medical staff NEWSLETTER

October 2015 volume 53, issue 10

From the President

The Mighty Pen

"If you don't read the newspaper, you're uninformed. If you read the newspaper, you're mis-informed."
– Mark Twain

Humans are innately inquisitive. It is the probably the hallmark of our species that we are always looking for new, shiny items of interest. We are drawn to the novel and even sensational, it stimulates us and makes us feel more informed and even, in some ways, more in control of our world. The Romans would espouse news from the rostrum in the Forum, to let the citizens know the latest events of the day. Runners and riders traversed empires to spread the latest decrees and court happenings. The printing press helped codify it to a piece of paper that could be bought at the local corner and the Internet brought it to each individual on a nearly instantaneous basis. The exchange of information has always remained the cornerstone and the currency by which civilizations thrived or withered. Today, its transmission and dissemination have become akin to fast food. As a result, journalistic ethics have become clouded by headlines rather than verification of fact. Unfortunately, medicine and its practice have drifted into this social media exchange of potential misinformation, leaving physicians to defend the facts and literature in order to help educate patients about their care and treatment.

The distribution of newspapers is big business; 24 billion papers were printed last year alone. (Hartson) Yet, it is argued to be an archaic and waning enterprise drawn into the tail wind of the current social media explosion. Stories have become shorter to aid in rapid consumption and quicker distribution, which can

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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 September 14, 2015 and by the Governing Board on September 24, 2015.

Administrative Reports

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

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Inside this issue:

Upcoming Medical Staff Mixer

November 5, 2015 at Mijares

5:30 – 8 p.m.

Don't forget your flu shot or mask required!

Huntington Hospital

Medical Staff Appointments

Campbell, Ronald A., MD
Orthopedic Surgery
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800 South Raymond Avenue
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Premiere Plastic Surgery
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Internal Medicine
Health Care Partners
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Medical Staff Appointments continued from page 2

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From the **President** continued from page 1

sometimes curtail the time taken for appropriate fact checking. Also, individuals are becoming increasingly involved in presenting their personal slant on the issues of the day. Medical topics have become a common source of discussion. This access to a steady stream of information about the latest medical issues has allowed for many individuals to rapidly garner a large number of potential sources for any given topic or diagnosis and also led to the potential repetition and expansion of pseudo-science and misquoted or out of context comments from the literature. An example of this is the continued concern about routine vaccination, despite numerous studies showing its efficacy and safety. The popularity of these sites has also impacted the mainstream press and network television, making them also prone to premature production and propagation of sensational stories of the potential successes or failures of standard treatments and even touting potential cures that lack firm support in the medical community.

In the sea of information that we all swim, it is the duty of medical professionals to help educate and guide patients in regards to source information that is relevant, current, and supported by clinically based observation and evidence. Patients need to be involved in their care and in the gaining of facts that help explain the nature of their medical problems and the avenues of treatment available to them. However, it is important to help guide them in this process of discovery to avoid the potential eddies and pitfalls of unsupported data.

James Shankwiler, MD
President of the Medical Staff

Bibliography

Barthel, Michael. "Podcasting: Fact Sheet." *Pew Research Centers Journalism Project RSS*. Pew Research Center, 29 Apr. 2015. Web. 12 Sept. 2015. <http://www.journalism.org/2015/04/29/podcasting-fact-sheet/>.

Hartson, William. "Ten Things You Never Knew About...newspapers." Express. London Daily Express, 3 May 2013. Web. 11 Sept. 2015. <www.express.co.uk/.../top10facts/.../Ten-things-you-never-kn...>.

From the **Health Science Library**

Should You Do Your Own Literature Searching?

Part 2: Tips for Getting the Most from a Search Request

Last month's article focused on some of the advantages and disadvantages to conducting your own search. While doing your own searching has pros and cons, there may be times when asking a librarian to conduct the search outweighs the benefit of doing it yourself. Ask yourself these questions to gauge what is right for you:

- How familiar am I with Medline and/or do I have the time right now to learn?
- Do I have the time to spend searching?
- Did I find the best information?

If you are not familiar with Medline, don't have the time it takes to conduct a search or are not confident that you've found the best evidence to support your clinical query then have the library conduct a search.

Here are some dos and don'ts that will maximize the potential for the library to find the most relevant articles for you:

Dos:

Do let the librarian know the details of what you are looking for. The electronic **Request a Search** form on the library's main page at http://huntingtonhospital.libguides.com/ provides an easy way to include all the specifics of the search, such as:

- Comprehensiveness
- Age groups
- Disease/condition/treatment subheadings (e.g. diagnosis, complications, adverse effects, etc.)
- Publication date range

Do limit your search by one or more of the above factors because the more specific you can be, the more relevant the results. If the library does not find anything relevant, we will automatically broaden the search to show you what is available.

Do include any relevant synonyms or acronyms.

Do tell us the timeframe for when you need the search completed.

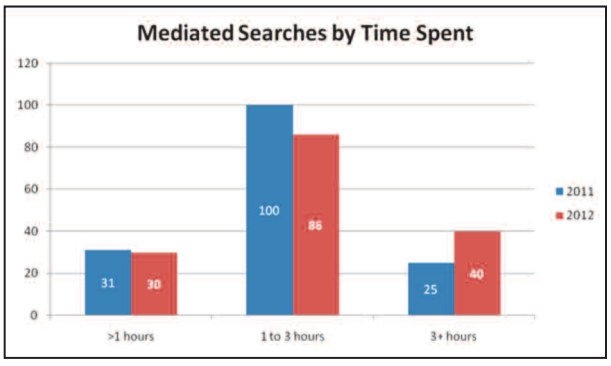
Do factor in the time it may take to order/retrieve the full-text articles (2-5 business days if non-RUSH)

Do ask the librarian to do a follow up search with new criteria if you find the results are too narrow or too broad.

Don'ts:

Don't expect the search to be completed within 5-10 minutes while you wait. A literature search can take anywhere from 15-30 minutes to over 6 hours (depending on the topic) with the majority taking 1 to 3 hours.

Don't expect that the full text of the articles will be automatically sent along with the search results. The results will be sent in citation with an abstract format with links to the OvidSP record to access the full text (if the library subscribes) or order full text via the link to Document Delivery.



From **Physician Informatics**

New SIRS/Sepsis Alert

Go-Live Effective Date: September 28, 2015

Introduction:

Sepsis can contribute up to an additional length of stay of 11 days per patient. Nationally, septic shock accounts for a mortality rate of 29 patients per every 1,000 patients. The Sepsis Recognition and Treatment solution continuously monitors patient data to immediately identify patients who meet the SIRS or sepsis criteria. It then alerts care givers and guides ordering evidence based diagnostic tests and antibiotic therapies along with tracking the stats of sepsis patients in real time.

Alert Criteria for SIRS/Sepsis:

Criteria	Concept (Unit of Measure)	Increment Factor	18 - 150YRS	
			Triggers When Less Than	Triggers When Greater Than
SIRS	Band Man(%)	0.1		>=10.1
SIRS	Blood Glucose(mg/dL)	1	200	141
SIRS	Blood Glucose(mmol/L)	1	11.1	7.83
SIRS	Glucose(mg/dL)	1	200	141
SIRS	Glucose(mmol/L)	1	11.1	7.83
SIRS	HR(bpm)	1		>=96
SIRS	RR(b/min)	1		>=23
SIRS	Temp(C)	0.1	36	38.4
SIRS	Temp(F)	0.18	96.8	101.12
SIRS	WBC(/mcl)	100	4000	12000
SIRS	WBC(/mm3)	100	4000	12000
SIRS	WBC(x10^3/uL)	0.1	4	12.1
SIRS	WBC(x10^9/L)	0.1	4	12.1
Sepsis	Bilirubin(mg/dL)	0.1	10	2.1
Sepsis	Bilirubin(umol/L)	1.71	171	35.91
Sepsis	Creatinine(mg/dL)	0		0.5 incr.
Sepsis	Creatinine(umol/L)	0		>=38.13
Sepsis	Lactate(mg/dL)	0.92		>=18.92
Sepsis	Lactate(mmol/L)	0.1		>=2.1
Sepsis	MAP(mmHg)	1	65	
Sepsis	SBP(mmHg)	1	90	

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From **Physician Informatics** continued from page 5

SIRS Alert:

- The algorithm will detect **SIRS criteria** via vital signs and laboratory results. When a patient meets three (3 or more) SIRS criteria, the following actions will occur:
  1. **SIRS** alert is sent to any nurse who has established a primary nurse relationship with the patient.
  2. A task is placed on the nursing task list that will instruct the RN to complete documentation of notification of the provider for SIRS.
     ******Note:*** The provider can open patient's chart and view criteria for alert firing under **Results Review**, and then click on SIRS/SEPSIS tab. (The results review tab is taking the place of the significant event component of the patient summary page).

Sepsis Alert:

- The algorithm will detect **Sepsis criteria** via vital signs and laboratory results. When a patient meets two (2 or more) SIRS criteria and 1 organ dysfunction criteria, the following actions will occur:
  1. **Sepsis** alert is sent to any nurse who has established a primary nurse relationship with the patient.
  2. Nurse notifies provider of alert.
     - ➢ If provider opens chart before nurse documents provider notification of alert, then provider will get the **Sepsis Alert**.
     - ➢ The provider can open patient's chart and view criteria for alert firing under **Results Review**, and then click on SIRS/SEPSIS tab. (The results review tab is taking the place of the significant event component of the patient summary page)
  3. If the provider receives the alert, he/she must acknowledge it by documenting action on the form that displays.
  4. Provider orders **Sepsis Management Advisor**. (Examples: SIRS or Sepsis.) ***The Sepsis Management advisor provides guidelines for treatment; however its use is optional as all relevant orders are also available within the listed powerplans.***
     ******Note:*** The Sepsis Management Advisor order is also found inside the following powerplans:
     - ➢ **ED Adult Severe Sepsis/Septic Shock** powerplan.
     - ➢ **Crit Severe Sepsis/Septic Shock** powerplan.

Timing of Alerts:

- The Alert will only fire at the time the system generates the Alert.
  1. **SIRS Alert** – will ONLY fire only once every 24 hours and goes only to nurses who have established a primary nurse relationship.
     - ➢ Nurse will then notify provider and document the notification.
  2. **Sepsis Alert** – will ONLY fire once every 48 hours and goes to both nurses with a primary relationship and all providers.
     ******Note:*** Alert will only be suppressed after a nurse/provider has addressed the alert.

If you need assistance, please contact Physician Support Services at (626) 397-2500
physinfo@huntingtonhospital.com

Cerner

CME Corner

MEDICAL GRAND ROUNDS:

Topic: Transcatheter Aortic Valve Replacement (TAVR)
Speaker: Robbin G. Cohen, MD & Azhil Durairaj, MD
Date: October 2, 2015
Time: Noon – 1 p.m.
Place: Research Conference Hall
Objectives:
1. Develop screening procedures using selection criteria for patients suitable for Transcatheter Aortic Valve Replacement and develop inclusions and exclusions for treatment.
2. Describe trends in cost-effectiveness for TAVR relative to surgical AVR for both self-expanding and balloon-expandable valves.
3. Discuss 5-year mortality and valve durability findings for TAVR based on PARTNER I inoperable patients.

Audience: Cardiovascular Disease, Internal Medicine, & Thoracic Surgery
Methods: Lecture
Credits: 1.0 *AMA PRA Category 1 Credits™*

SECOND MONDAY:

Topic: Identification and Management of Common Toxidromes
Speakers: Michael D. Levine, MD
Date: October 12, 2015
Time: Noon – 1 p.m.
Place: Research Conference Hall
Objectives:
1. Define toxidromes.
2. Discuss common presentations of important toxidromes, and present clues to suggest the diagnosis.
3. Review specific agents that may cause each of the toxidromes.
4. Present management strategies of the various toxidromes.[1]

Audience: Emergency Medicine, Internal Medicine, & Primary Care Physicians
Methods: Lecture
Credits: 1.0 *AMA PRA Category 1 Credits™*

1. A toxidrome (a portmanteau of toxic and syndrome) is a syndrome caused by a dangerous level of toxins in the body. The term was coined in 1970 by Mofenson and Greensher.

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

Celebrating Milestones

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

35 Years (on staff 10/1980)
Donald J. Williams, MD – Nephrology

30 Years (on staff 10/1985)
Mark T. Kidon, DPM – Podiatry
Sharon E. Nelson, MD – Obstetrics & Gynecology
Clayton E. Patchett, MD – Orthopedic Surgery
Thomas L. Vander Laan, MD – Surgical Critical Care

25 Years (on staff 10/1990)
Harry F. Bowles, MD – Anesthesiology
Kimberly A. Shriner, MD – Infectious Disease
Andreas T. Subadya, MD – Internal Medicine

20 Years (on staff 01/1995)
Brian Ross, MD – Neurology
Robert Siew, MD – Internal Medicine

15 Years (on staff 10/2000)
Greggory R. DeVore, MD – Maternal & Fetal Medicine
Robert J. Gottner, MD – Thoracic Surgery
Andrea Kovacs, MD – Pediatric Infectious Disease
Daniel R. Laster, MD – Orthopedic Surgery

10 Years (on staff 10/2005)
Alan B. Karme, MD – Psychiatry
Ian B. Ross, MD – Neurosurgery

From the **Clinical Documentation Specialists**

CDI Tip of the Month – October, 2015

ICD-10 is live as of October 1st. Despite the significant increase in the number of codes, the best way to ensure success in ICD-10 is to learn about the ***specificity of documentation*** that is necessary to assign the correct codes. The Association of Clinical Documentation Improvement Specialists (ACDIS) recently published an article listing the top 10 things physicians need to know about ICD-10. The full article is available online at the ACDIS website1, and a summary is included below.

Top 10 Documentation Tips for ICD-10:

1) **Document Laterality.** Clarify right, left, bilateral when appropriate, or quadrant when applicable
2) **Stage Diseases:** Acute, Chronic, Acute on Chronic; Stages of CKD
3) **Specify Anatomy.** Vessel of heart, lobe of lung, specific location of stroke or hemorrhage (intracerebral, subarachnoid, etc.)
4) **Link Conditions by using with or due to.** Examples include Diabetes type 2 **with** nephropathy, acute blood loss anemia **due to** bleeding gastric ulcer
5) **Type, location and acuity of MI** and vessel involved
6) **Seizure specificity** (ex. Grand mal, status epilepticus)
7) **Gustilo-Anderson scale** for open fractures
8) **Urosepsis does not exist.** Instead document **sepsis due to UTI**.
9) **Document tobacco** use, abuse, dependence, or withdrawal
10) **Document radiology findings in your assessment.** Coders cannot interpret lab, radiology or pathology data without interpretation in physician progress notes

[1] **http://www.hcpro.com/acdis/details.cfm?content_id=318966&topic=WS_ACD_HFEA**

Ask a CDI
Clinical Documentation Improvement

To reach a CDI, call extension 3362 or email hmhcdi@huntingtonhospital.com

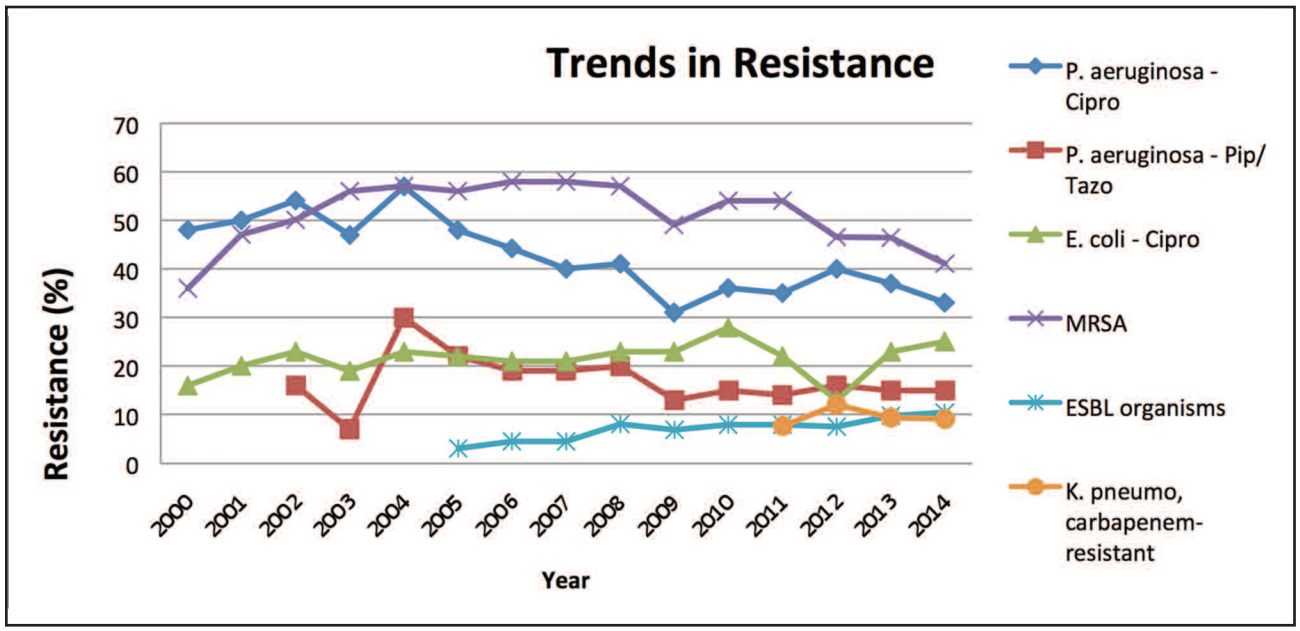
Karen Beal, RN, BSN, CCDS
Maria Gilda Villanueva, CCDS
Theresa Cardona, RN, CCDS

Gabriella Pearlman, MD, CDI Physician Advisor & ICD10 Champion, extension 5183

Huntington Hospital 2014 Antibiogram Trends

Pamela Ny, PharmD, Annie Wong-Beringer, PharmD, and Paul Nieberg, MD

July 2015



Huntington Hospital (HH) antibiogram is updated every year with antimicrobial susceptibility data on organisms isolated from patients at HH. The antibiogram can be accessed from Sharepoint by selecting Clinical Laboratory Information and the Antibiogram tab in the left column. Data obtained are used to monitor trends in antibiotic resistance and to make empiric antibiotic choices as well as formulary decisions.

Gram-negative pathogens. *Escherichia coli* and *Klebsiella pneumoniae* continue to be the most commonly isolated gram-negative pathogens. In uncomplicated UTIs, the most common organism found is *E. coli*. According to IDSA recommendations and current HH susceptibility data (98% for non-ESBL, 95% for ESBL), nitrofurantoin is the oral antibiotic of choice for outpatient treatment of uncomplicated cystitis in young females (18-40 years) (1). Note that nitrofurantoin should not be used in patients with suspected or confirmed pyelonephritis or those with impaired renal function (CrCl<60 ml/min) such as in the elderly. In the latter, other oral options such as cephalexin and cefpodoxime for the treatment of uncomplicated UTIs may be considered, where cefazolin is a good predictor of susceptibility (1, 2).

The prevalence of extended-spectrum beta-lactamase (ESBL) organisms (namely *E. coli* and *K. pneumoniae*) remains unchanged at a notable rate of 11%. Nearly 10% of all *K. pneumoniae* isolates are carbapenem-resistant (CRKP). Majority of CRKP isolates are from urine (67%) followed by respiratory (25%), blood (4%) and wound (4%) sites. We have published a recent study that evaluated non-bacteremic CRKP infections at HH and found that patients infected with CRKP are 7 times more likely to have received previous carbapenem therapy and up to 37 times more likely to be co-infected with other carbapenem-resistant pathogens during

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2014 Antibiogram Trends continued from page 9

their CRKP infection (3). CRKP-infected patients had prolonged hospital stays (13 days) and up to one third were readmitted within 30-days of discharge (3). These findings underscore the importance of reducing overall carbapenem use. Results from a recent medication use evaluation on meropenem use at HH indicate that nearly half of the patients could potentially be treated with an alternative narrower-spectrum agent. Hence, PT&D has approved restriction criteria regarding meropenem use for empiric and culture-directed therapy. Specifically, alternative agents such as cefepime for AmpC-producing organisms and ertapenem for ESBL-producers should be considered. The updated restriction criteria can be accessed from Sharepoint→References in the right column→Infectious Disease Corner→HH Antibiotic Formulary Criteria.

Since removing levofloxacin from HH formulary in 2005, *Pseudomonas aeruginosa* (PA) resistance to fluoroquinolones has decreased to 33% compared to 57% back in 2004. This is most likely attributable to our focused prescribing under continued restriction criteria for ciprofloxacin and moxifloxacin. Piperacillin-tazobactam remains the empiric regimen of choice if PA infection is suspected. Of note, PA respiratory isolates were relatively more resistant to antibiotics than isolates recovered from other body sites (42% cipro-floxacin-resistant). For patients admitted from skilled nursing or long-term acute care facilities, prior antibiotic use within 90 days, and multiple comorbidities, combination empiric therapy with piperacillin/tazobactam plus tobramycin is recommended. Antimicrobial activity of piperacillin-tazobactam can be maximized by administering the drug via extended infusion (over 4h), particularly in those who are critically ill. (4)

Gram-positive pathogens. The epidemiology of *Staphylococcus aureus* continues to change as now a majority of isolates causing bacteremia are methicillin-sensitive (59% MSSA vs. 41% MRSA). More than half of *S. aureus* isolates are from skin and soft tissue infections (SSTIs), followed by respiratory (19%) and blood (8%). Vancomycin is recommended as the empiric agent for patients suspected of MRSA infection and needing parenteral therapy who do not have documented allergy or significant renal dysfunction. Note that 70% of patients initiated on vancomycin empiric therapy do not have MRSA grown from cultures; thus de-escalation therapy should be considered upon C&S results. Oral agents with excellent bioavailability and activity against MRSA such as doxycycline (98%) and sulfamethoxazole-trimethoprim (91%) may be used to facilitate the transitioning of patients to outpatient therapy when appropriate. If *S. aureus* bacteremia is highly suspected, patients should receive vancomycin plus a beta-lactam empirically, since studies have shown patients on vancomycin alone with MSSA bacteremia have worse outcomes (5, 6). De-escalation of empirical vancomycin to definitive beta-lactam therapy appears inferior to initial beta-lactam therapy, which may be explained by the increasing vancomycin MIC among both MSSA and MRSA isolates; 67% of MSSA and 72% of MRSA blood isolates have vancomycin MIC of 2 (Etest).

In summary, nitrofurantoin or oral cephalosporins (e.g. cephalexin, cefpodoxime) for those who cannot tolerate nitrofurantoin remain oral antibiotics of choice for uncomplicated UTIs. Overprescribing of meropenem will need to be significantly curtailed; the rising resistance of *Pseudomonas* and increasing isolation of CRKP render it no longer an effective agent for the empiric therapy of multi-drug resistant gram-negative infections. Vancomycin should be considered as first line for empiric therapy in suspected MRSA infections and combination with a beta-lactam is recommended if *S. aureus* bacteremia is suspected with discontinuation or de-escalation when appropriate.

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2014 Antibiogram Trends continued from page 10

References

1. Gupta K, Hooton TM, Naber KG et al. International clinical practice guidelines for the treatment of acute uncomplicated cystitis and pyelonephritis in women: a 2010 update by the infectious disease society of America and the European society for microbiology and infectious diseases. Clin Infect Dis. 2011; 52 (5): e103-e102.
2. CLSI. Performance standards for antimicrobial susceptibility testing. CLSI document M100-S25. Wayne, PA: Clinical and Laboratory Standards Institute; 2015.
3. Ny P, Nieberg P, and Wong-Beringer A (in press). Impact of carbapenem resistance on epidemiology and outcomes of nonbacteremic *Klebsiella pneumoniae* infections. Am J Infect Control. 2015; (available at http://www.ajicjournal.org/article/S0196-6553(15)00668-9/fulltext).
4. Falagas ME, Tansarli GS, Ikawa K et al. Clinical outcomes with extended or continuous versus short-term intravenous infusion of carbapenems and piperacillin/tazobactam: a systematic review and meta-analysis. Clin Infect Dis. 2013; 56(2):272-82.
5. McConeghy KW, Bleasdale SC, and Rodvold KA. The empirical combination of vancomycin and a beta-lactam for staphylococcal bacteremia. Clin Infect Dis. 2013; 57 (12): 1760-1765.
6. Minejima E, Fang C, Wu J et al. Relationship of CYK response to empirical combination therapy for *Staphylococcus aureus* bacteremia. (Abstract accepted, ICAAC 2015, San Diego, CA).

Implementing Rapid Diagnostics in Microbiology at HH

Nancy Bui, PharmD, Pamela Ny PharmD, Annie Wong-Beringer, PharmD

Time to effective antibiotic therapy is a critical factor when considering clinical outcomes in patients with bloodstream infections (1). After the onset of hypotension, survival decreases 7.6% for every hour that appropriate antibiotics are delayed (2). The Biofire FilmArray system performs rapid identification of microorganisms by multiplex PCR analysis. The blood culture identification (BCID) panel can detect 24 pathogens (19 bacteria and five yeasts) and three antibiotic resistance genes within 1 hour of a positive blood culture thereby decreasing time to identification by 24-36 hours compared to conventional methods. The resistance genes detected are *mecA* (methicillin resistance), *van A/B* (vancomycin resistance), and KPC (carbapenem resistance). The use of rapid diagnostics in conjunction with antimicrobial stewardship has been shown to improve times to appropriate antibiotic therapy and shorten the duration of unnecessary antibiotics in patients (3). Our Anti-microbial Stewardship Program is currently working with Microbiology to implement the BCID panel at Huntington Hospital with a target date of November or December of this year. Once implemented, Pharmacy will notify physicians of BCID results and provide antibiotic recommendations according to medical staff-approved use criteria as appropriate. Conventional methods of susceptibility testing will continue as the Biofire FilmArray system does not conduct antibiotic sensitivity testing. The integration of rapid diagnostics at Huntington Hospital will help us excel at the timely delivery of optimal care to our patients.

References

1. Kothari A, Morgan M, and Haake DA. Emerging technologies for rapid identification of bloodstream pathogens. Healthcare Epidemiology 2014; 59: 272-8.
2. Kumar A, Roberts D, Wood KE et al. Duration of hypotension before initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock. Critical Care Medicine 2006; 34: 1589-96.
3. Bauer KA, Perez KK, Forrest GN, Goff DA. Review of rapid diagnostic tests used by antimicrobial stewardship programs. Clinical Infectious Diseases 2014; 59: S134-45.

October 2015 **Medical Staff Meetings**

monday	tuesday	wednesday	thursday	friday
			-1-	-2-
			- Noon Medicine Committee, North/South Room - Noon Trauma Services Committee, CR 5&6	- 7 a.m. Ortho Section, CR 5&6
-5-	-6-	-7-	-8-	-9-
- 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 - 12:15 p.m. Oral Section, CR 6	- 12:15 p.m. OB/GYN Dept, CR 5&6	- Noon QM Committee, East Room - 5:30 p.m. Neonatal/Pediatric Surgical Case Review, CR-10	- 7:30 a.m. Neurosurgery Section, CR-11 - Newsletter Submission -
-12-	-13-	-14-	-15-	-16-
- 9:30 a.m. SCAN Team, WT CR 10 - 10:30 a.m. PMCC, WT CR 10 - Noon Transfusion Committee, North/South - 12:30 p.m. Ophthalmology Section - CR-8	- 12:30 p.m. ENT Section, CR-10	- 10:00 a.m. PICU/Peds QI, CR 2	- 6:30 a.m. Anesthesia Peer, CR-7 - Noon PT&D Committee, North/South Room - Noon G.I. Section, CR-10 - 3 p.m. Neon QI, WT CR 10 - 6 p.m. Bioethics, CR 5&6	
-19-	-20-	-21-	-22-	-23-
	- 5:30 p.m. Surgery Committee, CR 5&6	- 12:15 p.m. Credentials Committee, CR-C	- 12:15 p.m. Pediatric Committee, East Room - 5:30 p.m. Metabolic & Bariatric Surgery Committee, CR-10	
-26-	-27-	-28-	-29-	-30-
- Noon Psychiatry Sct, CR-10 - 12:15 p.m. Urology Section, CR 5&6		- 12:15 Hem/Medical Onc, CR-5	- Noon IM Peer Review, CR-6	

October 2015 **CME Calendar**

monday	tuesday	wednesday	thursday	friday
			-1-	-2-
			- 7 - 8 a.m. Trauma Walk Rounds, Conf. Room B - 8 - 9 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: Transcatheter Aortic Valve Replacement (TAVR)** - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-5-	-6-	-7-	-8-	-9-
- 12:15 - 1:15 p.m. **OB/GYN Dept. Mtg,** **CR 5&6** **Topic: Fetal Surgery**	- 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. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-12-	-13-	-14-	-15-	-16-
- Noon - 1 p.m. **Second Monday,** **RSH** **Topic: Identification and Management of Common Toxidromes**	- 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**~~ ***cancelled***	- Noon - 1 p.m. Radiology Teaching Files, MRI Conf. Room	- 7 - 8 a.m. Trauma Walk Rounds, Conf. Room B - 8 - 9 a.m. Surgery M&M, Conf. Room B - Noon - 1 p.m. Thoracic Cancer Conf, Conf. Room 11	- 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-19-	-20-	-21-	-22-	-23-
	- 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	- 8 - 9 a.m. Surgery M&M, Conf. Room B	- 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-26-	-27-	-28-	-29-	-30
	- 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 - 8 a.m. Trauma Walk Rounds, Conf. Room B - 8 - 9 a.m. Surgery M&M, Conf. Room B	- 7:30 - 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon - 1 p.m. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11

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ADDRESS SERVICE REQUESTED

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.

Medical Staff Demographic Changes

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BEST REGIONAL HOSPITALS
U.S.News & WORLD REPORT
LOS ANGELES, CA
RECOGNIZED IN 9 SPECIALTIES
2015-16

2015-2016
Best Hospitals Report

#7 Hospital in the
Los Angeles Metro Area
#18 Hospital in California
Recognized in 9 specialties:
• Diabetes & Endocrinology
• Gastroenterology &
GI Surgery • Geriatrics
• Gynecology • Nephrology
• Neurology & Neurosurgery
• Orthopedics • Pulmonology
• Urology