# medical staff NEWSLETTER


April 2014

volume 52, issue 4


## From the President

***"The American public believes that health care is a right and not a commodity."***
- Michael Moore

***"Health care's like any other product or service: if the consumer is in charge of spending his money on it, then the market will make sure that it is affordable."***
- Rush Limbaugh

***"America has the best doctors, the best nurses, the best hospitals, the best medical technology, the best medical breakthrough medicines in the world. There is absolutely no reason we should not have in this country the best health care in the world."***
- Bill Frist

### Universal Health Coverage in Various Countries

#### Part One

The United States spends close to 16% of its gross domestic product (GDP) per year on health care, nearly 6.1% more than the average for other industrialized countries. Overall health care costs are rising faster than GDP growth and now total more than $2 trillion per year, more than Americans spend on housing, food, national defense, and automobiles. Despite the amount that is spent on healthcare, studies have shown that, compared to other countries, the United States health care system fell below par. According to the study published in the New England Journal of Medicine 2003, only a little more than half of American hospital patients receive the clinical standard of care.

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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 March 3, 2014 and by the Governing Board on March 27, 2014.

## Administrative Reports

### Rules and Regulations

#### Surgery Department Rules & Regulations

1. Metabolic and Bariatric Committee – Addition of the description of the new Metabolic and Bariatric Committee.

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

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

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Inside this issue:



**For H@NK questions call 626-397-4265**

Huntington Hospital

## **Medical Staff** Appointments

**Tyler Cheung, MD**
**Neurology**
Southern California
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**Sirak Darbinian, MD**
**Anesthesiology**
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**Andrew Freedman, MD**
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**Guangqiang Gao, MD**
**Cardiothoracic Surgery**
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323-442-5956 (fax)

**Neil Jones, MD**
**Plastic Surgery**
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Pavilion III
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714-456-7547 (fax)

**Steven Lerman, MD**
**Urology**
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**Shylaja Rachabattula, MD**
**Rheumatology**
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626-792-3611 (fax)

**Anya Rose, MD**
**Obstetrics & Gynecology**
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909-592-9712 (office)
909-592-7264 (fax)

**Jackson Wong, MD**
**Pediatric Critical Care**
100 West California Blvd.
PICU Department
Pasadena, CA 91105
626-397-3826 (office)
626-397-2181 (fax)

## **Medical Staff** Resignations

- Fadi Chahin, MD – Plastic Surgery
- John Gunnell, MD – Hematology/Oncology
- Payam Jarrahnejad, MD – Plastic Surgery
- Vijayalakshimi Lakshmanan, MD – Pediatrics
- Curtis Pickert, MD – Pediatric Critical Care
- Monica Serna, MD – Emergency Medicine
- Majid Seyedin, DPM – Podiatry
- Purificacion Tumbaga, MD – Neonatology
- Michelle Tyson, MD – Family Medicine

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

Critics recommend that the answer to the problems in the U.S. lie in a single-payer, national health care system. Under this system, health care would be financed through taxes rather than consumer payments or private insurance. The government would control costs by setting an overall national health care budget and reimbursement levels. Private insurance can only be allowed to provide supplemental services not covered by the government plan.

### *Measures used in Ranking Countries in Terms of Health Care Systems*

Ranking countries according to their health care system must be viewed with some skepticism. The areas used in the comparison may vary depending on the desired result to be achieved or the values of the one making the comparative ranking. The United States was ranked 37th out of 194 member states by the World Health Organization (WHO) for its health care system, yet it is worth noting that WHO ranked United States as first in the whole world for its quality of response to the needs of the patients. However, this study based on its conclusion on such highly subjective measures as "fairness", in which Health Savings Accounts was penalized because of its out of pocket cost, and criteria that are not strictly related to a country's health care system, such as "tobacco control". In addition, one of the measures for ranking health care quality in countries is life expectancy. In reality though, life expectancy is a poor measure as it can be affected by many factors such as violent crime, poverty, obesity, tobacco and drug use, and many other issues unrelated to health care. Moreover, infant mortality is another measure but it does not count the abortion rate as a factor. For instance, Michael Moore cites low infant mortality rates in Cuba, yet that country has one of the world's highest abortion rates, meaning that many babies with health problems that could lead to early deaths are never brought to term.

When it comes to treating diseases, United States is still ranked first. Prominent people from other countries go to the United States for treatment. Whether the disease is cancer, pneumonia, heart disease, or AIDS, the chances of a patient surviving are far higher in the U.S. than in other countries. According to a study published in Lancet 2007, the 5-year survival rate from cancer among men was 62.9% and among women was 66.3% in the U.S. compared to 59.7% in men and 49.8% in women in Italy, 59% in men and 49.5% in women in Spain, and 44.8% in men and 52.7% in women in the Great Britain. Not surprisingly, doctors from other countries often refer their patients to the U.S. such as the Mayo Clinic, Cleveland Clinic, the Brigham and Woman System at Harvard, John Hopkins Hospital, etc.

In terms of medical research and innovation, the United States still leads the other countries. Eighteen of the last 25 winners of the Nobel Prize in Medicine are either U.S. citizens or individuals working in the U.S. Half of all new major medicines introduced worldwide over the past 20 years were developed by U.S. companies. Many Americans received more advanced medicine compared to other countries. It was estimated 44% of Americans who could benefit from statins take the drug; whereas, there was only 26% of Germans, 23% of Britons, and 17% of Italians receiving this benefit.

### *Types of National Health Care Systems*

- Single-Payer Systems – Health care of the citizens is paid by the government from taxes. The government controls the flow of supply for health care and directly pays the provider. It sets aside a budget for health care and fixes the prices or rates of reimbursement for providers.
- Employment-Based Systems – In this system the employers are required to provide health insurance to their workers through a semi-government "sickness fund". The government

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sets the benefits and premiums. Taxes are deducted from the payroll and paid to the funds.

- Managed Competition – Private health care providers compete with each other in a market that is strictly controlled by the government. The citizens are mandated to buy health insurance although it also requires employers to provide their workers with insurance.

There are many variations in the implementation of the above health care systems in different countries. The variation will depend on the political, national, and historical trends of the country. Is one country system better than the other? Is the grass always greener in other parts of the world? In order to answer this, a closer look at the national health care systems in various developed democratic countries will be enlightening.

### *Healthcare Situation in Different Countries: An Overview*

### France

The French health care system, which is the world's third most expensive, costing roughly 11% of GDP, and is behind only the U.S. and Switzerland, provides a basic level of universal health insurance through a series of mandatory, largely occupation-based, health insurance funds which are heavily regulated and supervised by the French government. Premiums (funded primarily through payroll taxes), benefits, and provider reimbursement rates are all set by the government. These funds are separated into three domains. The largest one, which covers 83% of French residents, covers most nonagricultural workers and their dependents. Separate insurance plans cover agricultural workers, the self-employed, and certain special occupations like miners, transportation workers, artists, clergy, and notaries. Another fund covers the unemployed. Overall, about 99% of French citizens are covered by national health insurance.

In support of the French system, French employers must pay 12.8% of wages for every employee, while employees contribute an additional 0.75% of wages, for a total payroll tax of 13.55%. In addition, there is a 5.25% in general social contribution tax on income; most French workers are effectively paying 18.8% of their income for health insurance, whereas the U.S. paid six to 10% in the years prior to the Affordable Healthcare Act. To make the matter worse, there is out-of-pocket payment on health care spending.

Private insurance in France, which contributes to the majority of the nongovernment source of spending, is much less regulated compared to that in the U.S. No regulations specify what benefits must be included in coverage or mandate "guaranteed issue"; and pre-existing conditions may be excluded. It encourages citizens who have extra income to purchase additional coverage to cover benefits that the government is not providing.

Much of the burden for cost containment in the French system appears to have fallen on physicians. The average French doctor earns just €40,000 per year (U.S. $55,000), compared to the US where physicians earn $146,000 as primary care providers and $271,000 for specialists. However, one needs to keep in mind that French medical education is entirely funded by the French government making medical graduates free of tuition debt when they graduate from medical schools. Moreover, the French legal system is tort-averse, significantly reducing the cost of malpractice insurance.

The French system works in part because it has incorporated many of the characteristics that Michael More and other supporters of national health care dislike most about the U.S. system. France imposes substantial cost sharing on patients in order to discourage over-utilization,

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relies heavily on a relatively unregulated private insurance market to fill gaps in coverage, and allows consumers to pay extra for better or additional care, creating a two-tier system.

### Italy

The Italian system, which is similar to the British National Health Service, enjoys more decentralization. The central government sets goals on how money should be spent. Financing comes from both payroll taxes and general revenues. Payroll taxes have a regressive structure, starting at 10.6% of the first €20,660 of gross income and decreasing to 4.6% of income between €20,661 and €77,480.

Although Italian citizens enjoy inpatient care and primary care for free at the point of treatment, there are co-payments for diagnostic procedures, specialists, and prescription drugs. The size of the co-payment is steadily increasing over the years with some services requiring up to 30% of out-of-pocket cost from patients. Despite rising copayments, private health insurance is not widespread in Italy. Reasons for this is because it is not possible to opt out of the national health system and because private health insurance premiums are not tax deductible.

Besides increasing co-payments from patients, cost containment is made by reimbursing physicians on a capitated basis according to the number of patients served over a given time period rather than services actually provided. In addition, Italy has imposed a relatively strict drug formulary as well as price controls.

Despites these controls, the Italian health system is running a major financial deficit. Italians lack the finance to support widespread use of modern medical technology. Conditions in public hospitals are considered substandard, particularly in the south. Overcrowding within hospitals is widespread. Unsanitary conditions can be seen around such as garbage along hallways, unsafe radioactive materials, discarded medical records and medical staff smoking near patient area. The wait list for receiving various medical services become longer and longer. Furthermore, Italy's health care system is inflicted with bureaucracy, disorganization, and mismanagement. No wonder, dissatisfaction with the Italian health system is extremely high, by some measures the highest in Europe. Many citizens, reaching at an estimate of 60 percent, believe that a health care reform is urgently needed.

### Spain

The Spanish Constitution guarantees all citizens the right and equal access to health care. The national health care system in Spain is decentralized. The central government distributes a block grant from tax revenue to its country's 17 regions based on population. There are no earmarks on this fund permitting the region to spend whatever it desires for its health service. Therefore, the quality, spending, and waiting lists for medical services vary widely from region to region.

There are interesting contrasts between the health care systems in the U.S. and that in Spain. Some health services that U.S. citizens take for granted are almost totally unavailable. Services, such as rehabilitation, convalescence, and hospice care are usually left to the patient's family and relatives. In addition, Spain has fewer physicians and fewer nurses per capita than most European countries and the U.S. All hospital-based physicians and approximately 75% of all other physicians are considered quasi-civil servants and are paid a salary rather than receiving payment based on services rendered. Furthermore, Spain is also facing shortages of modern medical technologies. For example, Spain has 1/3 as many MRI units per million people as the U.S. Moreover, unlike the U.S. managed care, Spanish patients are not

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allowed to go "out of network" from its national/regional medical services unless the patient has private insurance.

Like Italy, Spain has a two-tier system in which the wealthy people are able to buy their way around the defects of the national health care system through private insurance and the poor are consigned to substandard services and long waiting lists for appropriate care.

Notwithstanding the shortcomings, many Spanish people are satisfied with their system. 60% rated their system "good" and only 46% see the urgent need for reform of their health care system in which they want more choice of doctors and hospitals and want the government to do a better job of dealing with waiting lists.

### Japan

Japan has a universal employment-based health insurance system. Companies with 700 or more employees provide a health insurance program to its employees; whereas, government-run small-business national health insurance programs covers companies with fewer than 700 employees. In both systems the employer and employee contributions, which are usually split 50/50, average around 8.2% to 8.5% of wage. Self-employed and retirees are covered by a separate program through self-employment tax. The Roken, an insurance program for the elderly, is financed by contributions from the above three schemes as well as contributions from the central government. There are small programs for special populations like farmers, fishermen, and government employees. Very few Japanese engage in private health insurance.

Benefits under the above schemes are generous, including hospital and physician care, as well as dental care, maternity care, prescription drugs, and even some transportation costs.

There are no restrictions on hospital or physician choice and generally no preauthorization or gatekeeper requirements. Since there is no competition in fee schedule which is set by the central government, the vast majority of hospitals and clinics are privately owned. Services rendered are paid by a fee-for-service basis. With the fee schedule being identical for in-patient and outpatient treatment, there is a strong push for outpatient services. Hospital physicians are salaried employees but non-hospital physicians working in the private sector have their income based on the fixed fee schedule fee-for-service system.

Japanese people practice a technology-intensive style of medicine with MRI units, CT scanners, etc. and are able to keep the cost down mainly through fixing the fee payment. In addition, factors in Japan, such as healthy lifestyles, low vehicle accident rates, low crime rates, low drug abuse rates, are helpful in making the universal coverage works without excessive rationing, and in keeping Japanese satisfied in their system.

The major challenges facing the Japanese national medical coverage is the rapid aging society. In 2050, Japan is expected to lose 35 million workers with 35% of its population in retirement. Therefore, if current trends continue, Japan will almost triple its government spending on health care in the next 20 years.

### Norway

Norway has a universal, tax-funded, single payer, national health system. All Norwegian citizens are covered by this system financed through tax revenues. Health care, which consumes 45% of Norwegian's GDP, not only covers all inpatient and outpatient care, diagnostic services, specialist care, maternity

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## From the **Health Science Library**

### AccessMedicine's New Platform Now Provides Off-Site & Mobile Access

**AccessMedicine** has a new look and features (http://accessmedicine.mhmedical.com/). It now provides:

- Mobile Device Access
- Download Images to PowerPoint
- Off-Site Access Using Your My Access Account

The library's subscription includes full text access to eight medical reference books:

Harrison's *Principles of Internal Medicine*
CMDT: *Current Medical Diagnosis & Treatment*
Hall's *Principles of Critical Care*
Hurst's *The Heart*
Goodman & Gilman's *The Pharmacological Basis of Therapeutics*
Williams' *Obstetrics*
Tintinalli's *Emergency Medicine*
Schwartz's *Principles of Surgery*

***Please note:*** *You may be able to search the content of other books on AccessMedicine's platform but full text access is only available for these eight titles.*

To set up your off-site* and/or mobile login:

1. From a hospital computer, navigate to: http://accessmedicine.mhmedical.com/
2. Click on **Huntington Memorial Hospital Program** at the top and select the option to **Login or Create a Free Personal Account** and follow the on screen registration instructions.

* *Physicians can access library resources from off-site via Citrix or Connect without having to create separate logins. For mobile access, create a personal account login.*

Contact the library for more information or to have an account set up for you: library@huntingtonhospital.com, 626-397-5161.

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services, preventive medicine, palliative care, prescription drugs, but also provides sick pay and disability benefits. However, the problem with the Norwegian's system is its long waiting lists and its care rationing through government agencies, such as the Health Care Priorities Commission.

The waiting lists to receive medical care in Norway are extremely long. Approximately 23% of all patients referred for hospital admission have to wait longer than 3 months for admission. The average wait for hip replacement surgery is more than 4 months; for a prostatectomy, close to 3 months; and for a hysterectomy, more than 2 months. With a population of just 4.6 million, nearly 280,000 Norwegians are estimated to be waiting for care on any given day.

Rationing of care is a common scheme in Norway. According to Knut Erik Tranoy, Professor Emeritus of the University of Oslo and an original member of the government's Health Care Priorities Commission: "It is important to see that, in a public health service of the Nordic type, any given amount of resources always has alternative uses. And it is neither medically nor morally defensible to put scarce resources to uses which will foreseeably yield less favorable outcomes than other uses – save fewer lives, cure few patients."

Although Norwegians are "fairly satisfied" with their universal health coverage, they very much would like the waiting lists to be dramatically shortened along with the ability to get involved in decisions making regarding care and treatment of their own.

Part two, which will be published in next issue, will address the medical systems in Portugal, Greece, Netherlands, Great Britain, Switzerland, Germany, and Canada.

**Edmund Tse, MD**
*President of the Medical Staff*

## From the **Health Science Library**

### MDConsult Replacement Trials in April

**The library's MDConsult** (MDC) subscription will be ending in May and the publisher, Elsevier, will discontinue the MDC platform at the end of 2014.

During the month of April the library will be evaluating three products as potential alternatives to MDC. The library would appreciate your participation in the trials so that we can find a replacement that supports your research and clinical needs.

How you can participate:

1. Access each product via the webpage URL below
2. Test each product by conducting 1 or more searches on topics relevant to your specialty
3. Fill out the short survey/questionnaire, at the same trial information link below

For trial information for each product go to:

- http://huntingtonhospital.libguides.com/trials
- password: hmhtrials

### About Each Product:

**eBrary** – eBrary is an electronic book search platform which includes medical eBooks from authoritative publishers such as Elsevier, Springer and Wiley. Selected book titles would be purchased individually or as subscription packages based on usage and need. eBrary would not include journals or clinics. (The library would subscribe to the individual journal and clinics titles directly through Elsevier and provide access via the Ovid Medline database.)

**R2 Digital** – Like eBrary, R2 Digital is an electronic book search platform including medical eBooks from top medical publishers. Books are purchased individually. Also like eBrary, R2 would not include journals or clinics; the library would subscribe to those separately and provide access via the Ovid Medline database.

**Clinical Key** – similar to MDC in that it is a one-stop search platform for Elsevier content: electronic books, journals, and clinics, First Consult point-of-care clinical monographs, Procedures Consult (procedural videos), Vitals (surgical point of care resource), Drug Monographs, Patient Education, Practice Guidelines and Multimedia (surgical & medical videos and images). ClinicalKey also provides a search interface to Medline and ClinicalTrials.gov.

For questions, contact the library at 626-397-5161, library@huntingtonhospital.com or text us at 626-344-0542.

## Celebrating Milestones

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

### 35 Years (on staff 04/1979)

Marion Quinn, MD – Dermatology

### 25 Years (on staff 04/1989)

Robert Cann, MD – Internal Medicine
W. Frederick Stephens, MD – Oral/Maxillofacial Surgery

### 15 Years (on staff 04/1999)

Kenneth Lam, MD – Radiation Oncology
Timothy Pham, MD – Allergy & Immunology

### 10 Years (on staff 04/2004)

Ira Felman, MD – Hematology/Oncology

## Getting to Know Your Medical Staff Leaders

**William Sutherling, MD**, has been a member of the Medical Staff since 1997. He is an Active Staff member in the Department of Medicine, Neurology Section. He is continuing his second term as Chair of the Neurology Section. Dr. Sutherling is the Medical Director of Huntington's Comprehensive Epilepsy Center, The Epilepsy and Brain Mapping Program. He is board certified by the American Board of Psychiatry and Neurology and is currently boarded in Adult Neurology, Clinical Neurophysiology and Epilepsy.

Dr. Sutherling is a member of the Board of Directors of the National Association of Epilepsy Centers (NAEC) and continues his 23rd year as reviewer for NIH grant applications in epilepsy and cortical localization. The NAEC represents all 180 epilepsy centers in the U.S., of which Huntington is a Level 4, the most advanced with neurology, neurosurgery, neurophysiology, neuropsychology and specialized nursing. Neurology is proud of its highly qualified physicians and joins the other excellent disciplines in medicine at Huntington to offer a bright future especially to people in our community and to people who seek us out from other states and countries.

Dr. Sutherling lives in Sherman Oaks with his wife Jeri. He loves spending time with his family. In his spare time, Dr. Sutherling likes to dictate reports and do paperwork.

## Eat Well, Work Well

### Brought to you by Huntington Hospital Concierge and Wellness PATH

**Huntington Hospital's monthly Eat Well, Work Well** event started in February. At each event you can shop for fresh, organic, seasonal fruits and vegetables. Payments may be made with Visa, MasterCard, cash or payroll deduction. The next event is scheduled for Friday, April 18 from 11 a.m. – 4 p.m. in the Center Courtyard.

You may also sign up for the Community Supported Agriculture (CSA) program. Get organic fruits and vegetables delivered to your front door via our partnership with *Farm Fresh to You*! Physicians, employees and volunteers receive a special 10% ongoing discount on *Farm Fresh to You* boxes of organic fruits and vegetables delivered to your doorstep.

It's easy to sign up for delivery!

1. Stop by the Concierge office and purchase *Farm Fresh to You* gift certificates at a 10% discount.
2. Use the certificate code to redeem online or by phone.

**OR**

1. Sign-up by visiting www.farmfreshtoyou.com and enter promo code **hh10**.
2. Choose the service and the delivery frequency that best meets your needs.
3. Exclude items you would rather not receive.

## **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*

Comments are from surveys received during February 2014:

### The Voice of the patient…

- My surgeon and anesthesiologist were warm, funny, and confident – lovely people – couldn't be happier.
- All physicians were courteous and gave me enough time to express how I felt.
- My doctor was professional & thorough. Great bedside manner sincerely caring.
- Saved me! Thanks!

### Improvement Opportunities

- I was there for 2 nights and 3 days, but only saw a physician twice. I was not kept informed at all.
- Too many doctors/specialists. Each had their own opinions about everything which was very confusing. Probably saw 6 different doctors.
- Most of the physicians were not communicative and did not address patient and patient's family's fear and concerns, and not voluntarily shared tests results. Not flexible at all.

If you have any suggestions for patient experience improvements please contact Alison Birnie, RN, Clinical Director ext. 3686; Bobbie DeLaRosa, Medical Staff Services Director, ext. 3778; or Stacy Miller, Volunteer and Customer Relations Director, ext. 5209.

## TOBACCO CESSATION Treatment Components

- ADDICTION
  - Treated as a chronic disease, remission and relapsing. Assess, treat, and have plan for nicotine dependence/withdrawal symptoms
- BEHAVIOR
  - "Motivational Interviewing" style communication opposed to "counseling"
  - Goals: Restructure behaviors, promote problem solving techniques, stress management and coping skills
- PHARMACOTHERAPY
  - Various products available, both Rx and OTC, long term and short term option. Provide prescriptions and recs on safe and effective use and combination of products
- RELAPSE PREVENTION
  - Aid patients in identifying triggers, using problem solving techniques, developing a plan, long term pharmacotherapy.

To refer patients, you can provide the brochure to the patient, or you and/or the patient can contact Mendy via the "Quit Line" 626-397-2230 to schedule an appointment. All non-HMO health insurances are accepted, and will cost the patient their outpatient office visit co-pay. Uninsured patients are welcome as well and may be eligible for financial assistance pending social worker evaluation.

Brochures will be available on all inpatient units. Contact Mendy Gonzalez to obtain brochures for use or display in your office at 626-397-2230 or mendy.gonzalez@huntingtonhospital.com.

## **CME** Corner

### Medical Grand Rounds

Topic: Global Health and Infectious Diseases
Speaker: Kimberly A. Shriner, MD
Date: April 4, 2014
Time: Noon – 1 p.m.
Place: Research Conference Hall
Objectives:
1. Understand the parameters of measuring global health.
2. Understand how infectious diseases influence global health status.
3. Become familiar with new and emerging infectious diseases that influence global health.
4. Understand modalities of improving global health by controlling infectious diseases.

Audience: Primary Care Physicians, Internal Medicine, all other interested specialties
Method: Lecture
Credit: 1.0 *AMA PRA Category 1 Credits*™

### Second Monday

Topic: Peri-Operative Issues in Geriatric Patients
Speaker: Matthew Butteri, MD
Date: April 4, 2014
Time: Noon – 1 p.m.
Place: Research Conference Hall
Objectives:
1. Better understand cardiovascular peri-operative risk assessment.
2. Better understand and treat peri-operative delirium.
3. Appropriate management of common pharmacy in the peri-operative setting.

Audience: Primary Care Physicians, Internal Medicine, Geriatrics, all other interested specialties
Method: Lecture
Credit: 1.0 *AMA PRA Category 1 Credits*™

### Special Courses

Huntington for Kids: Pediatrics Emergency Conference

Speakers: Stephen B. Treiman, MD; Steve Chen, MD; Ernie Maldonado, MD; and Jamie W. Powers, MD
Date: May 3, 2014
Time: 8 a.m. – Noon
Place: Huntington Hospital
Objectives:
1. The learner will gain an understanding of laparoscopic procedures for children requiring surgery.
2. The learner will be able to identify children presenting to the Emergency department with Asthma.
3. The learner will be to prioritize what care is needed for a newborn presenting to the Emergency Department.
4. The learner will be able to differentiate between shock in a child versus an adult.

Audience: Pediatricians, ER doctors, all other interested specialties
Method: Lecture
Credit: 4.0 *AMA PRA Category 1 Credits*™

Best Practices in Cardiac Arrest

Speakers: Dan Davis, MD, Professor of Clinical Emergency Medicine, UCSD Department of Emergency Medicine; William Koenig, MD, Medical Director of the LA County Emergency Medical Services; and Baxter Larmon, PhD, MICP, Professor of Medicine UCLA School of Medicine
Date: May 3, 2014
Time: Noon – 1:30 p.m.
Place: Braun Auditorium
Objectives:
1. Better understand cardiovascular peri-operative risk assessment.
2. Better understand and treat peri-operative delirium.
3. Appropriate management of common pharmacy in the peri-operative setting.

Audience: HMH ED Physicians, ED RNs, Code Blue/Code Rapid Response Team, ICU RNs, ICU Intensivists, Cardiologists and EMS Leaders
Method: Lecture
Credit: 1.5 *AMA PRA Category 1 Credits*™
1.5 hours of Instructor Lead credit by the California Board of Registered Nursing, Provider # CEP 351

*Please RSVP to jenny.vanslyke@huntingtonhospital.com by April 18.*

## Bioethics Consultation

**Huntington Hospital maintains** an active Bioethics Committee which serves as a resource to patients, families/healthcare decision-makers, healthcare team members and the community in matters of medical ethics. It is composed of the hospital Bioethicist, physicians, professional staff, administration, nurses, social workers, clergy, ethicists and lay persons who discuss issues of medical ethics. The three main functions of the Bioethics Committee are case consultation, staff and community education, and policy writing. Members of the Bioethics Committee are on-call 24 hours, including weekends, for the purpose of assembling on an emergency basis to meet with patients, families/healthcare decision-makers and healthcare team members, when requested.

When an ethical issue is not resolved through the healthcare team via a case conference and/or family conference, a Bioethics consult may be obtained by contacting the Bioethicist (Wendy Kohlhase, Ph.D. ext. 2036), the Chair (Nathan Lewis, MD), the hospital Operator, the Medical Staff Office, or the Administrative Supervisor. Anyone may request a Bioethics consultation, including the patient and/or decisionmaker. The Bioethics Committee will assist the healthcare team with the application of the principles of biomedical ethics, while attempting to support the wishes of the patient and family/healthcare decision-maker for the most appropriate treatment of the patient. The Bioethics Committee functions as an advisory, rather than a decision-making group.

### The Healthcare Decision-Making Team

The Healthcare Decision-Making Team (HDT) at Huntington Hospital is not under the purview of Bioethics, although a bioethics designee is required to participate on the team. The HDT is able to make decisions for patients who are unrepresented, lack capacity and are in need of non-emergent procedures that require consent or decisions about care. These guidelines may be used in lieu of the other options that often confront physicians when treating these patients; such as, applying for conservatorship or withholding the indicated procedure while waiting to see if it becomes emergent. A common example might be that of a patient who presents from a skilled nursing facility needing a g-tube placement. The patient has severe dementia and a diligent search has revealed no legally-recognized decision-maker. Or, the patient may be in need of hospice care or a change in the code status and is unrepresented and lacks capacity. The HDT could be activated in such situations. The Medicine and Surgery Committees provide the oversight for the HDT process.

For more information about the Bioethics Committee or the Healthcare Decision-making Team, contact Wendy Kohlhase, Ph.D. at ext. 2036 or cell 626-823-1103.

## Reminders

### Online Evaluations

This year the Huntington Hospital's CME program will undergo reaccreditation through the IMQ. Evaluations are critical for the hospital to retain accreditation and to improve our future programs. *The evaluations are also required to receive your CME credit.*

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, the CME Coordinator at 626-397-3770 or via email at Maricela.Alvarez@huntingtonhospital.com.

## Huntington Care Network

**As many of you already know**, Huntington Care Network, our new Medicare Accountable Care Organization (ACO), has been approved and formally started operating on January 1, 2014. The ACO members – all primary care practitioners at this time – will be required to send out letters (approved by the Centers of Medicare and Medicaid Services, CMS) to their patients informing them about the existence of the ACO and allowing them to opt out of having their personal claims data shared. Being a part of the ACO has no effect upon the way patients use their Medicare benefits; they are still free to see any physician (who accepts Medicare) they want.

Since you may be responsible for treating some of these patients, we want you to be aware of this letter and have enough information to be able to answer any questions that your patients may have. If you have any questions, please do not hesitate to let me know.

Sincerely,
**Edmund Tse, MD**
*President of the Medical Staff*

## Medical Staff Services Corner

### 2014 is an Election Year!

The Medical Staff will be electing officer positions for the 2015-2016 term:

- President-Elect, Medical Staff
- Secretary/Treasurer, Medical Staff
- Chair, Quality Management Committee
- Chair, Credentials Committee

In order to quality for office, you must select a member of the Active staff at the time of nomination and election and must remain a member in good standing during the time in office. Failure to maintain such status shall immediately create a vacancy in the office involved.

The officers will be nominated by the Nominating Committee which is comprised of two (2) past Medical Staff Presidents (who are currently on Active Staff), the four (4) current Department Chairs, and one (1) additional member from each department. The committee shall be chaired by the President-Elect of the Medical Staff who votes only in case of a tie.

The Nominating Committee will convene no later than June, and may select one or more nominees for each elected office.

## President's Recognition Corner

The Chief of Staff would like to recognize the outstanding care provided by members of the Medical Staff based on one or more of the following: letter from a patient and/or their family, nursing compliment, and/or a collegial recommendation.

This month the Chief of Staff would like to recognize **Dr. Raha Akhavan**.

"We here at SDS (Same Day Surgery) want to thank Dr. Akhavan for being a great source and for his quick intervention. Thank you for saving our patient's life!! We love your professionalism, your calmness, your quick thinking and excellent skills. Your attitude under pressure sets an example that we all want to strive to achieve. You are amazing and we admire you."

# April 2014 **Medical Staff Meetings**

**No Board meeting this month**

| monday | tuesday | wednesday | thursday | friday |
|---|---|---|---|---|
| | -1- | -2- | -3- | -4- |
| | - 12:15 p.m. Oral Section - CR-6 | - Noon Medicine Nominating Committee - CR-C<br>- 12:15 p.m. OB/GYN Peer Review - CR 5&6<br>- 3 p.m. QM Pre-Agenda - CR-C | - Noon Medicine Committee - N/S Room<br>- Noon Trauma Services Committee - CR 5 & 6 | - 7 a.m. Orthopedic Section - CR 5 & 6 |
| -7- | -8- | -9- | -10- | -11- |
| - 12:15 p.m. OB/GYN Dept - CR 5&6<br>- 5:30 p.m. Medical Executive - Board Room<br>- Newsletter Submission - | | - 10 a.m. PICU/Peds QI - CR-2 | - Noon QM Committee - East Room<br>- 5:30 p.m. Neonatal/Pediatric Surgical Case Review Ctte - CR 10 | - 7:30 a.m. Neurosurgery Section - CR 11 |
| -14- | -15- | -16- | -17- | -18- |
| - 9:30 a.m. SCAN Team - CR-10<br>- 10:30 a.m. PMCC - CR-10<br>- Noon Transfusion Committee - CR<br>- 12:30 p.m. Ophthalmology Section - CR 8 | - 12:15 p.m. Credentials Committee - CR C | - 5:30 p.m. Surgery Committee - CR 5 & 6 | - 6:30 a.m. Anesthesia Peer Rev - CR-7<br>- Noon PT&D Committee - CR 5 & 6<br>- 1 p.m. Thoracic Surgery Section - CR-11<br>- 3 p.m. Neon QI - CR-10<br>- 6 p.m. Bioethics - CR 5&6 | |
| -21- | -22- | -23- | -24- | -25- |
| | - 5 p.m. Robotic Committee - CR-5 | - 12:15 Hem/Medical Onc - CR-5 | - Noon Cancer Committee - CR 5 & 6<br>- Noon IM Peer Rev - CR-8<br>- 12:15 p.m. Pediatric Committee - East Room | |
| -28- | -29- | -30- | | |
| - Noon Psychiatry Sct - CR-10<br>- 12:15 p.m. Urology Sct - CR 5 & 6 | | - 3 p.m. QMC Pre-agenda - CR C | | |

# April 2014 **CME Calendar**

| monday | tuesday | wednesday | thursday | friday |
|---|---|---|---|---|
| | -1- | -2- | -3- | -4- |
| | - 7:30 - 8:30 a.m. MKSAP, Conf. Room A<br>- Noon - 1 p.m. General MDisc Cancer Conf, Conf. Room 11 | - Noon - 1 p.m. Genitourinary Cancer Conf., Conf. Room 11<br>- Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room | - 7 - 10 a.m. Trauma M&M, Conf. Room B<br>- Noon - 1 p.m. Thoracic Cancer Conf., Conf. Room 11 | - 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11<br>- Noon - 1 p.m. Medical Grand Rounds, RSH<br>**Topic: Peri-Operative Issues in Geriatric Patients**<br>- 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. Mt, CR 5 & 6<br>**Topic: HANK** | - 7:30 - 8:30 a.m. MKSAP, Conf. Room A<br>- 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<br>- Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11 |
| -14- | -15- | -16- | -17- | -18- |
| - Noon - 1 p.m. Second Monday, RSH<br>**Topic: Global Health and Infectious Diseases** | - 7:30 - 8:30 a.m. MKSAP, Conf. Room A<br>- Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11 | - Noon - 1 p.m. Genitourinary Cancer Conf., Conf. Room 11<br>- Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room | - 7 - 8 a.m. Trauma Walk Rounds, Conf. Room B<br>- 8 - 9 a.m. Surgery M&M, Conf. Room B<br>- Noon - 1 p.m. Thoracic Cancer Conf., Conf. Room 11 | - 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11<br>- Noon - 1 p.m. Medical Case Conference, RSH<br>- 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<br>- 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<br>- Noon - 1 p.m. Medical Case Conference, RSH<br>- Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11 |
| -28- | -29- | -30- | | |
| | - 7:30 - 8:30 a.m. MKSAP, Conf. Room A<br>- Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11 | - 7:30 - 8:30 a.m. Cardiac Cath Conference, Cardiology Conf. Room<br>- Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11 | | |

Huntington Hospital

**Medical Staff Administration**
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Pasadena, CA 91109-7013

ADDRESS SERVICE REQUESTED



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

## **Medical Staff** Demographic Changes

**Neville Anderson, MD**
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321 North Larchmont Blvd.
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323-960-8500 (office)
323-960-8585 (fax)

**Annette Ermshar, PhD**
**Psychology**
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San Marino, CA 91108
626-405-0521 (office)

**Clayton Lau, MD**
**Urology**
South Pasadena Cancer Center
630 S. Raymond Avenue
Suite 220
Pasadena, CA 91105

**Roger Satterthwaite, MD**
**Urology**
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630 S. Raymond Avenue
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**Bertram Yuh, MD**
**Urology**
South Pasadena Cancer Center
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Pasadena, CA 91105

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