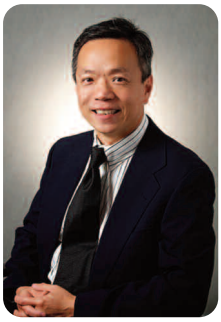
medical staff NEWSLETTER

June 2014

volume 52, issue 6

From the President



"To know what you know and what you do not know, that is true knowledge."

"The superior man makes the difficulty to be overcome his first interest; success only comes later."

- Confucius
551 BC - 479 BC

Evidence Based Medicine

In the medical field, it is essential that the best sources of reliable information be used. This is why evidence based medicine, which is defined as the, "integration of best research evidence with clinical expertise and patient values" is sought out. With aspects such as experience, research, and patient feedback, evidence based medicine is an effective and powerful tool used by physicians to help patients.

The purpose of evidence based medicine is to compile data, such as those from randomized controlled trials, and allow physicians to effectively make decisions based on a wide range of scientific evidence. This practice is favorable to the physician as it allows for the development of critical thinking, and application of evidence and experience. This practice is also favorable to the patient as it allows for better efficiency and patient safety. With evidence based medicine, both the patient and physician benefit, as constantly updating information can be shared between doctors for the best results.

Evidence Based Medicine via IT

In this day and age, technology has become an integral part in many aspects of our everyday

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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 April 7, 2014 and May 5, 2014 and by the Governing Board on May 22, 2014.

Administrative Reports

Surgery Department Rules & Regulations

General Surgery Call Panel

The General Surgery ED Call Panel will be published on a quarterly basis.

Revised Privilege Sheets

1. Pulmonary
   Revisions include the addition of privileges and criteria for Electromagnetic Navigational Bronchoscopy.
2. Pediatrics
   Revisions include the addition of privileges for Pediatric Physical Medicine and Rehabilitation.
3. General Surgery
   Revised to include privileges and criteria for Foregut Advanced Surgery privileges.

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Call extension 4265 for Cerner issues

Huntington Hospital

Revised Privilege Sheets continued

4. Otolaryngology
   Revised to reduce the overall number of cases requiring proctoring from six to four. Revised the proctoring requirements for Category 2 Advanced privileges to read: "Of the four required proctoring cases, two (2) must be from the Category 2 Advanced privilege section, if Category 2 privileges are requested."
5. Plastic Surgery
   Addition of "Amputation and revisions of amputations". (This was previously on the privilege sheet and dropped off during the last revision.)

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

- Administrative Policies and Procedures
- Formulary Management
- Departmental Policies and Procedures and Order Sets

Medical Staff Appointments

Chandrasoma, Brooke, MD
Pulmonary Disease
39 Congress Street
Suite 201
Pasadena, CA 91105
626-486-0181 (office)
626-486-0189 (fax)

Eby, Joseph, MD
Plastic Surgery
625 Fair Oaks Avenue
Suite 270
Pasadena, CA 91105
626-537-3737 (office)

Filart, Marcel, MD
Internal Medicine
1300 N. Vermont Avenue
HPMC, Room 908,
Doctors Tower
Los Angeles, CA 90027
323-662-0050 (office)
866-349-0893 (fax)

Francis, Brian, MD
Ophthalmology
Doheny Eye Institute
622 W. Duarte Road
Suite 101
Arcadia, CA 91007
626-254-9010 (office)
626-254-9019 (fax)

Gurudevan, Swaminatha, MD
Cardiovascular Disease
401 S. Fair Oaks Avenue
Pasadena, CA 91105
626-795-2244 (office)

Irvine, John, MD
Ophthalmology
Doheny Eye Institute
622 W. Duarte Road
Suite 101
Arcadia, CA 91007
626-254-9010 (office)
626-254-9019 (fax)

Sahakian, Ann, MD
Pediatrics
Huntington Medical
Foundation
1346 E. Foothill Blvd.
Suite 201
La Canada, CA 91011
818-790-5583 (office)
818-790-9517 (fax)

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Medical Staff Resignations

- Coward, Christine, MD – Ophthalmology – effective 9/30/14
- Crabb, Jonathan, MD – Emergency Medicine – effective 5/22/14
- Hakim, Amy. MD – Gynecologic Oncology – effective 6/30/14
- Harris, Kent, PhD – Psychology – effective 6/30/14
- Kozinn Spencer, MD – Urology – effective 6/30/14
- Kurkjian, Azad, MD – Child Psychiatry – effective 5/22/14
- Lee, Steve, MD – Anesthesiology – effective 5/22/14
- Levine, Reed, MD – Neurology – effective 6/30/14
- Saxon, Leslie, MD – Electrophysiology – effective 6/30/14
- Thomas, Jay, MD – Hospice & Palliative Medicine – effective 5/22/14
- Ting, Grace, MD – Emergency Medicine – effective 6/30/14
- Vanis, Richard, MD – Orthopedic Surgery – effective 5/22/14
- Zhao, Lisa, MD – Emergency Medicine – effective 5/22/14

From the **President** continued from page 1

lives. However, the most innovative forms of technology have not yet reached all forms of application; this is seen in the healthcare sphere in terms of Information Technology (IT) in the United States. In America, $8,000 is spent annually per capita on healthcare delivery and this number is expected to increase to $11,000 by the year 2015. Although we dedicate high monetary value – the highest in the world – to healthcare delivery, we are ranked 33rd in the world of longevity. Furthermore, 30% of our country's total annual expenditure on healthcare is spent ineffectively, and healthcare premiums have risen about 84% between 1999 to 2009. There figures can change if we implement the use of Evidence Based Medicine, which potentially possesses the benefits of increasing efficiency and patient care while decreasing cost.

Evidence Based Medicine is the practice of delivering patient-centered care in an open environment, more specifically through the means of Information Technology. This will allow caregivers and physicians to view an immense set of data pertaining to medical practice as well as an analysis of the data, thus providing them with constantly updated and reliable information. With this information, physicians would be able to increase efficiency as well compare their experience and practices with others in order to increase decision-making. On a larger scale, this is highly beneficial and essential for a country that is continuing inefficient healthcare practices with constantly rising costs.

Despite these advantages, there are reasons that the drive for Evidence Based Medicine through an Information Technology approach has been slowed down and not effectively implemented. One of these reasons is the startup factor. In order for Evidence Based Medicine to be fully functional, electronic health records must be used by all clinics. The problems faced here are that some physicians are resistant to the change for technical purposes. Switching form current practices to electronic health records may take time to adjust and may be a hassle to install. Furthermore, individuals of latter generations may not be as accustomed to technology as the more current generations, which may also cause a resistance to change. Not only do these problems for individual clinics arise, but also all that are participating in electronic health records must be standardized.

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This is difficult since there are many different electronic health record formats currently used by a variety of clinics that are distinct. Switching from one electronic health record format to another would again take time and adjustment. Even if all clinics began using the same formats, there are many more base standards that must be set. Some of these base standards include terminology, relevance, and method or practice, which are essential for highest efficiency and functionality of Evidence Based Medicine.

A second reason that drives for Evidence Based Medicine has be restrained is the cost factor. First of all, the cost of organization is relatively high due to the full integration of a proposed electronic health record system. This compounded with maintenance cost of the system can greatly increase expenses, which may be distasteful for many clinics. Another cost experienced is the cost of productivity. It is estimated that productivity in the clinic drops about 20% after implementation of a new system. Training to effectively use the system must also be implemented which takes time and effort. Although these costs are short term and will be accounted for in the long run, they enough to give rise to second thought in the minds of many physicians and clinicians.

Given the challenges faced, there are also many benefits of using Evidence Based Medicine. Among these include better physician decisions, improved patient safety, and reduced overall costs. Because the Information Technology will theoretically provide patient information from the lab, their home, and clinic all in one place, physicians will have an easier time in making better decisions for the patient with a more comprehensive view. Physicians will also be able to compare their practices with those of others to yield better results. For example, if a patient with a certain age or ethnic group were effectively treated in a certain way, other physicians would be able to acknowledge the treatment and use if for their own patients. Patients will also actively be able add to the benefits by logging their own information such as exercise, diet, and medication, which will contribute to better physician decision-making. Patient safety would also increase with the use of Evidence Based Medicine. Studies show that paper-based medical records are unavailable about 33% of the time when they are needed, and flaws in patient information accounts for 18% of medical errors. Both these figures would be drastically reduced by the use of electronic health records with Evidence Based Medicine, as physicians would have all needed information instantly in one place. Finally, overall cost of healthcare would be reduced. Since all patient information is provided by Evidence Based Medicine implementation, cost of the access of this information by CMS (The Centers for Medicare and Medicaid Services) would be reduced and perhaps completely eliminated. Also, since mistakes would be less prevalent, cost for misrepresentation or resolution of claims disputes over treatment billing for patient would be considerably reduce. Since the method of Evidence Based Medicine can result in better physician decision-making, improved patient safety, and lower costs, the benefits outweigh the challenges and it should be implemented.

A few successful models similar to full implementation of Evidence Based Medicine have been studied and show to be beneficial. One of these cases is the “My HealtheVetProtal” by the US Department of Veterans Affairs. Initially, the Veterans Health Administration needed to design a portal that would be able to consolidate all patient information and be secure yet allow access to certain individuals such as physicians. With the launch of the “My HealtheVet Portal”, veterans were able to

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From the **President**

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manage their healthcare and providers were able to make better decisions regarding the veterans' health based on constantly updating, accurate patient information. The Department of Veterans Affairs has since grown from 48 hospitals and 30,000 employees to become the second largest federal agency in the nation, with the portal supporting over 377,000 veterans and 9 million users since August 2005. Another case is the Physician Quality Reporting Initiative program resulting from Medicare Improvements for Patients and Providers Act of 2008. This initiative provides a financial incentive for physicians to submit "quality measures data". Since its start, the initiative has strived to promote Evidence Based Medicine ideology. Furthermore, the CMS has created an automated system that allows participating physicians ease of access and use. Both these cases have shown that Evidence Based Medicine is practical, possible, and beneficial for both patients and providers.

Overall, despite its challenges of implementation due to decreased productivity and monetary cost, the method of Evidence Based Medicine through Information Technology is essential in this day and age. The benefits of better physician decision-making, increased patient safety, and reduced overall costs of healthcare definitely outweigh and challenges. If implemented correctly and efficiently, the final product will be greatly beneficial and the short-term setbacks will be easily forgotten.

Edmund Tse, MD
President of the Medical Staff

Celebrating Milestones

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

30 Years (on staff 06/1984)

W. James Henneberg, MD – OB/GYN

25 Years (on staff 06/1989)

Samuel Bruce, MD – Maternal & Fetal Medicine

Joseph Pachorek, MD – Internal Medicine

Richard Shubin, MD – Neurology

20 Years (on staff 06/1994)

John De Beixedon, MD – Internal Medicine

Lillian Ngaw, MD – Internal Medicine

Sunil Hegde, MD – Physical Medicine and Rehab

10 Years (on staff 06/2004)

Howard Kaufman, MD – Colorectal Surgery

Giovanni Smith, MD – Pulmonary Disease

SAVE THE DATE!

The Medical Staff Leadership cordially invites members of the medical staff for a summertime **Happy Hour** event to greet colleagues and meet new medical staff members.

Location: Mijares Restaurant
Date: Friday, June 20, 2014
Time: 5:30 – 7:30 p.m.

One guest per member.
This is not a hospital sponsored event.

From the **Health Science Library**

ClinicalKey has replaced MDConsult

Thank you to all physicians who gave feedback on the alternative resources to replace MDConsult. In accordance to your recommendations, the Health Sciences Library will soon start its subscription to the ClinicalKey product. ClinicalKey gives you access to Elsevier's current medical and surgical content from 2007 to present. It also includes:

- Books - over 1,100 of Elsevier's medical and surgical reference books
- Journals - over 500 of Elsevier's medical and surgical journals
- Procedures Consult - all Procedures Consult content and associated procedural videos in various specialties
- First Consult - over 750 Point-of-Care clinical monographs
- Drug Monographs - over 2,900 clinical pharmacology drug monographs from Gold Standard
- Vitals - over 450 trusted, surgical, point-of-care content
- Patient Education - over 15,000 patient education handouts
- Clinical Trials - all clinical trials from the ClinicalTrials.gov database
- Practice Guidelines - over 4,000 practice guidelines
- MEDLINE - more than 20 million MEDLINE abstracts
- Multimedia - over 13,000 medical and surgical videos and over 5 million images
- CME is also included and is sponsored by Cleveland Clinic Center for Continuing Education

*ClinicalKey journal content will also be linked from the OvidSP Medline databases.

The best way to access ClinicalKey and other library resources from off-site is via Citrix:

1. Go to Citrix at: https://my.huntingtonhospital.com
2. When prompted, enter your user Citrix ID and password
3. Click on the H@nk-Prod icon
4. Click on the Links pull down menu at the top
5. Select Intranet from the menu to get to the hospital's Sharepoint, then click on the Health Sciences Library link under Sites Most Used section
6. ClinicalKey will be listed under the Quick Access section in the middle of the library's homepage

For more information and questions, contact the library by email at library@huntingtonhospital.com, phone 626-397-5161 or fax 626-397-2908.

From **Physician Informatics**

In the days and weeks following the HANK go live, our HANK team has continued to work diligently on addressing issues. We have brought in additional resources to assist with resolving issues, continue to assist physicians with questions, and conduct additional training classes.

As we address issues, our approach has been to focus first on potential patient safety issues and those with regulatory impact. Also of utmost importance are global issues that affect all or nearly all providers. I'd like to provide you with an update on the top three.

Alerts

We have received feedback on this topic and have made some changes to ease the number of alerts that providers will receive when placing orders. The first change was related to the interaction severity on drug-to-drug alerts. The interaction severity was adjusted to alert for the most severe interactions only. The second change was to the creatinine alert. We have adjusted this so that it will only perform its check if the patient has a creatinine level or creatinine clearance result available in the chart.

Within Cerner, there are many different layers to alerts. Therefore, we continue to ask for your feedback on the specific alerts that you feel that are inappropriate or excessive.

Message Center

Message center has been another hot topic. The feedback we have received can be categorized into three specific categories.

First, there has been feedback regarding the inconsistency of results going to message center. We have made some changes to the configuration of the message center to address this.

Second, we have heard that orders for co-signature are being sent when they shouldn't be. In investigating this issue, we have found that this was due to a clinical staff member selecting the wrong communication type when placing the order or initiating a PowerPlan. The communication type is what drives whether co-signature is necessary or not. For example a phone order would need to be co-signed but orders placed by the provider via CPOE do not need to be co-signed. We have addressed this with Clinical leadership and are continuing to educate staff on this.

Lastly, we have received feedback about optimizing what goes to message center and how messages are filed. Some good examples are: (1) some providers do not want lab results coming to message center, (2) some providers want only critical results coming to message center, and (3) some would like additional folders and the filing of messages to be different. These changes represent areas where we need providers to come together and provide a final decision on how they would like it to work. Thus, this will be one of the topics for the Task Forces to address and decide.

Printing Update

We have heard and clearly understand the challenges that printing has posed both within the hospital setting, as well as from your offices and other remote locations. In response, we engaged other vendors and other organizations in our search for a solution. This has led us to investigating a new solution by a different vendor. We are currently working on a pilot project to ensure the solution meets the identified requirements.

In closing, as you have heard four Task Forces are being formed and will begin

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From **Physician Informatics** continued from page 7

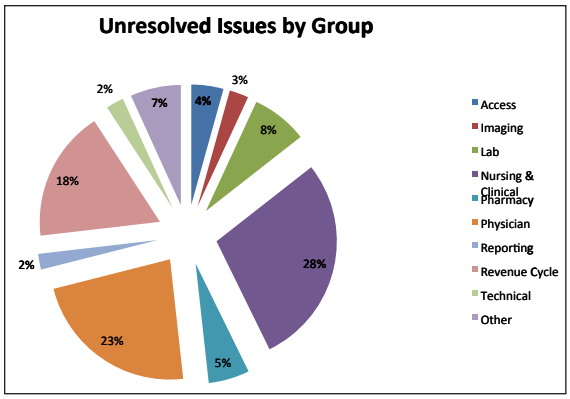
meeting in May. They will provide guidance on further prioritization of issues as well as input on how to refine and optimize problematic workflows. Some of the topics that these Task Forces will tackle are:

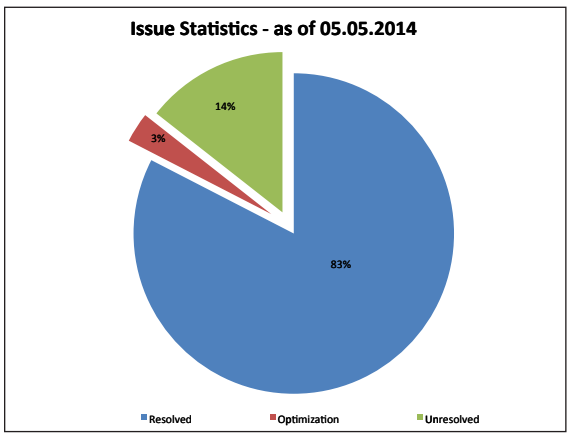
- Blood Transfusion Process
- Transition of Care Process
- Medication & Orders Reconciliation Process
- Discharge Process
- Optimization of Message Center
- Optimizing Orders to make it more intuitive
- Prioritization of New PowerPlan and PowerNote requests

I want to personally thank you for all of your support and feedback. This is a key element to refining and optimizing the system and workflows so that they are efficient and more closely aligns to your needs.

Sincerely,
Debbie Tafoya,
Vice President, CIO

HANK Issue Management Update





H@NK Topic of the Week

In an effort to help you be more efficient and improve your understanding of the H@NK system functionality, a new topic will be posted on the Physicians Only area of our website every week. Topics will include:

- Message Center
- PowerPlans – Initiating and Planning
- Medication and Transfer Reconciliation
- PowerNote Management
- Blood Product Transfusion

These "Topics of the Week" will be distributed to the Physician Lounges and Dining Room and will be emailed to all physicians with an email on file. (If you are not receiving these and would like to, contact the Medical Staff Office at 626-397-5913 to ensure your proper email address is on file.)

For suggestions on topics for this site, email ideas to AskHank@HuntingtonHospital.com.

From the **Infection Control Department**

Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Advisory

The Centers for Disease Control and Prevention (CDC) has issued a health advisory reporting the first confirmed case of **MERS-CoV** in the United States, identified in Indiana and confirmed by the CDC on May 2, 2014.

The first known cases of MERS-CoV occurred in Jordan in April 2012. The virus is associated with respiratory illness and high death rates, although mild and asymptomatic infections have been reported as well. There is no vaccine yet available and no specific treatment recommended for the virus. In some cases, the virus has spread from infected people to others through close contact. However, there is no evidence of sustained spread of MERS-CoV in community settings.

Here is the CDC information on patient identification/surveillance:

Consider MERS-CoV in the following patients

- Fever (≥38°C, 100.4°F) and pneumonia or acute respiratory distress syndrome (based on clinical or radiological evidence);

AND EITHER

- History of travel from countries in or near the Arabian Peninsula within 14 days before symptom onset; (Countries considered in or near the Arabian Peninsula: Bahrain, Iraq, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian territories, Qatar, Saudi Arabia, Syria, the United Arab Emirates (UAE), and Yemen.)
- Close contact with a symptomatic traveler who developed fever and acute respiratory illness (not necessarily pneumonia) within 14 days after traveling from countries in or near the Arabian Peninsula;

OR

- Is a member of a cluster of patients with severe acute respiratory illness (e.g. fever and pneumonia requiring hospitalization) of unknown etiology in which MERS-CoV is being evaluated, in consultation with state and local health departments.

Additional information regarding MERS-CoV is available at:
http://www.cdc.gov/coronavirus/mers/index.html.

For more information, for consultation or to report possible cases, please contact the Infection Control Department at 626-397-5138.

Medical Staff Services Corner

Annual Review of the Medical Staff Bylaws and Rules and Regulations

The Medical Staff leadership is conducting an annual review of the organization's primary governing documents. Please be advised that you are invited to review these documents and make your comments known to the Bylaws Committee by June 20, 2014. Copies will be available in the Medical Staff Office and in the Physician Lounges located near the Cafeteria and in the Wingate Building. They are also available online at either the hospital's Sharepoint site, which can be accessed via Citrix (http://hhi/sites/md-staff/default.aspx), or by visiting the hospital's website (www.huntingtonhospital.com/PhysiciansOnly/MedicalStaffRulesRegs.aspx). Please contact Medical Staff Services at 626-397-3767 or bobbie.delarosa@huntingtonhospital.com if you would like a copy sent to you via email.

Physician's...You are the Patients Experience!

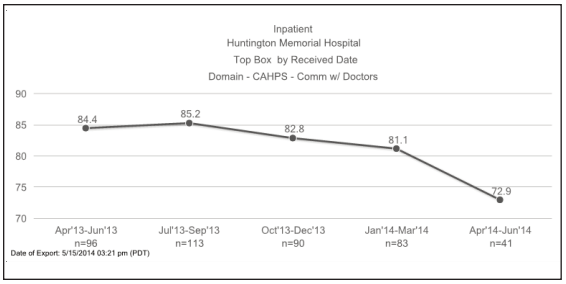
A monthly communication to assist physicians in patient engagement and the patient experience.

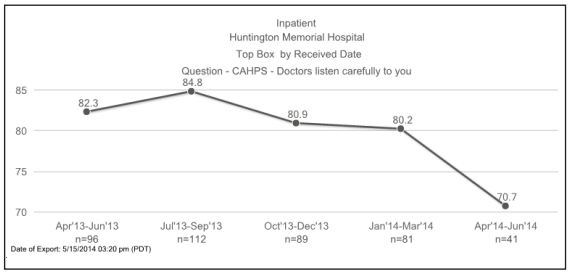
The Hospital uses a variety of methods to understand "Patient Experience".

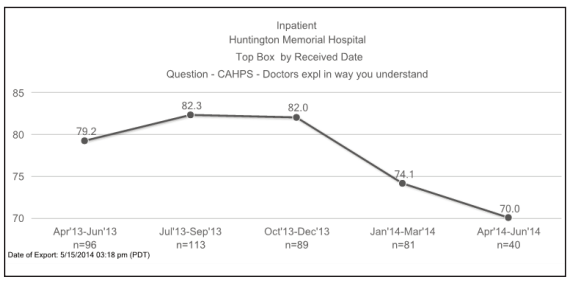
Patient satisfaction has become the latest catch phrase throughout hospitals, especially since reimbursement to the hospital by CMS is impacted by patient satisfaction scores. Huntington Hospital utilizes several methods to understand and improve the patient experience.

The **HCAHPS** (*Hospital Consumer Assessment of Healthcare Providers and Systems*) Survey is the survey of patients' perspectives of hospital care. HCAHPS (pronounced "H-caps"), is a 27-item post-discharge survey and data collection methodology for measuring patients' perceptions of their hospital experience. HCAHPS is reported publicly and allows for valid comparisons to be made across hospitals locally, regionally and nationally.

At this time there's good news and there's bad news to report. The HMH Medical Staff has always scored highly, however a downward trend has been observed. This will be monitored for a potential plan of correction.







Press Ganey partners with roughly 40% of hospitals in the US to measure and improve quality of care. Part of Press Ganey's business model includes sending surveys to patients who have visited a hospital asking them about their impressions of the facilities, the staff, and the physicians. Hospitals use the Press Ganey data to judge not only the quality of care being provided in different hospital departments, but also to compare their hospital to other hospitals within the Press Ganey database. The database may be used to compare survey data for specific physicians.

Internal methods incorporate the monitoring of **Customer Complaints as well as Compliments** which are tracked throughout the organization. Physician-specific comments are added to the individual's OPPE report (Ongoing Professional Practice Evaluation) and reappointment review. Additional monitoring activities include "ER Throughput", "Outpatient Services" and concurrent "Rounding" surveys.

Getting to Know Your Medical Staff Leaders

Christina Yeon, MD joined the Medical Staff in 2004. She is the Chair of Hematology/Medical Oncology Section from 2013 to 2014. Dr. Yeon is board certified by the American Board of Internal Medicine and is currently boarded in Medical Oncology and Hematology.

Dr. Yeon attended UCLA from College through Hematology Fellowship training, a total of fourteen years – that is a rarity these days for someone to stay at one place for so long! Dr. Yeon currently works at the City of Hope South Pasadena office as an Assistant Clinical Professor in the Department of Medical Oncology. She is involved with the San Gabriel Valley Chapter of the American Cancer Society (ACS) and is a former President of the Executive Board of this chapter. Dr. Yeon continues to be a member of the ACS.

Dr. Yeon lives in La Crescenta with her husband and three children, ages 7, 10 and 12. She really loves living in the community that she works/serves. Dr. Yeon does pilates three to four times a week. She loves reading and watching old MGM musicals.

Hospital Compliance With CMS 1559-F – "Two-Midnight Rule"

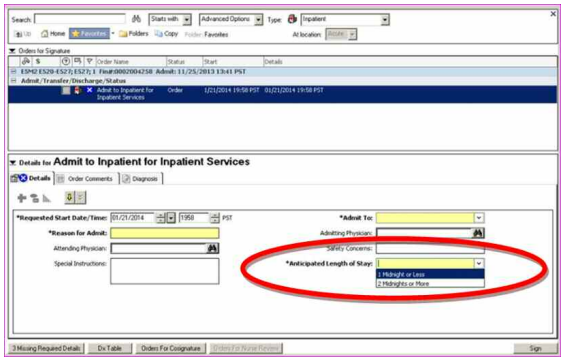
- CMS ruling, 1599-F, became effective October 1, 2013
- Although full enforcement of the rule has been postponed until March 31, 2015, hospitals must be **compliant as of October 1, 2013**.

The main components of "certifying" an inpatient admission are:

- Documentation of the Anticipated Length-of-Stay according to the "Two-Midnight-Rule"
- Documentation to support your decision for inpatient admission in your H&P and Progress Notes
- Admit orders entered at or before the time of admission

What are we asking the admitting physician to do?

To document the anticipated length of stay, when admitting a patient please choose **"1 midnight or less" or "2 midnights or more" (circled in red below)**. If choosing "1 midnight or less", please consider ordering "Place in Observation" in the Clinical Observation Unit (COU) as opposed to Inpatient Admission, if the patient does not meet inpatient criteria.



Huntington Hospital thanks you for your partnership and compliance to CMS guidelines.

Questions/Concerns: Revenue Integrity 626-387-3990 or Arlene Eckert 626-720-7773, arlene.eckert@huntingtonhospital.com.

Reference: http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-09-05-13.pdf

CME Corner

Medical Grand Rounds

Topic:	Novel Anticoagulant in Atrial Fibrillation
Speaker:	Mayer Y. Rashtian, MD
Date:	June 6, 2014
Time:	Noon – 1 p.m.
Place:	Research Conference Hall
Objectives:	1. Physicians will become comfortable to manage and prescribe the novel agents in appropriate patients with atrial fib.
Audience:	Specialties Internist, Cardiologist, Primary Care Physicians
Methods:	Lecture
Credit:	*1.0 AMA PRA* Category 1 Credits™

Cerner Physician Task Force

On April 7, 2014, the Medical Executive Committee approved the implementation of a Cerner Task Force which will serve the medical staff members to expedite the process of developing specialty-specific power plans and to coordinate and support the resolution of Cerner problems identified by medical staff members or other groups. Each department has been asked to solicit members for their respective Task Force; Medicine, OB/GYN, Pediatrics, and Surgery.

Relevant hospital and medical staff members will also be represented in the Task Force groups or will be part of the review and approval process. These members will include IT, Nursing, Pharmacy, PT&D Committee members, Quality Management, Laboratory, and Radiology, as indicated.

Process:

1. Power Plans: Each Task Force will establish their mechanism for prioritizing the order of the requests submitted to them and will solicit delegates from each specialty to work with the Task Force to develop and test Power Plans.
    a. Once a Power Plan is drafted, it will be scheduled for review/approval by the respective section. This may be accomplished through a virtual meeting mechanism (the Section will be notified via email or fax that the draft proposal has been posted to the website or Share Point (HMH intranet) and that there will be a deadline for – review/comment).
    b. If approved by the Section and Task Force, it will be scheduled for review and approval by the iDoc Committee. A representative from the referring Task Force will be asked to support the referral to the iDoc Committee.

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The Navigator Program at Huntington Hospital (Part II)

In the May issue of the Newsletter, the medical staff was introduced to Huntington's Navigator Program. The article went over the background and provided an overview of the program as a whole. The second part of the article will go over patient navigation for specific diagnoses.

Overview of COPD patient navigation

Primary teaching about COPD and medications is provided by the Respiratory Care Practitioners at the bedside. A pulmonary function test is routinely performed prior to discharge. Navigators reinforce the provided education, assess for patient's self-management ability, knowledge of COPD and exacerbation signs and symptoms, adherence to prescribed medications, smoking status, timely follow up with both pulmonologist and PCP and participation in pulmonary rehabilitation. Post discharge, patients' barriers to care are assessed and addressed, symptoms are monitored and reportable signs and symptoms are reinforced. Patients are counseled about smoking cessation/continued abstinence, the importance of adherence to medications and the follow-up plan, as well as early recognition and reporting of exacerbation symptoms. Patients are connected with appropriate community resources and programs. Pertinent assessment findings are communicated to the PCP and pulmonologist. Follow-up calls are done to ensure adherence to the recommended treatment plan. Outpatient care is coordinated for 30 days post discharge.

Overview of CHF patient navigation

The navigator assesses patients' adherence to medications, understanding of CHF exacerbation signs and symptoms, reportable weight parameters, adherence to daily weight monitoring, and adherence to sodium and fluid restriction. The cardiologist and PCP are contacted as needed with any patient concerns and indicators of possible fluid overload. Patients are encouraged to ask the cardiologist about cardiac rehabilitation and connected to appropriate community resources. CHF management teaching and lifestyle changes are reinforced. Follow-up calls are done to ensure adherence to the recommended treatment plan. Outpatient care is coordinated for 30 days post discharge.

Please contact the navigator provider hotline at 626-397-3738 or contact me directly, at 626-397-3763, for any questions or further information.

Nayiri Ketchedjian, NP
Nurse Practitioner
Navigator Program

Cerner Physician Task Force

continued from page 12

c. If approved, it will go into the Cerner Production phase for formatting and testing.
d. If effective, it will be scheduled for implementation and the Section will be notified.

2. Problems/Issues: Each Task Force will review and prioritize issues/problems submitted by members or groups of their department. The Task Force will communicate the prioritized list to hospital Informatics employees to determine if the concerns can be fixed and will assist with plans of correction as needed.

How to report an issue and open a ticket for the Task Force:

1. Call the H@NK extension at 4265 (you must call from within the hospital).
2. Please state: The name of the Task Force who should review the issue, your name, specialty, contact information, specific details about the issue.

JUNE 2014 **Medical Staff Meetings**

monday	tuesday	wednesday	thursday	friday
-2-	-3-	-4-	-5-	-6-
- 12:15 p.m. OB/GYN Dept - CR 5&6 - 5:30 p.m. Medical Executive Committee - Board Room		- Noon Plastic Surgery Section - CR-10 - 12:15 p.m. OB/GYN Peer Review - CR 5&6 - 3 p.m. QMC Pre-agenda – CR-C	- Noon Medicine Committee - N/S - Noon Trauma Services Committee - CR 5&6 - 12:15 p.m. Cerner Task Force Committee Meeting Dept. of OB/GYN - CR-C	- 7 a.m. Ortho Section - CR 5&6 **- Newsletter Submission -**
-9-	-10-	-11-	-12-	-13-
	- 7:30 a.m. EP Subsection - Cardiology Conf. Room	- 10 a.m. PICU/Peds QI - CR-2	- Noon QM Committee - East Room - 5:30 p.m. Neonatal/Pediatric Surgical Case Review - CR-10	
-16-	-17-	-18-	-19-	-20-
	- Noon Cerner Task Force Committee Meeting Dept. of Surgery - CR-C - 12:15 p.m. Credentials Committee - CR-C	- 5:30 p.m. Surgery Committee - CR 5&6	- 6:30 a.m. Anes Peer - CR-7 - Noon PT&D Committee - CR 5&6 - 1 p.m. Thoracic Sect CR-11 - 3 p.m. Neon QI - WT CR-10 - 6 p.m. Bioethics - CR 5&6	
-23-	-24-	-25-	-26-	-27-
	- Noon Bylaws Committee - CR-C - 5 p.m. Robotic Committee - CR-5		- Noon IM Peer Rev - CR-6 - 12:15 p.m. Pediatric Committee - East Room	
-30-				

June 2014 **CME Calendar**

monday	tuesday	wednesday	thursday	friday
-2-	-3-	-4-	-5-	-6-
- 12:15 - 1:15 p.m. OB/GYN Dept. Mtg, CR 5&6 **Topic: Massive Hemorrhage Protocol**	- 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11	- 7:30 - 8:30 a.m. Neonatal/Perinatal M&M, Conf. Room 10 - Noon - 1 p.m. Genitourinary Cancer Conf., Conf. Room 11 - Noon -1 p.m. Radiology Teaching Files, MRI Conf. Room	- 7 -10 a.m. Trauma M&M, Conf. Room B - Noon - 1 p.m. Thoracic Cancer Conf., Conf. Room 11	- 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. Medical Grand Rounds, RSH **Topic: Novel Anticoagulant in Atrial Fibrillation** - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-9-	-10-	-11-	-12-	-13-
	- 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11	- Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room	- 8 - 9 a.m. Surgery M&M, Conf. Room B	- 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-16-	-17-	-18-	-19-	-20-
	- 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11	- Noon - 1 p.m. Genitourinary Cancer Conf., Conf. Room 11 - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room	- 7 - 8 a.m. Trauma Walk Rounds, Conf. Room B - 8 - 9 a.m. Surgery M&M, Conf. Room B - Noon - 1 p.m. Thoracic Cancer Conf., Conf. Room 11	- 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-23-	-24-	-25-	-26-	-27-
	- 7:30 - 8:30 a.m. MKSAP, Conf. Room A - Noon - 1 p.m. General MDisc Cancer Conf., Conf. Room 11	- 7:30 - 8:30 a.m. Cardiac Cath Conf., Cardiology Conf. Room - Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room	- 8 - 9 a.m. Surgery M&M, Conf. Room B	- 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-30-				

Huntington Hospital

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

ADDRESS SERVICE REQUESTED

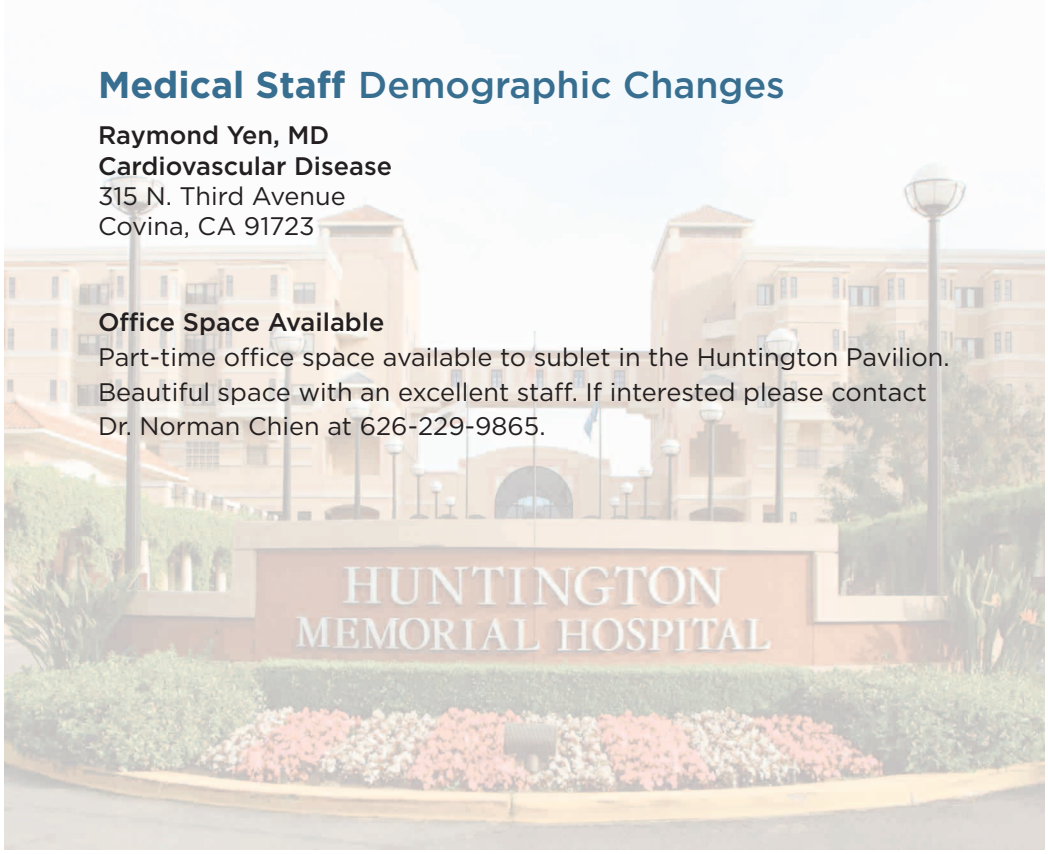
Medical Staff Leadership

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

Raymond Yen, MD
Cardiovascular Disease
315 N. Third Avenue
Covina, CA 91723

Office Space Available
Part-time office space available to sublet in the Huntington Pavilion. Beautiful space with an excellent staff. If interested please contact Dr. Norman Chien at 626-229-9865.



BEST HOSPITALS
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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