for documenting that in the patient's medical record.

continued on page 9



Bioethics Corner continued

Exceptions

Special circumstances in which a physician is not required to fully inform the patient:

- When the patient has requested that he/she not be so informed. (Thoroughly document this request in the medical record).
- Therapeutic Privilege Defined as whenever such disclosure would likely result in serious harm rather than benefit to the patient. In these instances the physician shall fully document in the medical record the facts that resulted in invoking therapeutic privileges. See policy #113, Consent, Obtaining, and Documenting.
- Emergency Treatment immediate treatment required to alleviate severe pain or prevent serious disability or death.
 - Only emergency condition may be treated
 - No evidence exists to indicate that the patient (or legal representative) would refuse the treatment, for example, religious belief, relative's statement of patient's wishes, etc.
 - ◆ The physician is required to document the medical emergency condition and the required emergent intervention/ procedure. The physician may want to obtain a second verification of the emergency condition from another physician, which is advisable but not required. Only one physician signature is required on the "Authorization for and Consent to Surgery, Care, Treatment, Special Diagnostic, or Therapeutic Procedures" Form.

Process for Obtaining Authorization for Non-Emergency Care/Treatment (invasive/surgical that generally requires consent) for Patients who Lack Capacity and are Unrepresented

 A healthcare decision-making process (team) has been formed to provide authorization for treatment/procedures when a patient lacks capacity, has no known healthcare decision-maker (or no known relative who can be reached or is willing and able to participate in the consent process) or advance directive, and is in need of non-emergent treatment or procedure. The Healthcare Decision-Making Team (HDT) (refer to policy 8740.263) is utilized when hospital informed consent policy and rules and regulations would require informed consent or when the treatment plan involves with holding or withdrawing of life-sustaining treatment, including Do Not Attempt Resuscitation (DNAR) orders.

- HDT members are specific to the patient care process. A HDT would not be needed for treatments/procedures that have been certified by the physician as being emergent, as noted above.
- The HDT process ensures that the proposed treatment/procedure is necessary and appropriate and that the decision is in the best interest of the patient. The HDT process at Huntington Hospital was established in accordance with the California Hospital Association's recommendation in April 2008 regarding healthcare decision-making for unrepresented patients.
- The process for initiating the HDT is, as follows:
 - The social worker conducts a diligent search according to hospital policy in order to locate the appropriate decision-maker.
 - When the social worker is unable to locate a decision-maker, a notation of that outcome is placed in the patient's medical record.
 - When the physician proposes a treatment/procedure that requires consent, he/she notifies the social worker to convene the HDT. The HDT meeting is held as soon as possible following the request.

continued on page 10

Getting to Know Your Medical Staff Leaders

Ted Shen, MD has been a member of the Medical Staff since September 2010. He is a member of the Department of Surgery specializing in Otolaryngology. Dr. Shen received his medical degree from the Keck School of Medicine. Additionally, he completed



his residency and fellowship training at the LAC/USC Medical Center in Otolaryngology/Head and Neck Surgery. Dr. Shen is board certified in Otolaryngology and is a Fellow of the American Academy of Otolaryngic Allergy. Currently, Dr. Shen is the chair of the Otolaryngology Section for the 2013-2014 term. As Chair, he represents the Section at the Surgery Committee meetings.

During his career Dr. Shen has received many awards, including: the 2010 Honorary Research Presenter from the American College of Surgeons, Edmondson Research Fellow at the University of Southern California School of Medicine, Resident Teaching Award, USC General Surgery, third prize at the 2009 Annual Conference Presentations at the American Society of Pediatric Otolaryngology, and high honors for his senior thesis on Factor Analysis Study of Hospital Service Areas at Dartmouth College.

In his spare time, Dr. Shen spends time with his three children, Max, Maddie, and Maddox. Additionally, he enjoys his saltwater aquarium reef and fishkeeping. In his former life, he was a violinist.

Bioethics Corner continued

- ◆ The membership of the HDT is: the patient's physician (the physician requesting the treatment/procedure), a second physician (who may not be involved with the patient care but preferable with the same specialty or related specialty), the patient's nurse, the social worker, the Bioethicist or their designee, and a community member of the Bioethics Committee. Based on the specific circumstances of the case, other members may include Risk Management or Spiritual Care.
- The propose treatment/procedure must be authorized by all participating HDT members prior to the initiation of care.
- If agreement is not reached by the HDT, the Bioethics Committee will meet with the team to explore their disagreement and facilitate resolution.
- The HDT meeting is documented by the physician on a pre-printed yellow progress note in the patient's medical record. The social worker will also document the meeting on the Healthcare Decision-Making Team Record in the EMR.

For general consent questions, please contact Farnaz Datomi, Director, Risk Management at extension 3383 or Debra Starr at extension 3559. For information regarding the Healthcare Decision Team (HDT), please contact Wendy Kohlhase, Ph.D., Bioethicist at extension 2026.

Telemetry

Dear Physicians,

Over the past several months some of the initiatives in healthcare have highlighted the issue of telemetry use. The Joint Commission has issued a National Patient Safety Goal on Alarm Management on which hospitals are expected to have taken action by January 2014. These are some of the issues around alarm management.

- Large numbers of false or low level alarms that do not require an action by the RN can lead to alarm fatigue and cause missed responses to truly serious alarms
- Patients who remain on tele but no longer really meet criteria for tele contribute to this problem

Another initiative is Improving the Patient Experience. Alarms increase noise level on units, leading to a decrease in patient satisfaction. Telemetry leads are an annoyance to patients, also leading to a decrease in satisfaction. Decreasing telemetry use should help improve patient's perceptions around noise levels.

In response to this National Patient Safety Goal, the Cardiology Section collaborated with nursing to evaluate the issue. Discussion with many different specialties' physicians revealed many misconceptions around telemetry.

- Ordering tele does not guarantee more frequent vital signs, including blood pressure
- Ordering tele because of initial concerns but then not evaluating whether or not it is still needed
- Patients who receive orders to go "Off Tele for test" should possibly have telemetry discontinued
 if clinically stable and tele is not indicated

The action plans to address the issues include the following:

- Chart Flyers with AHA* recommendations for monitoring are placed in the chart of telemetry
 patients as a reminder to reevaluate continued need each day
- Changes in the admit order set
 - Admit order set Revisions:
 - Telemetry: discuss continued need with physician daily (included with any order for tele)
 - Gives the physician the option for more frequent vital signs or blood pressures and duration

The decision to remove the patient from telemetry is a physician's decision. Nursing will ask the question each day but the decision is yours. This initiative was approved by the Cardiology Section and Surgery and Medicine Committees. Nurses have begun this dialogue with physicians; the go-live date was September 3, 2013. If you have questions or concerns, please contact myself, Alison Birnie, RN, Nursing Director (extension 3686), or Jenny McFarlane, CNS (extension 3913).

Sincerely,

Gregory Giesler, MD

Vice Chairman, Quality Management Committee

CME Corner

Medical Grand Rounds

Topic: A Lipoprotein with an Attitude Speakers: Prediman K. Shah, MD Date: October 4, 2013 Time: Noon – 1 p.m.

Place: Research Conference Hall
Objectives: 1. Understand the complex

relationships between HDL and atherosclerosis.

2. Understand the importance of HDL function compared to HDL levels.

3. Learn about novel HDL based therapeutic interventions in development.

Audience: Primary Care Physicians and any

other interested specialties

Methods: Lecture

Credit: 1.0 AMA PRA Category 1 Credits[™]

CME Follow Up - Did you know?

Postaxial Polydactyly

Hand postaxial polydactyly refers to an anomaly where a person develops an extra digit next to the little finger. It develops more commonly in African Americans and it occurs less frequently in Caucasians. It is also has a frequent recurrence in first degree relatives. However, one study found foot postaxial polydactyly to be more common in Native Americans.

Castilla, E. E., Dutra, M., da Fonseca, R. L., Paz, J. E. Hand and foot postaxial polydactyly: Two different traits. *American Journal of Medical Genetics*. 1997;73(1):48-54.

Second Monday

Topic: Managing Psychiatric Disorders

During Pregnancy

Speaker: Emily Dossett, MD and

Barney Rosen, Ph.D.

Date: October 14, 2013 Time: Noon – 1 p.m.

Place: Research Conference Hall

Objectives: 1. Assess for perinatal mood and

anxiety disorders.

2. Distinguish between affected and unaffected pregnancies.

3. Discuss post partum depression and anxiety with patients.

4. Understand evidence-based treatment approaches.

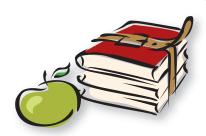
Audience: OB/GYN, Pediatricians, Psychiatry,

Internal Medicine, and any other

interested specialties

Methods: Lecture

Credit: 1.0 AMA PRA Category 1 Credits[™]



New Medical Director

Effective October 2013, Daryl Banta, MD has accepted the position of Respiratory/ Pulmonary Medical Director. Huntington Hospital would like to thank Dr. Michael Gurevitch for all of his years of service and many contributions during his tenure as director.



Joint Commission (TJC) Readiness

Huntington Hospital is now in the survey window for its tri-annual hospital accreditation survey which means TJC could come anytime between now and October 28, 2014. In addition, the hospital will also have a primary stroke and joint replacement re-certification survey that will occur this year between September 20 and December 20. Each of these programs will be surveyed by TJC for a full day by a clinical surveyor and will include direct observation of care processes, review of documentation, and testing of our processes, systems, and facilities.

As a reminder here is a summary of the policies and procedures that should always be followed, as required by TJC:

- Wear your ID badge at all times.
- Know and practice the National Patient Safety Goals.
- Protect patient confidentiality.
- Make sure that patient information cannot be viewed by other patients or visitors.
- Log off your computer when you are away from your desk.
- Do not discuss patients in open areas or in front of other employees who may not need to know the information being discussed.
- Complete patient records and documentation.
- Complete admission assessments, including for pain.
- Obtain consents.
- Complete the plan of care/ambulatory summary sheet.
- Remember education/teaching.
- Complete discharge plans.

Continuous survey readiness and designations such as Primary Stroke Center/Joint Replacement (Hip and Knee) are all part of the same focus: providing the very best care and service to the hospital's patients and their families. The hospital thanks you for the active role you play in making this happen.

From Physician Informatics

If you have yet to do so please remember to sign up for HANK/Cerner training. You can visit the Physician Only section of the hospital website, http://www.huntingtonhospital.com/PhysiciansOnly/PhysiciansOnly.aspx, to view the training schedule; training will be going on through October 26, 2013. Space is limited, so to ensure you get the training session you want, we ask that you please sign up as soon as possible. In order to register for training you can fill out the registration form, call 626-397-5913, or send an email to edmond.mouton@huntingtonhospital.com.

October 2013 **Medical Staff Meetings**

monday	tuesday	wednesday	thursday	friday
	-1-	-2-	-3-	-4-
	- 12:15 p.m. Oral Section — CR-6	- 12:15 p.m. OB/GYN Peer Review — CR 5 & 6 - 3 p.m. QMC Pre-agenda — CR-C	- Noon Medicine Committee — North/South Room - Noon Trauma Services Comm — CR 5 & 6	- 7 a.m. Ortho Section — CR 5 & 6
-7-	-8-	-9-	-10-	-11-
- 12:15 p.m. OB/GYN Dept — CR 5 & 6 - 5:30 p.m. Medical Executive — Board Room	- 12:30 p.m. ENT Section — North/South Room	- 10 a.m. PICU/Peds QI — CR-2	- Noon QM Committee — East Room - 5:30 p.m. Neonatal/Pediatric Surgical Case Review — CR-10	- 7:30 a.m. Neurosurgery Section — CR-11
-14-	-15-	-16-	-17-	-18-
- 9:30 a.m. SCAN Team — WT CR-10 - 10:30 a.m. PMCC — WT CR-10 - 12:30 p.m. Ophthalmology Section — CR-8 - Newsletter Submission -	- 12:15 pm Credentials Committee — CR-C	- 5:30 p.m. Surgery Committee — CR 5 & 6	- 6:30 a.m. Anesthesia Peer — CR-7 - Noon PT&D Committee — North/South Room - Noon G.I. Section — CR-10 - 3 p.m. Neon QI — WT CR-10 - 6 p.m. Bioethics — CR 5&6	
-21-	-22-	-23-	-24-	-25-
		- 12:15 p.m. Hem/Medical Onc — CR-5	- Noon Cancer Committee — North/South Rm - 12:15 p.m. Pediatric Committee — East Room	
-28-	-29-	-30-	-31-	
- Noon Psychiatry Sct CR-10 - Noon Graduate Medical Education East Room - 12:15 p.m. Urology Section — CR 5&6			- Noon IM Peer Review — CR-6	

October 2013 **CME Calendar**

monday	tuesday	wednesday	thursday	friday
	-1-	-2-	-3-	-4-
	- 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: HDL - Noon — 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-7-	-8-	-9-	-10-	-11-
-12:15 — 1:15 p.m. OB/GYN Dept. Mtg, CR 5 & 6 Topic: ACOG Ultrasound Guidelines	- 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	- Noon — 1 p.m. Medical Case Conference, RSH - Noon — 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-14-	-15-	-16-	-1 <i>7</i> -	-18-
- Noon — 1 p.m. Second Monday, RSH Topic: Psychiatric Disorders During Pregnancy	- 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	- 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
-21-	-22-	-23-	-24-	-25-
	- 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
-28-	-29-	-30-	-31-	
- Noon — 1 p.m. Pelvic Floor Clinical Conf., Conf. Room 11	- 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	- 7:30 — 8 a.m. Trauma Walk Rounds, Conf. Room B - 8 — 9 a.m. Surgery M&M, Conf. Room B	



Medical Staff Administration

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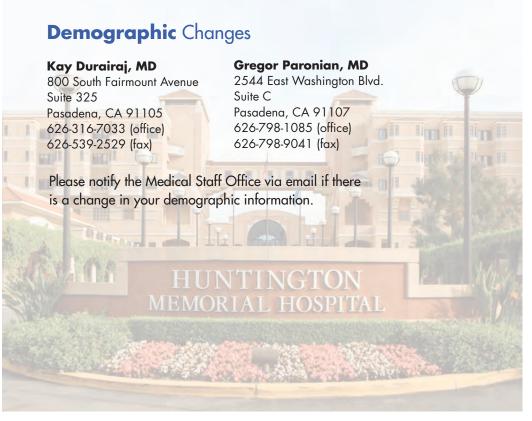
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2013 – 2014 Best Hospitals Report

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