medical staff NEWSLETTER

July 2015

volume 53, issue 7

From the President

A Bit of Fitness or Wearable Medical Devices

"Big brother is watching you."
- George Orwell

Like gravity, Moore's law has remained a constant. It is the observation put forth, originally in 1965, by Gordon Moore, co-founder of Intel, that the number of transistors in an integrated circuit would double approximately every two years. This has allowed greater miniaturization and capability with smaller and more portable devices, such as cell phones, over the last few decades. This advancement has also opened the door for the creation of wearable medical devices that may provide: monitoring of chronic conditions, home based health care, instant athletic performance data, evaluation of rehabilitation goals, medication compliance or reaction, and telemedicine with remote access to health care. We are entering a terra nova with the expanding use and utility of these devices in medicine.

The first true wearable medical device was the Holter monitor, which allowed for data acquisition that could be reviewed to aid in establishing cardiac diagnosis. With the explosion in technology over the last twenty years and the incorporation of applications that were previously limited to programs such as NASA, for astronaut monitoring, and the U.S. Army, for its Land Warrior Program, a host of new technologies have become available to the consumer (Fotiadis, Constantine, and Likas). The "wearable's" market is rapidly expanding with 50,000 apps already available and Credit Suisse estimating its financial worth at 3 to 5 billion dollars per annum (Standen). In addition, large corporations, like Apple, see the benefit and potential financial reward of this new market and are partnering with both Epic

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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 June 1, 2015 and by the Governing Board on June 25, 2015.

Administrative Reports

Please go to SharePoint→ Medical Staff Services → Board Approved Items → 2015 and select June 2015 to see:

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Huntington Hospital

Medical Staff Appointments

Chon, John, DO
Emergency Medicine
100 West California Boulevard
Emergency Department
Pasadena, CA 91109
Tel: (626) 397-5111
Fax: (626) 397-2981

Derebery, M. Jennifer, MD
Otolaryngology
2100 West Third Street
Los Angeles, CA 90057
Tel: (213) 483-9930
Fax: (213) 989-7473

Fischel, David, DO
Internal Medicine
100 W. California Blvd.
Internal Medicine
Residency Program
Pasadena, CA 91109
Fax: (626) 397-2950

Garimella, Sree N., MD
Internal Medicine
207 S. Santa Anita Avenue
Suite 205
San Gabriel, CA 91776
Tel: (626) 795-2244
Fax: (626) 254-8250

Luxford, William M., MD
Otolaryngology
House Clinic
2100 West Third Street
Suite 111
Los Angeles, CA 90057
Tel: (213) 483-9930
Fax: (213) 989-7473

Minasyan, Lilit, MD
Ophthalmology
625 S. Fair Oaks Avenue
Suite 240
Pasadena, CA 91105
Tel: (626) 817-4747
Fax: (626) 817-4748

Parihar, Jaspreet, MD
effective 8/1/2015
Urology
1500 East Duarte Road
Duarte, CA 91010
Tel: (626) 218-0521
Fax: (626) 301-8285

Schwartz, Marc S., MD
Neurosurgery
2100 West 3rd Street
Los Angeles, CA 90057
Tel: (213) 353-7067
Fax: (213) 484-5900

Stefan, Michael R., MD
Internal Medicine
2100 West Third Street
Suite 260
Los Angeles, CA 90057
Tel: (213) 484-2957
Fax: (213) 484-2970

Medical Staff Resignations

- Carvajal, Sam, MD – General Surgery – effective June 30, 2015
- Chang, Laura, MD – Internal Medicine – effective June 30, 2015
- Dikranian, Hagop, MD – Urology – effective September 30, 2015
- Kolb, Bradford, MD – Obstetrics & Gynecology – effective August 31, 2015
- Manrique, Oscar, MD – Plastic Surgery – effective June 30, 2015
- Matthews, Ray, MD – Cardiology – effective June 30, 2015
- Ong, Oliva, MD – Ophthalmology – effective July 31, 2015
- Prabharasuth, Derek, MD – Urology – effective June 30, 2015
- Sheng, Alexander, MD – Physical Med & Rehab – effective June 25, 2015
- Tamayo, Joana, MD – Obstetrics & Gynecology – effective August 31, 2015

From the **President** continued from page 1

and the Mayo Clinic to create a product, termed HealthKit, which would integrate wearable devices and the medical world (HCRI).

The FDA has stepped into the fray by stating that it will continue to regulate devices that can be used for the diagnosis or treatment of medical conditions; however, the FDA will not regulate "low-risk devices" that are intended only to promote general wellness, i.e. weight loss, stress management, or physical fitness. This leaves the field wide open for the acquisition and permutation of personal medical data with wearable technologies that can be garnered for other uses such as blood pressure or heart rate monitoring (Standen).

At the other end of all this technological wizardry sits the doctor. The amount of data collected by these devices is substantial, if not staggering. Patients now can present spreadsheets of data to be analyzed during their visits or request remote evaluation and interpretation by a physician. This could potentially bypass the need for physician led patient examination and a potential loss of more important subtle data that may not otherwise be obtained by a device--in essence, possibly relegating us to true data analysts like Maytag repairmen.

The advent of truly wearable electronic health care devices has opened the door to many significant advances in our understanding of disease processes, appropriate intervention, preventative care, and community wellness. Yet, like all new shiny technologies, the bugs need to be worked out of the system. Physicians will need to educate their patients on the appropriate uses and important data points and guard against micromanagement and technological perseveration. It will also be our duty to continue to physically interact and guide our patients with the healing touch that defines our profession.

James Shankwiler, MD
President of the Medical Staff

Works Cited

Fotiadis, Dimitrios I., Constantine Glaros, and Aristidis Likas. "Wearable Medical Devices." *ResearchGate*. University of Ioannina, 8 July 2014. Web. 7 June 2015. <http%3A%2F%2Fwww.researchgate.net%2Fpublication%2F228007289_Wearable_Medical_Devices>.

HCRI Staff. "Wearable Tech: Is 2015 the Year of Resurgence for Medical Device Innovation?" *HCRI Network*. HealthCare Recruiters International, 12 Feb. 2015. Web. 07 June 2015. <http://www.hcrnetwork.com/wearable-tech-is-2015-the-year-of-resurgence-for-medical-device-innovation/>.

Standen, Amy. "Sure You Can Track Your Health Data, But Can Your Doctor Use It?" *National Public Radio*. NPR, 19 Jan. 2015. Web. 07 June 2015. <http://www.npr.org/sections/health-shots/2015/01/19/377486437/sure-you-can-track-your-health-data-but-can-your-doctor-use-it>.

Hello all Pediatricians

HMH is opening a Bili (bilirubin) and weight check clinic on Saturdays from 9 am to noon. Clinic will be opening June 6, 2015 including holiday weekends.

The clinic will be staffed by one of the Maternity RN's. The service will be provided to any infant who is delivered at Huntington Hospital. The pediatrician will pre-register the patient with the maternity unit secretary.

There are a few steps and paperwork that will need to be completed. We will need an order from the pediatrician, which includes an order for the outpatient visit, TCB, and weight check. The primary care RN will provide instructions to the patient on appointment time, arrival, and place to check in.

On Saturday the patient will check in with the LD secretary and have a seat in the LD waiting room. The Maternity RN will greet the patient, and take the patient to the HRIF (high risk infant follow-up) clinic which is located in the admitting department. The transcutaneous bilirubin will be assessed along with the current weight. The pediatrician will receive a phone call from the maternity RN on the results of the TCB and weight check. If the TCB is reading greater than 12 mg the pediatrician will need to order a TSB (serum bili). Serum bili results will be called to the pediatrician once available. The pediatrician will decide on discharging patient home with further instructions of follow up in the office or admit to NICU or PEDs. The physician will contact the NICU or PEDs department for a direct admission.

Thank you very much. If you have any further questions please contact Rav at 626-397-3269 or Cathy at 626-397-3265

Ravinder Johl RN, BSN
OB Department Manager

Celebrating Milestones

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

45 Years (on staff 07/1970)
Joseph A. Oliver, MD – Gynecology

30 Years (on staff 07/1985)
Michael J. Gurevitch, MD – Pulmonary Disease

25 Years (on staff 07/1990)
Edward A. Helfand, DPM – Podiatry
David A. Voron, MD – Dermatology

20 Years (on staff 07/1995)
Mayer Y. Rashtian, MD – Electrophysiology

10 Years (on staff 07/2005)
Kjell N. Hult, MD – Anesthesiology
Kevin O. Lawrence, MD – Physical Med & Rehab
Stefanie L. Lehfeldt, MD – Anesthesiology
Viguen G. Movsesian, MD – Psychiatry
Shanika D. Perera, MD – Anesthesiology
Vyshali S. Rao, MD – Interventional Cardiology

Corrections

From the January newsletter:
40 Years (on staff 01/1975)
Joseph A. Oliver, MD – Gynecology

From the April newsletter:
15 Years (on staff 04/2000)
J. Gordon McComb, MD – Pediatric Neurosurgery
Henry H. Tsai, MD – Obstetrics & Gynecology
Roger C. Yang, MD – Emergency Medicine

From **Physician Informatics**

Celebrating our Surgeons:

So far, we have achieved our goal of a compliance rate of 90% or better on the Joint Commission mandated hard stop for the Informed Consent/Attestation note in the Operating Room. We would like to thank all of you for cooperating with the process and for achieving such a high compliance in a short period of time.

An issue with compliance fallouts now is the accuracy of the H&P attestation choices made by the surgeons – we are working diligently with surgeons on this.

In October 2014 the Surgery Committee recommended as an action item that informed consent be documented in a separate Informed Consent/Attestation note in Cerner. This was approved by the Medical Executive Committee in November 2014.

A few surgeons are not completing the informed consent portion of this Note, choosing to leave the informed consent attestation in their H&P, progress note or elsewhere, if at all. The nurses are getting confused about what is complete and have trouble finding the informed consent, as previously, on paper, it was all in one place. As always they are also required to document that this is present as part of the pre-op check list.

In the past an informed consent has been required prior to a procedure, but there has not been a hard stop if it was not located in the separate Informed Consent/Attestation note. Please be prepared to work with the nurses and support teams in ensuring completeness of this portion of the Informed Consent/Attestation note before your patient can be brought back to the operating room.

We thank you again for your positive attitude and cooperation with this process.

Dr. David Lourié, MD, Physician Champion,
Vice-Chair Quality Management
Steven Battaglia, MD, Chair Dept of Surgery
James Shankwiler, MD, President Medical Staff

Cerner Training

Do you still have questions about Cerner or want some additional training? The Cerner Fundamental Refresher classes are offered Monday, Wednesday and Fridays throughout May at 8:30 a.m. and 1:30 p.m. Please register via bookeo.com/huntingtonhospital or call ext. 2500.

From the **Clinical Documentation Specialists**

What is Clinical Document Improvement (CDI)

Clinical documentation is pivotal in determining and supporting **medical necessity**. Hospitals throughout the country employ Clinical Documentation Improvement Specialists (CDIS), who review the patient record to facilitate an accurate representation of healthcare services through complete and accurate reporting of diagnoses and procedures. CDIs provide feedback in the form of a written query or electronic message. At Huntington, the queries are found in the Message Center of Cerner.

The queries are designed to ensure that all documentation is of high quality and paints a true picture of the care being provided to the patient, and is a proper reflection of the RAMI (risk adjusted mortality index) that determines the hospital and provider's profile/health ratings.

When proper documentation is made, it leads to the proper code, DRG, Severity of Illness (SOI) and Risk of Mortality (ROM) and makes the patient record more impervious to auditor oversight.

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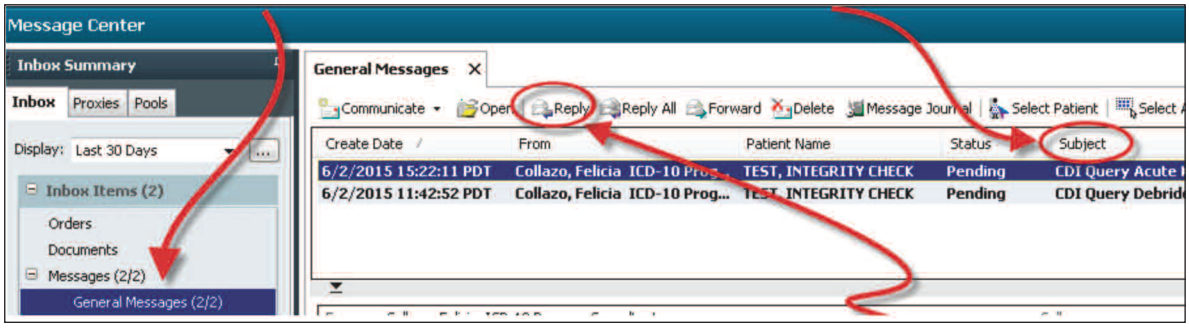
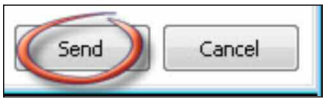
From the **Clinical Documentation Specialists** continued from page 5

How to Respond to a Query:

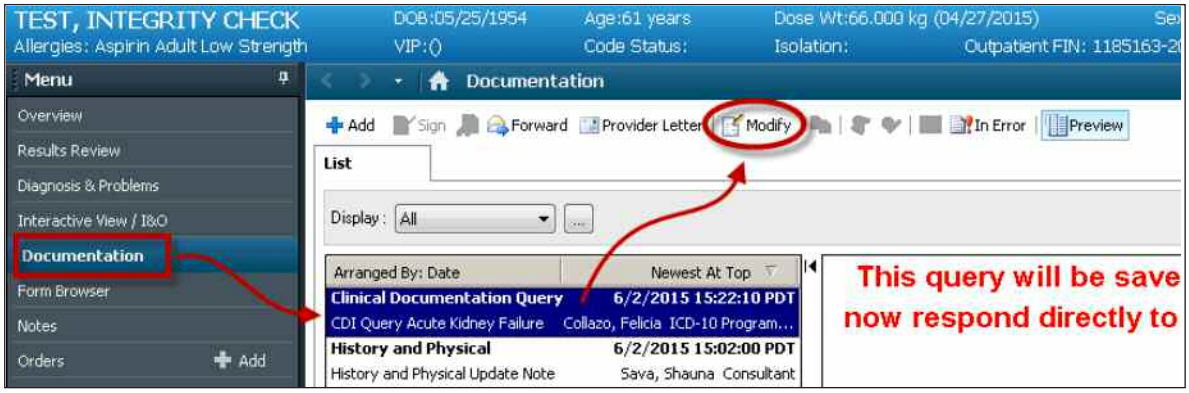
1. Queries are sent to your Message Center in Cerner. They are located in the General Messages folder and can be filtered by the Subject "CDI Query".



2. To respond directly to a query from the Message Center: Select "Reply" > Enter your response > Select "Send".



3. To respond to the query from within the patient's record: Go to "Documentation" > Open the query, select "Modify" > Enter your response as an Addendum, select "Sign".



Ask a CDI
Clinical Documentation Improvement

The CDI team is here to assist you with your documentation needs. Please feel free to call us if you have any questions.

Karen Beal, RN, BSN, CCDS, ext. 2024
Maria Gilda Villanueva, CCDS, ext. 3665
Theresa Cardona, RN, CCDS, ext. 3787

Gabriella Pearlman, MD, CDI Physician Advisor & ICD10 Champion, ext. 5183

Bioethics Corner

Wendy Kohlhase, Ph.D.
Ext. 2036

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units

Published June 1, 2015 in the American Journal of Respiratory and Critical Care Medicine

An ad hoc committee of The American Thoracic Society composed of nineteen healthcare clinicians has been meeting over the past several years to discuss the issue of how to best manage requests by patients or surrogates for treatments that the clinicians believe should not be provided; treatments the ad hoc committee defines as "potentially inappropriate." The ad hoc committee focused on cases presenting to the ICU. The purpose of establishing the ATS/AACN/ACCP/ESICM/SCCM Policy Statement is to provide recommendations on both preventing and managing these cases in the ICU.

Huntington has progressed away from using the term "futile" treatment and currently uses the terms "medically ineffective" and "medically non-beneficial" treatment to remain consistent with CA Probate Codes that pertain to this subject. The ATS/AACN/ACCP/ESICM/SCCM Policy Statement, however, encourages the use of the term "potentially inappropriate" treatment. In addition, Huntington's "DNAR/Withholding and Withdrawing of Life-Sustaining Treatment" policy # 8740.050 describes procedures on responding to requests for medically ineffective or non-beneficial treatment (section IV of the policy). The procedure described in Huntington's policy is quite similar to the process described in the ATS/AACN/ACCP/ESICM/SCCM Policy Statement in regards to conflict resolution. Of note, Huntington has not yet endorsed or implemented the ATS/AACN/ACCP/ESICM/SCCM Policy State mentor its recommendations, but is circulating this information for review and input.

The following are highlights of the ATS/AACN/ ACCP/ESICM/SCCM Policy Statement recommendations:

Recommendation 1- Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultants.

1. Collaborative decision-making is a fundamental aspect of good medical care and is therefore a valuable ethical goal to foster. The ad hoc committee specifically recommends efforts to teach clinicians end-of-life communications skills, including strategies to achieve shared decision-making conflict resolution skills, and skills to emotionally support surrogates.
2. Once conflicts become intractable, there are only "second best" resolution strategies which are likely to be protracted and burdensome to all parties involved.
3. Most disagreements in ICUs arise not from the intractable value conflicts, but from breakdown in communication interventions. Evidence suggests that most clinician-patient/surrogate conflicts can be resolved through ongoing communication or with the help of expert consultants, such as ethics or palliative care consultants.
4. The committee recommends increased efforts to teach clinicians end-of-life communication skills, including strategies to achieve shared decision-making, conflict resolution skills, and skills to emotionally support surrogates facing difficult decisions.
5. Clinicians and Administrators should ensure that reliable systems are in place to achieve timely, effective clinician-surrogate communication.
6. Hospitals should implement strategies to identify and intervene on growing conflict in the ICU by

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encouraging involvement of individuals skilled in negotiation and communication, such as ethics or palliative care consultants or social workers and chaplains.

Recommendation 2– The term "potentially inappropriate" should be used, rather than "futile" to describe treatment that should have at least some chance of accomplishing the effect sought by the patient, but clinicians believe that competing ethical considerations justify not providing. Clinicians should communicate and advocate for the treatment plan they believe is appropriate. Requests for potentially inappropriate treatments that remain intractable despite intensive communication and negotiation should be managed by a fair process of conflict resolution.

1. The word "inappropriate" conveys more clearly than the word "futile" or "ineffective" that the assertion being made by clinicians depends both on technical medical expertise and a value-laden claim, rather than strictly a technical judgment.
2. The word "potentially" signals that the judgments are preliminary, rather than final, and require review before being acted on.
3. The ethical concerns that may be raised to justify the refusals include concerns that treatment is highly unlikely to be successful, is extremely expensive, or is intended to achieve a goal of controversial value.
4. Several considerations justify a procedural approach to conflict resolution, rather than giving all decision-making authority to either surrogates or individual clinicians.
5. Hospitals should develop and adopt conflict-resolution processes that contain the seven characteristics detailed below:
    a. Enlist expert consultation to aid in achieving a negotiated agreement
    b. Give notice of the process to surrogates
    c. Obtain a second medical opinion
    d. Provide review by an interdisciplinary hospital committee
    e. Offer surrogates the opportunity for transfer to an alternate institution
    f. Inform surrogates of their opportunity to pursue extramural appeal
    g. Implement the decision of the resolution process
6. Management of time-pressured decisions
    a. When time pressures make it infeasible to complete all steps of the conflict-resolution process and clinicians have a high degree of certainty that the requested treatment is outside accepted practice, they should refuse to provide the requested treatment and endeavor to achieve as much procedural oversight as the clinical situation allows.

Recommendation 3– There are two less-common situations for which the committee recommends different management strategies.

1. Requests for strictly futile interventions- the term "futile" should only be used in the rare circumstances that an intervention simply cannot accomplish the intended physiologic goal.
    a. This narrow definition is used because it highlights a basic distinction between interventions that cannot work [futile treatment: performing CPR on a patient with signs of irreversible death, ie. rigor mortis] and those that might accomplish the desired physiologic effect but raises countervailing ethical concerns [potentially inappropriate treatment- example: performing CPR on a critically ill patient with widespread metastatic cancer.
2. Requests for legally proscribed or legally discretionary treatments
    a. Legally proscribed treatments are those that are prohibited by applicable laws, judicial precedent, or accepted public policies. Example- A surrogate of a patient requests that physicians expedite liver transplantation by circumventing existing organ allocation practices; the clinician is justified in refusing the request.

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b. Legally discretionary treatments are those treatments for which there are specific laws or polices that give physicians permission to refuse to administer them. Example- State probate statutes that allow physicians permission to forego CPR and other procedures in strongly defined circumstances.

Recommendation 4– The medical profession should lead public engagement efforts and advocate for policies and legislation about when life-prolonging technologies should not be used.

1. Developing clear societal policies and legislation about the appropriate boundaries of medical practice near the end of life would foster transparency in limit setting and may allow more efficient resolution of individual cases.
2. Informed patients must partner in developing substantive policies and legislation because they will experience the effects of such decisions and because the boundaries of acceptable medical practice require value judgments that go beyond the expertise of clinicians.
3. Public engagement should have a goal of eliciting informed, considered judgments from key stakeholders to promote input into policy development.

See site link for abstract and access to full text: http://www.atsjournals.org/doi/abs/10.1164/rccm.201505-0924ST?journalCode=ajrccm#.VXT-30YjnV8

Physicians Inspiring Donors: Dr. Sunil Hegde

Grateful patients make generous donors and, according to nationwide data, **physicians are overwhelmingly influential to a donor's decision to make a gift to the hospital.**

Dr. Sunil Hegde speaking at a check presentation by the Flintridge La Canada Guild last spring.

Each year, charitable support for Huntington Memorial Hospital fills the ever-widening gap between revenue and expenses, helping to pay for the critical programs, facilities and services that today's informed patients demand. The Office of Philanthropy at Huntington Hospital is grateful for the exceptional physicians who help us engage potential donors.

Dr. Sunil Hegde, Medical Director of Rehabilitation Services, has assisted the office of philanthropy in several important ways. Recently, by authoring a mail appeal requesting funds for the NeuroRehab Center, Dr. Hegde helped to secure nearly $600,000 from more than 800 community donors, which will directly benefit Rehabilitation Services and the patients Dr. Hedge and his colleagues are serving. Additionally, Dr. Hedge has helped the office of philanthropy cultivate meaningful relationships with donors and prospective donors which will continue leading to charitable donations to Huntington Hospital.

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

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

The Doctor-Computer- Patient Relationship: A New Paradigm

The traditional interaction between doctors and patients included an empathetic association attained by a face to face interaction. This contributed to the assessment of the person's condition and in turn an increased compliance in accepting and following medical advice. Over the last five decades, it was recognized that a disease is not only a disruption of bodily functions produced by an external factor, but rather a constellation of symptoms, where other elements such as anxiety, despair, socio-economic issues, family matters, emotional derangements and personal issues, among others, play a significant role in causation and outcome. In other words: context is as important as etiology. When these and other elements are being taken into consideration the disease becomes part of the totality of the patients' life situation. It is no longer a bacteria that produces an infection, but a myriad of other factors that contributes to its occurrence; which explains why only some exposed to a same agent become sick and also the variation in severity and response to treatment.

When medical technology moved forward, and doctors became overwhelmed by the demands of their profession, the face- to- face interaction between patients and physicians became less common. This was recognized by Medical Schools and health agencies, which added to their curricula subjects to foster patient-centered attitudes. They started teaching medical students and physicians the significance of non-verbal communication, body language, empathy, the concept of transference and contra-transference, social and family issues, patient satisfaction, compliance, psychosocial problems, health outcomes, coping strategies, stress management and the variables in the physician decision actions. In spite of these efforts, many doctors are failing patients by not attending to their emotional needs. In contrast, other care providers have what it takes to make patients happy. I have seen this as a leader of Balint's groups. Michael Balint was the pioneer in the understanding of doctor-patient relationship and wrote a seminal book "The Doctor, His Patient and the Illness". He taught practitioners the skills to improve the care of their patients by incorporating the psychological aspects of the disease. In my fifty years of practice I came to recognize those physicians who provide effective and competent care with a human touch. In almost all the cases they have an innate ability to connect with patients and their milieu or have learned the importance of bonding with the infirm at an emotional level.

Over the last several years the introduction of electronic medical records (EMR) has become part of the standard of care. It has been designed to collect data to improve the quality of care, prevent medical errors, improve care coordination, diminish health risks and expand best practices. According to a recent paper published in the New England Journal of Medicine it is an effective tool in providing better quality care. Although this may be indisputable, what has not been taken into consideration is the role that the computer has in interfering with the long-established doctor-patient relationship. The eye contact, the appreciation of the body language, non-verbal gestures, and the reception and acknowledgment of patient's emotions is greatly diminished. It is now the notebook, the laptop or the computer that requires the physician's attention in detriment to the patient. Is no longer the doctor's brain asking questions but rather the software used by practitioner that formulates all the queries. As the doctor enters all the data, the interaction between two human beings is sent into exile. Perhaps a new application may be developed which will order the doctor to stop gazing at the keyboard, look at the patient, smile, note the color of the eyes, elicit her/his preoccupation about the disease and show genuine sympathy and compassion.

David S. Cantor MD
Past President of Medical Staff 2003-2004
Huntington Memorial Hospital

Getting to Know Your Medical Staff Leaders

Douglas Willard, MD has been a member of the Department of Medicine, Emergency Medicine Section, since 1988. He is the Chair of the Emergency Medicine Section for the term 2015-2016. Dr. Willard is board certified in Emergency Medicine and Internal Medicine.

Dr. Willard was born and raised in Southern California. He obtained his MD degree in 1979. He completed his Medical Internship at Harbor-UCLA in 1980, followed by Residency training in Internal Medicine/Emergency Medicine at Huntington Hospital from 1980 to 1983. He stayed on at Huntington to complete his Fellowship training in Liver Diseases from 1983 to 1985.

Dr. Willard exclusively practiced primary emergency medicine since 1985, and has been a full-time staff emergency physician at Huntington since 1992. Dr. Willard has served on the Trauma Services Committee in the past and currently serves on the Quality Management Committee.

Dr. Willard is married and has twin 19-year old sons who have finished their freshman year in college. Dr. Willard enjoys reading non-fiction, including history, philosophy and current events. For regular exercise he enjoys walking. He relaxes with the family golden retriever and tangerine cat. His favorite spectator sport remains baseball.

Revised IR/Rad Procedure Consent Process

The "IR gen" order power plan and the informed consent workflow for radiological procedures have been revised. This new workflow and power plan will **go live throughout the hospital in Cerner on July 21st**. The changes will optimize safety, standard of care practices, and continue to maintain patient rights regarding procedure consent processes. **The patient will no longer sign the informed consent on the floor. The patient will sign the informed consent in the Radiology department after speaking with the Radiologist performing the procedure.** After discussing the recommended procedure and options with the patient, the ordering physician will place a "request" in Cerner, which should be entered as "IR procedure request". There are new required fields in the power plan that must be addressed before signing. **This power plan will be an "automatic initiate" after signing.** The requisition for the order will print in the Radiology department and at that juncture, the Radiologist will determine the appropriate modality for the request (ie, CT, U/S, fluoro, etc.). If a patient is incapacitated/medicated and cannot consent, the next of kin or designated DPOA will need to be contacted ahead of time by the floor RN or ordering physician to ensure their availability for the procedure consent. The nursing staff and physicians will receive the Cerner update and appropriate training as deemed necessary by the Cerner support staff before the go live date. Please be patient while we adjust to this new workflow.

Wafaa Alrashid, MD

Huntington Hospital Cancer Center

Receives National Outstanding Achievement Award from American College of Surgeons' Commission on Cancer

Award recognizes cancer programs that achieve excellence in providing highest quality care to cancer patients

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes
100+years

Commission on Cancer®
ACCREDITED PROGRAM

The Huntington Memorial Hospital Cancer Center (HHCC) was recently presented with the 2014 Outstanding Achievement Award by the Commission on Cancer (CoC) of the American College of Surgeons (ACS). HHCC is one of a select group of only 75 U.S. health care facilities with accredited cancer programs to receive this national honor for surveys performed last year. The award acknowledges cancer programs that achieve excellence in providing quality care to cancer patients. "A cancer diagnosis is among one of the most challenging experiences a patient can face," said Howard Kaufman, MD, medical director of HHCC. "This accreditation, in combination with the Outstanding Achievement Award, validates the exceptional care our team of physicians and nurses provides to help improve the quality of life for our patients during this difficult time."

HHCC cancer program was evaluated on 34 program standards categorized within four cancer program activity areas: cancer committee leadership, cancer data management, clinical services, and quality improvement. The cancer program was further evaluated on seven commendation standards. All award recipients must have received commendation ratings in all seven commendation standards, in addition to receiving a compliance rating for each of the 27 other standards.

CME Corner

Please note Second Monday and Medical Grand Rounds will resume in September.

If you would like a copy of you CME credit report please contact Maricela Alvarez via email at Marciela.Alvarez@huntingtonhosptial.com

MEDICAL GRAND ROUNDS

Topic:	Stroke Prevention
Speaker:	Arbi G. Ohanian, MD
Date:	***September 4, 2015***
Time:	Noon – 1 p.m.
Place:	Research Conference Hall
Audience:	Neurology, Internal Medicine & Primary Care Physicians
Methods:	Lecture
Credits:	1.0 *AMA PRA Category 1 Credits™*

SECOND MONDAY

Topic:	Hyperthyroidism
Speakers:	Charles F. Sharp, MD
Date:	***September 14, 2015***
Time:	Noon – 1 p.m.
Place:	Research Conference Hall
Audience:	Endocrinology, Internal Medicine, & Primary Care Physicians
Methods:	Lecture
Credits:	1.0 *AMA PRA Category 1 Credits™*

Huntington Memorial Hospital

Becomes First in the San Gabriel Valley to Offer Patients a New Heart Failure Monitoring Solution

Dr. Vyshali S. Rao, Interventional Cardiologist

Implantation of a new miniaturized, wireless monitoring sensor to manage heart failure (HF) is a new technique now available at Huntington. The CardioMEMS HF System is the first and only FDA-approved heart failure monitoring device that has been proven to significantly reduce hospital admissions when used by physicians to manage heart failure. The CardioMEMS HF System features a sensor that is implanted in the pulmonary artery (PA) during a procedure to directly measure PA pressure. Increased PA pressures appear before weight and blood pressure changes, which are often used as indirect measures of worsening heart failure. The new system allows patients to transmit daily sensor readings from their homes to their health care providers allowing for personalized and proactive management to reduce the likelihood of hospitalization.

"CardioMEMS is an exciting and valuable tool and we are proud to bring this specialized care to our patients and the community," said interventional cardiologist Dr. Vyshali S. Rao. The CardioMEMS sensor is designed to last the lifetime of the patient and doesn't require batteries. Once implanted, the wireless sensor sends pressure readings to an external patient electronic system. The CHAMPION trial studied the effectiveness of the system in New York Heart Association (NYHA) Functional Classification System class III heart failure patients who had been hospitalized for heart failure in the previous 12 months. Results of the trial demonstrated a statistically significant 28 percent reduction in the rate of heart failure hospitalizations at six months, and 37 percent reduction in heart failure hospitalizations during an average follow-up duration of 15 months. Roughly 1.4 million patients in the U.S. have NYHA Class III heart failure, and historically these patients account for nearly half of all heart failure hospitalizations. According to the American Heart Association, the estimated direct and indirect cost of heart failure in the U.S. for 2012 was $31 billion and that number is expected to more than double by 2030.

For more information, visit http://www.heartfailureanswers.com/.

Dr. Arbi Ohanian

Honored with Stroke Hero Award from the American Stroke Association

Arbi Ohanian, MD, medical director of Huntington Memorial Hospital's Primary Stroke Center, was recently honored with the American Stroke Association's Stroke Hero Award. Dr. Ohanian received this award after being nominated by Tammy Rocker, American Heart Association Senior Vice President. "We are proud to honor Dr. Arbi Ohanian for his exemplary service supporting stroke survivors as they work to beat stroke," said Ms. Rocker.

July 2015 **Medical Staff Meetings**

monday	tuesday	wednesday	thursday	friday
		-1-	-2-	-3-
		- Noon CME Committee - CR-8 - 12:15 p.m. OB/GYN Peer Review - CR 5&6	- 8 a.m. Neurology - CR 8 - Noon Medicine Committee - N/S Conf. Room	July 4th Holiday 
-6-	-7-	-8-	-9-	-10-
- 12:15 p.m. OB/GYN Dept - CR 5&6 - 5:30 p.m. Medical Executive - Board Room	- 8 a.m. QMC Pre-agenda - CR-C	- 10 a.m. PICU/Peds QI - CR 2 - 12:15 p.m. OB/GYN Committee - CR 5&6 - Newsletter Submission -	- 6:30 a.m. Anesthesia Sct - CR-7 - Noon QM Committee - East Room - 5:30 p.m. Neonatal/Pediatric Surgical Case Review - CR-10	- 7:30 a.m. Neurosurgery Sect - CR 11 - Noon Trauma Services - CR B Wingate Bldg.
-13-	-14-	-15-	-16-	-17-
- Noon Transfusion Subcommittee - N/S Room - 12:30 p.m. Ophthalmology Sct - CR-8	- Noon Critical Care Section - CR 5&6	- 7:30 a.m. Cardiology Section - Cardiology Conf. Room - 12:15 p.m. Credentials Committee - CRC	- 6:30 a.m. Anes Peer - CR-7 - Noon G.I. Section - CR-10 - Noon PT&D Comm - CR 5&6 - 3 p.m. Neonatal QI - CR-10 - 6 p.m. Bioethics - CR 5&6	- 7:30 a.m. Spine Committee - CR-11
-20-	-21-	-22-	-23-	-24-
- 9:30 a.m. SCAN Team - CR-10 - 10:30 a.m. PMCC - CR-10 - 8 a.m. Emergency Medicine Sct - ED Conf. Room - 12:15 p.m. Urology Section - CR 5&6	- 5:30 p.m. Surgery Committee - CR 5&6	- 12:15 p.m. Hem/Med Onc. - CR-5	- Noon Cancer Committee - N/S Room - 12:15 p.m. Pediatric Committee - East Room - 5:30 p.m. Metabolic & Bariatric Surg. Committee - CR-10	
-27-	-28-	-29-	-30-	-31-
- Noon Psychiatry Sect. - CR 10 - Noon GME - East Room	- 7:30 a.m. Interdisciplinary Practice - CR-C - Noon General Surgery Section - CR 5&6 - 5 p.m. Robotic Committee - CR 5&6			

July 2015 **CME Calendar**

monday	tuesday	wednesday	thursday	friday
		-1-	-2-	-3-
		- Noon - 1 p.m. Genitourinary Cancer Conf., Conf. Room 11 - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room	- Noon - 1 p.m. Thoracic Cancer Conf., Conf. Room 11	
-6-	-7-	-8-	-9-	-10-
- **12:15 - 1:15 p.m. OB/GYN Dept. Mtg, CR 5&6**	- 7:30 - 8:30 a.m. MKSAP, Wingate Doctors' Lounge - Noon -1 p.m. General MDisc Cancer Conf., Conf. Room 11 - **4 - 5 p.m. HMRI Lecture Series, RSH**	- Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room		- Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-13-	-14-	-15-	-16-	-17-
	- 7:30 - 8:30 a.m. MKSAP, Wingate Doctors' Lounge - Noon -1 p.m. General MDisc Cancer Conf., Conf. Room 11 - **4 - 5 p.m. HMRI Lecture Series, RSH**	- Noon - 1 p.m. Genitourinary Cancer Conf., Conf. Room 11 - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room	- Noon - 1 p.m. Thoracic Cancer Conf., Conf. Room 11	- Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-20-	-21-	-22-	-23-	-24-
	- 7:30 - 8:30 a.m. MKSAP, Wingate Doctors' Lounge - Noon -1 p.m. General MDisc Cancer Conf., Conf. Room 11 - **4 - 5 p.m. HMRI Lecture Series, RSH**	- Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room		- 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-27-	-28-	-29-	-30-	-31-
	- 7:30 - 8:30 a.m. MKSAP, Wingate Doctors' Lounge - Noon -1 p.m. General MDisc Cancer Conf., Conf. Room 11 - **4 - 5 p.m. HMRI Lecture Series, RSH**	- 7:30 - 8:30 a.m. Cardiac Cath Conf., Cardiology Conf. Room - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room		- 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11

Huntington Hospital

Medical Staff Administration
100 West California Boulevard
P.O. Box 7013
Pasadena, CA 91109-7013

ADDRESS SERVICE REQUESTED

Medical Staff Leadership

James Shankwiler, MD - President
Christopher Hedley, MD - President Elect
Harry Bowles, MD - Secretary/Treasurer
Thomas Vander Laan, MD - Chair, Credentials Committee
Gregory Giesler, MD - Chair, Quality Management Committee
Peter Rosenberg, MD - Chair, Medicine Department
Jonathan Tam, MD - Chair, OB/GYN Department
Mark Powell, MD - Chair, Pediatrics Department
Steven Battaglia, MD - Chair, Surgery Department

Newsletter Editor-in-Chief – Glenn D. Littenberg, MD

If you would like to submit an article to be published in the Medical Staff Newsletter please contact Maricela Alvarez, 626-397-3770 or Maricela.alvarez@huntingtonhospital.com. Articles must be submitted no later than the first Friday of every month.

BEST HOSPITALS
U.S.News & WORLD REPORT
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2013-14

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