

# MEDICAL STAFF

Huntington Hospital NEWSLETTER

VOLUME 48, NUMBER 8 August, 2010

## From *The President*



*The railroad track is miles away,  
And the day is loud with voices speaking,  
Yet there isn't a train goes by all day  
But I hear its whistle shrieking.  
All night there isn't a train goes by,  
Though the night is still for sleep and dreaming,  
But I see its cinders red on the sky,  
And hear its engine steaming.  
My heart is warm with the friends I make,  
And better friends I'll not be knowing;  
Yet there isn't a train I wouldn't take,  
No matter where it's going.*

**Edna St. Vincent Millay**

Los Angeles Union Station is a beautiful architectural tribute to the early Spanish Culture of old California, as well as a monument to the glory days of the railroads, when intercity transportation was almost exclusively by rail, and train travel was an exciting and luxurious experience. I had the opportunity to ride the *San Diegan* to the 92<sup>nd</sup> annual meeting of the Endocrine Society, this year held at the San Diego Convention Center. After early morning Saturday rounds with my resident, I climbed aboard the Amtrak train just prior to its on time departure at 11:15 and sat back in relaxed comfort as the train glided out of Union Station onto

*Continued on page 2*

## Summary of the *Minutes*



## Executive Committee Meeting

The following items were approved by the Medical Executive Committee on July 12, 2010, and by the Governing Board on July 22, 2010.

### PRESIDENT'S REPORT

Dr. Sharp presented the June findings related to post-operative documentation. Seven Sections had less than 90% compliance.

### MEDICAL STAFF APPOINTMENTS

- Asuncion, Joanne, MD Pediatrics (Neonatology)  
– joining Children's Clinic
- Dorr, Lawrence, MD Orthopedics – solo
- Lin, Yvonne, MD Gyn/Onc  
– joining USC Gynecologic Oncologists
- Lugo, Brian, MD General Surgery  
– joining Amal Obaid, MD
- Madden, Kevin, MD Pediatrics (Pediatric Critical Care)  
– joining University Children's Medical Group
- Paronian, Gregor, MD Internal Medicine  
– HH Chief Medical Resident
- Srephichit, Sekasa, MD Anesthesia  
– joining Pacific Valley Medical Group

*Continued on page 2*

## Inside:

From the President	~~~~~1-3
Summary of the Minutes	~~~~~1-2
Trends in HH Antibigram	~~~~~4-5
New at the Health Sciences Library	~~~~~5
Physician Informatics Corner	~~~~~6
Thank You for Not Smoking	~~~~~7
CME Corner	~~~~~7

# Summary of the *Minutes*

## Executive Committee Meeting

*continued from page 1*



### MEDICAL STAFF RESIGNATIONS

- Anderson, Clarke, MD Pediatric Hematology/Oncology
- Boddula, Madhay, MD Orthopedic Surgery Fellow
- DeMeester, Tom, MD Thoracic Surgery
- House, John, MD Otolaryngology
- Kirk, Jason, MD Internal Medicine
- Muller, Ridgely, MD Emergency Medicine
- Yang, Alisa, MD Internal Medicine

### ADMINISTRATIVE REPORTS

Administrative reports were tabled

### DEPARTMENTAL AND SECTION RULES AND REGULATIONS REVISION

- Cardiology Section Rules and Regulations
  - amendment to the election process
- Hematology/Medical Oncology Rules and Regulations
  - amendment to the election process
- Pulmonary Section Rules and Regulations
  - amended to include provisions for proctoring and sleep study

### PRIVILEGE CARD REVISIONS

- Electrophysiology competency requirements
- Cardiology privilege card
- GI Section privilege card
- Podiatry privilege card

### DEPARTMENTAL POLICIES AND PROCEDURES

- Department of Medicine
  - o Treatment Protocol for AMI patients
  - o Newborn Abandonment
  - o Animal Bite Reporting
  - o Respiratory Therapy Medi-tech Upgrade Policy Changes
  - o Outpatient Sleep Health Center Policies and Procedures
  - o Respiratory Services Clinical Policies and Procedures
- Department of Obstetrics and Gynecology
  - o Scheduling Policies and Procedures in Labor and Delivery
  - o Fetal Spiral Electrode Placement
  - o Central Fetal Monitoring Record Keeping

- Department of Pediatrics
  - o Intravenous Therapy Protocol
  - o IV Therapy

### ORGANIZATION WIDE POLICIES AND PROCEDURES

*For specifics go to Medical Staff Services on MyAlliance*

4 items were approved

#### Standardized Procedures

7 items were approved

#### Formulary Changes

2 items were approved

**William Coburn, DO**

*Secretary / Treasurer Medical Staff*

## From The President

*continued from page 1*

the west bank of the Los Angeles River, gaining speed and whistling intermittently. Most of the first hour now is essentially an urban back alley experience, in contrast to the panorama of orange groves that formerly occupied that terrain. Lunch was a delicious hot dog and a Heineken in the empty dining car. After San Juan Capistrano, the view was of beautiful beaches, sunbathers, and surfers almost the rest of the way to San Diego, where the terminus is the old Santa Fe station that was patterned along Spanish-Colonial architecture and was opened during the 1915 Panama-California exposition. From the station it was a short hop to my hotel. No car to park, no traffic to fight. The trip back was a mirror image, except that my train arrived during rush hour on a weekday; which made the Gold Line ride home all the more delicious. (Look at all the cars waiting for me, for a change.)

*Continued on page 3*

## From *The President* continued from page 2

From the middle of the 19<sup>th</sup> century until 1920, nearly all intercity travelers in the United States moved by rail. The rails and the trains were owned and operated by private, for-profit corporations. Approximately 65,000 railroad passenger cars operated in 1929.

Rail passenger revenues declined dramatically between 1920 and 1934 because of the rise of the automobile, but in the mid-1930s, railroads engineered a resurgence with improvements in service and new, diesel-powered streamliners like the Santa Fe *Chief* and the Southern Pacific *Daylight*. The great trains of this grand age of continental surface travel in the United States were, according to Lucius Beebe, “but an extension of the luxury, décor, and facilities that were part of the hotels which were, in effect, their terminals or junction points.” The finest meals in America were served on the rails, from the Fred Harvey cuisine aboard the *Chief* and *Super Chief* of the Atchison, Topeka and Santa Fe to the gastronomic delight aboard the *Twentieth Century Limited* of the New York Central. The great resort hotels of Pasadena, Phoenix, Tucson and Los Angeles of the late 19<sup>th</sup> century emerged as a result of the pullmans of the Santa Fe, whose Pasadena station was under the porte cochere of Pasadena’s Green Hotel.

World War II, because of troop movements and restrictions on automobile fuel, generated a sixfold increase in passenger traffic from the low point of the Depression. After the war, railroads rejuvenated over-worked and neglected fleets with fast and often luxurious streamliners. But the railroads were challenged by the development of the Interstate Highway System, huge taxes on their right of ways, labor issues, and unfunded federal mandates. For years, railroads tried to abandon the federal mandate to provide passenger service, on the grounds that automobiles, buses, and airplanes had already taken the passenger market away. The postwar resurgence was brief. By 1946, there remained 45 percent fewer passenger trains than in 1929. As passengers disappeared so did trains they rode. Few trains generated profits; most produced losses. By 1965, only 10,000 rail passenger cars were in operation, 85% fewer than in 1929 and passenger service was provided on only 75,000 miles of track, a stark decline. Passenger

rail services suffered from decrepit equipment, gloomy and empty stations in declining urban centers, and management that seemed intent on driving away the few remaining customers. When railway post office revenues were rescinded in the 1960s hardly any of the passengers trains could break even.

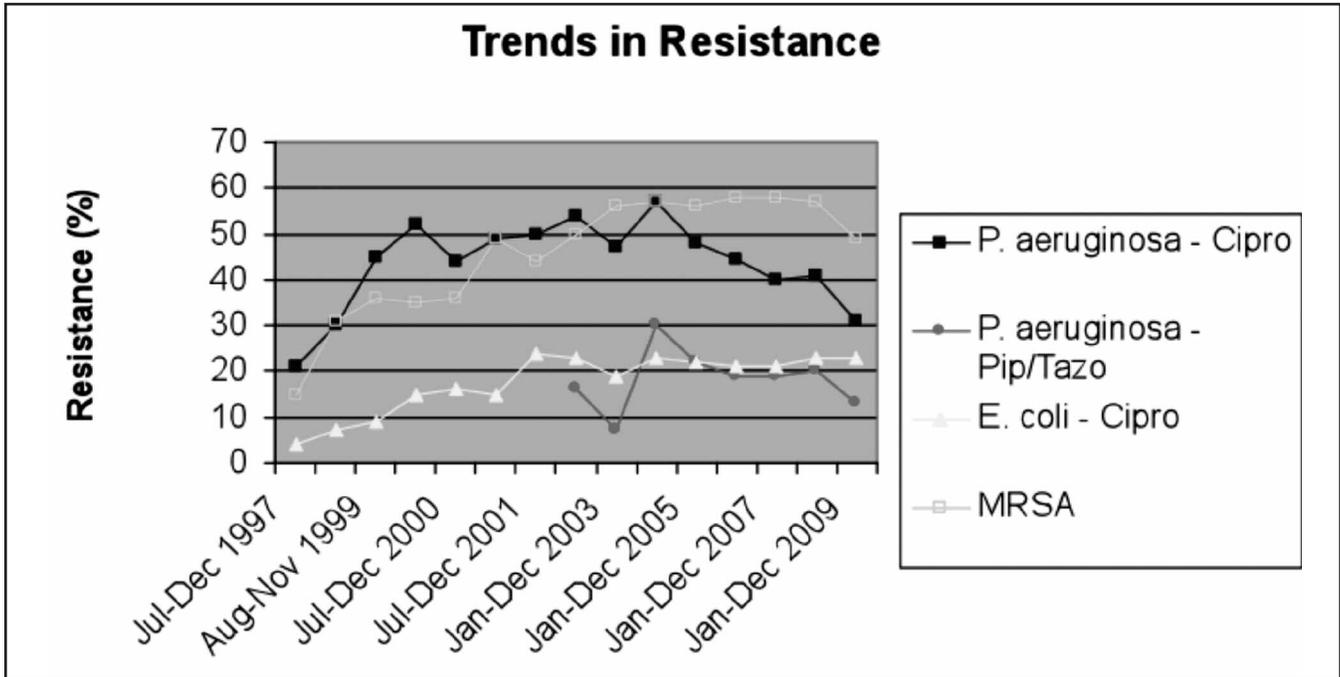
Passenger traffic now constitutes only about 7 percent of all rail service, in the United States. Hauling passengers is far more expensive than transporting commodities, so naturally, the major goal of most railroads has for decades been providing service to their industrial customers. AMTRAK was conceived as a compromise in 1971. AMTRAK somehow managed to get multiple railroads to allow access to their rail lines, make passenger trains a priority and use trunk routes with destinations in the heart of urban centers. In order to provide a modicum of passenger service at reasonable rates, AMTRAK owns very little real estate and leases space in most terminals; expenses are carefully watched. Despite a difficult inception, and despite the fact it was frankly expected to fail, AMTRAK is a relatively successful federal agency and has provided critical leadership in the development of urban mass transit. Gone are the fine dining, the barber and bath, the valet, the tailor, soda fountain, cigar stand, library (with librarian), and the luxurious appointments. The rolling stock is old, the food is mediocre, and some of the service employees act just as you might expect of federal workers; yet intercity rail transportation has survived all the same.

Can we assume by analogy that the Federal Government will be as successful in its impending takeover of medical care in the United States? After all, various federal agencies have developed quality measures, guidelines and mandates; and patients have been assured that the quality of their care will not suffer. Somehow, I have serious reservations. But it’s summer, and much more fun to ride the rails and just enjoy the journey. May you all have a wonderful August.

**Charles F. Sharp, Jr., M.D.**  
*President Medical Staff*

# TRENDS IN HH ANTIBIOGRAM

Eva Barker, Pharm.D.  
Annie Wong-Beringer, Pharm.D.



**E**ach year, the microbiology laboratory compiles data on the antibiotic susceptibility for organisms isolated from patients at HH. The antibiogram can be accessed through My Alliance under Department Information and selecting Clinical Laboratory Information where the Antibiogram tab will be on the top right. Starting from 1997, we have used this data to follow the rates of resistance development and thus make appropriate empiric antibiotic recommendations and adjustments in the formulary.

The most notable change in 2009 has been significant improvements in susceptibility of *P. aeruginosa* towards all antipseudomonal agents. This trend has been observed over time since the removal of levofloxacin from our Formulary and the adoption of beta-lactam based therapy in 2007. The following shows *Pseudomonas* susceptibility in descending order: amikacin (99%), tobramycin (91%), gentamicin (90%), piperacillin/tazobactam (87%), meropenem (86%), imipenem (84%) ceftazidime (82%), cefepime (78%), and ciprofloxacin (69%). The trend above plus results from our *Pseudomonas pneumonia* outcomes study support our current recommendation for empiric therapy: piperacillin-tazobactam plus tobramycin; cefepime

in place of piperacillin-tazobactam for penicillin allergic patients. Note that we recommend cefepime over ceftazidime as cefepime has the additional coverage for gram-positives and mouth anaerobes for empiric coverage; ciprofloxacin remains least active compared to other agents and should not be used empirically.

For the other gram-negative pathogens, *E. coli* remains highly susceptible to ceftriaxone/cefotaxime at 98% (compared to 68% for TMP/SMX and 77% for ciprofloxacin). Isolation of *E. coli* and *K. pneumoniae* strains that produce extended-spectrum beta-lactamases has remained stable with *E. coli* and decreased slightly with *K. pneumoniae* (10% vs. 14%) from 2008. It is important to adjust antibiotics once culture and sensitivity results are available and follow infection control measures to prevent the spread of these resistant strains within HH. Notably, *P. mirabilis* and *Morganella morganii* continue to trend downward with 50% or less remaining sensitive to ciprofloxacin. This trend will need to be monitored vigilantly as these resistance genes may serve as a reservoir for resistance to other pathogens. For now, we recommend ceftriaxone/cefotaxime as first line empiric therapy in urosepsis and intra-abdominal infections (plus metronidazole).

*Continued on page 5*

## TRENDS IN HH ANTIBIOGRAM ...continued

With regards to gram-positive pathogens, the number of *Streptococcus pneumoniae* isolates in 2009 was limited (blood=25, respiratory=32) while the sensitivity to cefotaxime has increased slightly to 92% (vs. 88% from 2008). *S. aureus* remains the second most isolated pathogen at HH, but the prevalence of MRSA has slightly decreased from 57% in 2008 to 49%. Majority (88%) of the blood MRSA isolates had borderline susceptibility to vancomycin with Etest MIC >1 µg/ml, requiring trough concentration of 15-20 µg/ml for effective therapy per recommendations from the Infectious Diseases Society of America and the American Thoracic Society.

Vancomycin is recommended for empiric treatment in patients with suspected MRSA infection based on the following reasons: 1) study published here at HH indicated that aggressive initial dosing achieves optimal early outcome against MRSA strains with high MIC and 2) most patients (77%) initiated on vancomycin do not have documented MRSA infections and therefore would not need continued therapy past the reported onset of vancomycin-associated nephrotoxicity at 4 to 7 days. It is imperative that vancomycin be discontinued in the absence of documented infections caused by MRSA as high dose therapy is associated with increased risk of nephrotoxicity in at risk patients who have: (1) concomitant nephrotoxin or vasopressor therapy, (2) duration of therapy greater than one week, and (3) intensive care unit admission.

In patients without concomitant nephrotoxicity risk, the reported incidence of nephrotoxicity was < 8% and did not differ between patients attaining high ( $\geq 15$  mg/dL) or standard trough (<15 mg/dL). Of note, pharmacy dosing protocol is applying the new diagnostic criteria for acute kidney injury (AKI) to vigilantly monitor patients on vancomycin: Scr 0.3mg/dl increase over a 48-h period. Preliminary data on a study conducted at HH (n=145) indicates a 19% incidence of AKI; the rate of occurrence did not differ based on trough levels (15-20 or < 15) but was 2-fold higher in patients with concomitant nephrotoxic risks (22% vs 11%). Use of the new criteria detects patients with early stage AKI more readily, allowing prompt intervention before significant change in renal function occurs.

In summary, the resistance trend with gram-negatives continues to strongly support  $\beta$ -lactam based empiric therapy and avoidance of fluoroquinolones whenever possible. We recommend vancomycin as first line empiric therapy but prompt discontinuation is imperative in the absence of positive MRSA cultures or continued clinical need to minimize risk of nephrotoxicity. Alternative agents such as linezolid and daptomycin should be reserved for those who are at risk for nephrotoxicity or have MRSA strains with documented reduced susceptibility to vancomycin.

## New at the Health Sciences Library on the Library's My Alliance site

**T**he 3<sup>rd</sup> quarter ABOG (American Board of Obstetrics & Gynecology), list is now available with links to the articles.

The mobile version of Micromedex has a new password: username: MBL\_THC\_6661; password: WJOIQE. This will change quarterly,

A new bibliography, "Implementing an EHR", has been posted to provide current articles pertinent to Electronic Health Record implementation for small physician practices. Full text of articles is provided when available and the list is updated quarterly.

Two new Guides to Resources are now available

- Medical Image Resources - A list of online resources for finding images, videos, graphs and tables. Terms of use and copyright information provided when available. Of use when writing papers or giving presentations.
- Patient Education Resources - See what's available in the Huntington Community Health Library for Patient Education.

# Physician Informatics Corner

## Pop-Up Notification to Sign Documents/Telephone Orders

On June 7, 2010 the Medical Executive Committee determined that physicians should receive a pop-up upon sign in if they have any reports and/or telephone orders to electronically sign. Beginning July 6<sup>th</sup>, all physicians are receiving this pop-up.

### ***What can I do in this alternate version?***

You can batch sign or reject your orders by checking the orders you wish to act on and click on either the **Sign** or **Reject** buttons at the bottom of the screen.

You can sort your documents/order in your sign queue by clicking on **Sort** and selecting the criteria for sorting, example "Queued Date".

You can sign for another physician by clicking the **Sign for Other** button.

You can click on **Cancel** and this will return you to your Meditech Main Menu and to the current version of how to sign your documents/orders.

### ***Physician Documentation Templates***

Selected Physician Notes are currently being electronically documented directly in the Meditech system. If you are interested in participating or have questions about the current notes available, please contact our office.

If you have any questions call us at 626-397-2500 or email:

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## Thank You for Not Smoking

**B**y now, most of you have heard about Huntington Hospital's plan to become a tobacco-free campus as of January 1, 2011. We are taking this step to show our commitment to the good health of our community by eliminating the use of tobacco in any form from our campus.

Over 50 percent of hospitals nationwide are tobacco-free. Locally we will join several prominent hospitals that do not allow smoking including Childrens Hospital Los Angeles, Cedars-Sinai Medical Center, City of Hope, Hoag Memorial and Henry Mayo. There are bans on smoking in public gathering areas throughout Pasadena, and other cities have similar prohibitions. As a major leader in healthcare advocacy for Pasadena, it is a natural progression for our campus to be identified as smoke/tobacco free.

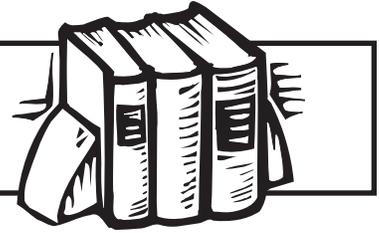
We are not requiring anyone (employee, physician, volunteer) to stop smoking, just asking that they do not do it anywhere on our campus. We will have resources available at different locations on campus, such as the cafeteria, gift shop and the library, to help smokers combat cravings, and, like now, there will be smoking cessation workshops available free of charge for employees and any others who choose to participate.

We are finalizing our communication plan around becoming tobacco-free, as well as plans to train staff to deal with any issues that might arise as a result of this change in policy. Though this may be a challenge for some, we hope the decision to become a tobacco-free campus will be viewed for what it is: a significant way to demonstrate our commitment to a healthy lifestyle.

If you have questions or concerns, please email them to:

[Tobaccofree.campustaskforce@huntingtonhospital.com](mailto:Tobaccofree.campustaskforce@huntingtonhospital.com)

# CME Corner



PLEASE NOTE THAT THERE WILL BE NO FIRST THURSDAY IN AUGUST

## UPCOMING PROGRAMS FOR THE FIRST THURSDAY MEDICAL WORKSHOPS:

2010

08/05/10 – No meeting  
09/02/10 – Winter Infections

## UPCOMING MEDICAL GRAND ROUNDS:

08/06/10 – Treatment of Rheumatoid Arthritis with Biological Agents  
09/03/10 – No meeting scheduled at this point in time  
10/01/10 – Appropriate Use of Fresh Frozen Plasma  
11/05/10 – Meningitis

## MEDICAL GRAND ROUNDS:

**Topic:** Treatment of Rheumatoid Arthritis with Biological Agents

**Date:** August 6, 2010

**Time:** 12:00 p.m.

**Place:** Research Conference Hall

**Gap Analysis:** *Knowledge Gap:* Biologic agents are commonly used in therapy of rheumatoid arthritis. There is a need for education of primary care physicians in the appropriate use of those compounds and their complications.

**Objectives:**

1. Understand indications for biologic agents in rheumatoid arthritis
2. Know complications of biologic agents in rheumatoid arthritis
3. Be aware of contraindications to use biologic agents in rheumatoid arthritis

**Audience:** Primary Care Physicians

**Methods:** Lecture with a question and answer period

**Evaluation:** Post-activity evaluation form

**Speaker:** Nourollah Parhami, MD, FACP, FACR; Keck School of Medicine of USC;  
The Center for Rheumatic Diseases

**Credit:** 1 AMA PRA Category 1 Credit™



## Huntington Hospital

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# MEDICAL STAFF

N E W S L E T T E R

August, 2010