

## From the President

Dear Colleagues,

The deadline for submitting these editorials comes at you fast. Despite Jennifer's gentle reminders, I always find myself behind schedule. I have decided to include a timely submission of this article as one of my New Year's Resolutions.



Some idle Googling informed me that this tradition dates back to 153 B.C. – Janus, a mythical king of early Rome, was placed at the head of the calendar (January). With two faces, Janus could at once reflect on past events and look forward to the future.

As there are only two more for me to submit, I ought to be able to keep it.

I invite you to join me in a collective set of New Year's resolutions.

1. I will write legibly, and improve my documentation.
2. I will complete my medical records on time.
3. I will date and time my chart entries, and dictate operative notes on time.
4. I will sign my telephone and verbal orders within 48 hours.
5. I will control my temper, and treat everyone with due respect.
6. I will not use invalid abbreviations.
7. I will attend all my meetings to the best of my ability.
8. I will be prompt in returning my calls.
9. I will take all measures to avoid unnecessary patient stay in hospital.
10. I will maintain an active lifestyle and dine healthily, to the best of my ability.

I wish every one a very Happy New Year.

**M. Ali Khan, M.D., F.A.C.S.**  
President, Medical Staff

## New Medical Staff Members

Please join us in welcoming the following new Members to the Medical Staff of Prince George's Hospital Center:

- Steven Andescavage, DO**...PGHC Emergency Medicine  
**Sargine Brutus, M.D.** .....Bowie Emergency Medicine  
**Frederick Burke, M.D.**.....Bowie Emergency Medicine  
**Meher Chaudhry, M.D.**.....PGHC Emergency Medicine  
**Yau Chung, M.D.**.....Ophthalmology  
**Michael Costa, M.D.**..... Pathology  
**Wei Cui, M.D.** ..... Internal Medicine/General Medicine  
**Swapna Gaddipati, M.D.** .....Internal Medicine/General Medicine  
**Sheri Hamersley, M.D.** .....Ob/Gyn – Maternal Fetal Medicine  
**Kavita Kalra, M.D.**.....Internal Medicine/Hematology-Oncology  
**Adedeji Karunwi, M.D.**.....Internal Medicine/General Medicine  
**Homayoon Mahjoob, M.D.**.....Internal Medicine/Gastroenterology  
**Anupama Neelakanta, M.D.**.....Internal Medicine/General Medicine  
**Zina Novak, M.D.**..... Medical Imaging  
**Monique Powell-Davis, M.D.** ..... Ob/Gyn  
**Yousuf Qureshi, M.D.** .....Ophthalmology  
**Fahd Rahman, M.D.** .....Internal Medicine/General Medicine  
**Tahir Shaikh, DO**...Internal Medicine/General Medicine  
**Atitegeb Tibebu, M.D.** ..... Internal Medicine/General Medicine  
**Nikia Wooten, DO** .....Bowie Emergency Medicine

*Welcome Aboard!*

## Patient Identifiers

All of us are aware of National Patient Safety Goal (NPSG) 01.01.01, which requires that at least 2 patient identifiers are used when providing care, treatment, and services. The same requirement should apply when phoning a family member or responsible individual of a patient.

Frequently, there are patients in the hospital with the same last name. Rarely (but it has occurred), the wrong family may be called. To avoid any confusion, the NPSG should be applied here as well.

The best approach would be:

- "This is Dr....."
- "I am calling about Jane Doe" (plus some second identifier such as date of birth)

Although this may seem to be somewhat unnecessary, its application may prevent needless anxiety on a family's part and prevent any confusion.

# Calendar of Meetings, Conferences, and CME Programs



## January 2010

Fri	1	HOSPITAL CENTER HOLIDAY – NEW YEAR'S DAY		
Tue	5	8:00 a.m.	Trauma M&M Conference	AUD
		12:00 p.m.	Credentials Committee	Lounge
		12:00 p.m.	Ob/Gyn Grand Rounds	AUD
Wed	6	12:00 p.m.	Wednesday Lecture	AUD
Fri	8	7:30 a.m.	Cath Lab Conference	Lounge
		8:35 a.m.	Cath Lab Peer Review Committee	Lounge
		12:00 p.m.	Orthopedic Grand Rounds	Lounge
Mon	11	1:00 p.m.	Pharmacy & Therapeutics Committee	Med Staff Conf
Tue	12	11:00 a.m.	Ob/Gyn Peer Review	K200 Conf Rm
		12:00 p.m.	Ob/Gyn Grand Rounds	AUD
		5:30 p.m.	Medical Executive Committee	Med Staff Conf
Wed	13	12:00 p.m.	Wednesday Lecture Series	AUD
			<i>Topic To Be Announced</i>	
Thu	14	7:30 a.m.	Operating Room Committee	Lounge
Tue	19	7:30 a.m.	Medical Education Committee	Lounge
		11:00 a.m.	OB CQI	K200 Conf Room
		12:00 p.m.	Ob/Gyn Grand Rounds	AUD
Wed	20	12:00 p.m.	Wednesday Lecture Series	AUD
		3:00 p.m.	Medicine/CCC Peer Review Committee	Lounge
Thu	21	7:30 a.m.	Surgery Peer Review Committee	Lounge
Tue	26	12:00 p.m.	Ob/Gyn Grand Rounds	AUD
		3:30 p.m.	Med Staff Quality Oversight Committee	Med Staff Conf
Wed	27	7:00 a.m.	Emergency Dept Staff Meeting	ER Conf Room
		9:00 a.m.	Emergency Department Peer Review	ER Conf Room
		12:00 p.m.	Wednesday Lecture Series	AUD

## February 2010

Tue	2	8:00 a.m.	Trauma M&M Conference	AUD
		12:00 p.m.	Ob/Gyn Grand Rounds	AUD
Wed	3	12:00 p.m.	Wednesday Lecture	AUD
			<i>Topic To Be Announced</i>	
Mon	8	1:00 p.m.	Pharmacy & Therapeutics Committee	Med Staff Conf
Tue	9	11:00 a.m.	Ob/Gyn Peer Review	K200 Conf Rm
		12:00 p.m.	Ob/Gyn Grand Rounds	AUD
			<i>M&amp;M Conference</i>	
		12:00 p.m.	Institutional Research Committee	Lounge
Wed	10	12:00 p.m.	Wednesday Lecture	AUD
			<i>Topic To Be Announced</i>	
Thu	11	7:30 a.m.	Operating Room Committee	Lounge
Fri	12	7:30 a.m.	Cath Lab Conference	Lounge
		8:35 a.m.	Cath Lab Peer Review Committee	Lounge
		12:00 p.m.	Orthopedic Grand Rounds	Lounge
Tue	16	11:00 a.m.	Ob/Gyn Peer Review	K200 Conf Rm
		12:00 p.m.	Ob/Gyn Grand Rounds	AUD
			<i>M&amp;M Conference</i>	
Wed	17	12:00 p.m.	Wednesday Lecture Series	AUD
			<i>Topic To Be Announced</i>	
		3:00 p.m.	Medicine/CCC Peer Review Committee	Lounge
Thu	18	7:30 a.m.	Surgery Peer Review Committee	Lounge
Tue	23	12:00 p.m.	Ob/Gyn Grand Rounds	AUD
		3:30 p.m.	Med Staff Quality Oversight Committee	Med Staff Conf
Wed	24	7:00 a.m.	Emergency Dept Staff Meeting	ER Conf Room
		9:00 a.m.	Emergency Department Peer Review	ER Conf Room
		12:00 p.m.	Wednesday Lecture Series	AUD
			<i>Topic To Be Announced</i>	

## ID Badges

As many of you are aware, the Hospital's Customer Service initiative includes requiring that all staff wear their ID badges to properly identify themselves to our customers. For many reasons (from customer service to patient safety) this requirement extends to all members of our Medical Staff.

Please be sure to wear your Prince George's Hospital Center ID badge when you are in our building. Your ID badge should be worn on your lapel, or on a lanyard that hangs above your waist. If your badge is old, and worn down, please go to the Security Department (Access Control Office) on the first floor of the ACF building for a

replacement badge. This replacement will be free if you turn in your old ID badge.

Never give your ID badge to another person for ANY reason. This is a violation of Hospital policy, and jeopardizes patient and staff safety. Please remember that access to secure areas is granted to you as a physician. Whenever your badge is swiped at any door, a permanent record of that swipe is registered in the computer system. If another person uses your ID badge to enter a secure area, it will register that YOU entered that area.

If you have not yet received an ID badge, please contact the Medical Staff Office at (301)618-3550 to make arrangements for your photo to be taken.

## Pharmacy News

### Studies in Brief.....

#### *Niacin — An Old Drug...A New Meaning*

Results of a recently published study have indicated that adding extended-release niacin to statin therapy leads to significant regression of atherosclerosis as measured by carotid intima-media thickness (IMT). These findings however did not hold true for ezetimibe (Zetia®), an inhibitor of intestinal cholesterol.

The **AR**terial **B**iology for the **I**ntervention of the **T**reatment **E**ffects of **R**educing Cholesterol 6: **HDL** **A**nd **LDL** **T**reatment **S**trategies in Atherosclerosis (ARBITER 6-HALTS) study was a prospective, randomized, open-label, blinded endpoint trial that compared treatment strategies of either HDL-raising therapies or LDL reduction for dyslipidemia on carotid atherosclerosis. The primary end-point was the change in carotid IMT between groups after 14 months. Eligible individuals included patients with known atherosclerotic coronary or vascular disease or patients at high cardiovascular risk who were being treated with a statin. The study was terminated prematurely based on results of a prespecified, blinded interim analysis indicating the superiority of niacin over ezetimibe. A total of 208 patients completed the trial compared to an initial estimated enrollment of 400 patients.

Results indicated that mean HDL cholesterol levels increased by 18.4% in the niacin group whereas mean LDL cholesterol levels decreased by 19.2% in the ezetimibe group. Compared to ezetimibe, niacin had a greater change in the mean common carotid IMT over 14 months that was statistically significant ( $P=0.003$ ). The incidence of major cardiovascular events was lower in the niacin group compared to the ezetimibe group (1% vs 5%,  $P=0.04$ , by chi-square test). Additional studies assessing HDL cholesterol levels and the risk of a major cardiovascular event are currently being undertaken. These include the AIM-HIGH study comparing extended-release niacin and simvastatin to simvastatin alone and HPS2-THRIVE, a placebo-controlled trial with extended-release niacin and

laropiprant, a specific prostaglandin D2 inhibitor. Results of these studies are expected in 2011 and 2013 respectively.

#### *Vitamin D and your Heart.....*

Inadequate levels of vitamin D are associated with an increased risk of cardiovascular disease and death. These are the findings of a recent observational study that was presented at the American Heart Association 2009 Scientific Sessions. Researchers followed more than 27,000 individuals aged 50 years or older with no history of cardiovascular disease for approximately one year. Subjects with very low levels of vitamin D ( $\leq 15$  ng/ml) were 77% more likely to die, 45% more likely to develop coronary artery disease, and 78% more likely to have a stroke than those with normal ( $> 30$  ng/ml) vitamin D levels. Researchers also noted that even with a moderate deficiency of vitamin D, there was an increased association with coronary artery disease, heart failure, stroke, and death. Due to the observational nature of the study however, researchers added that it is unknown whether this is a cause and effect relationship and further studies would be necessary in order to better establish such an association.

Previously published studies have also suggested that individuals with moderate to severe vitamin D deficiency are at an increased risk of cardiovascular disease. Research has shown that vitamin D deficiency activates the renin-angiotensin-aldosterone system and causes a predisposition to hypertension and left ventricular hypertrophy. In addition, increases in parathyroid hormone leading to insulin resistance, diabetes and cardiovascular risk can all be observed in individuals with chronically low levels of vitamin D. Estimates indicate that approximately 30-50% of the general population is vitamin D deficient. Several large randomized trials are underway to further evaluate and establish the relevance of vitamin D and cardiovascular health.

# The Physician Satisfaction Team is Here for You!

Greetings from the Physician Satisfaction Team (PST)! The PST was formed in October 2009. Our mission is to identify tools and resources that will improve quality services to our doctors, patients and families. To accomplish our task, we will work collaboratively with all teams, departments and healthcare professionals to create a cooperative environment for our physician community.

We are a group of dedicated professionals from different departments in the hospital assembled to develop better communication channels between the Medical Staff and the hospital. You may know us already, as we are your administrative support, information technology, and direct patient care professionals who work closely with you and your patients every day. Our members are as follows:

- Anna Awah-Cross** ..... Pharmacy
- Tanya Bates** ..... Nursing/E900
- Jennifer Bell** ..... Medical Staff Office
- Beverly Calloway** ..... OR
- Valerie Groff** ..... MIS
- Autumn Henderson** ..... Emergency Dept.
- Caroline Malfara** ..... Cath Lab
- Penny Martin** ..... Medical Library

- Christine Mobley** ..... Clin. Documentation
- Althea Reid** ..... Laboratory
- Rose Tasin** ..... Education
- June Taylor** ..... DHA-OB/GYN
- Diana Williams** ..... Case Management

You will hear from us over the next few months. We will seek your input to create new ways to support your efforts. Let us know how we can better assist you and your patients. We are here for you! Thank you for all that you do.

— Your Physician Satisfaction Team

The Leader is published bi-monthly by the Medical Staff of Prince George's Hospital Center. Please submit news, comments, and inquiries to:

The Medical Staff Office Prince George's Hospital Center  
3001 Hospital Drive, Cheverly, Maryland 20785 • (301) 618-3550  
Jennifer.Bell@dimensionshealth.org



Editorial Staff

M. Ali Khan, M.D., President      V. Prem Chandar, M.D., President-Elect  
Jennifer Bell, C.P.M.S.M., C.P.C.S., Director, Medical Affairs



Prince George's Hospital Center  
3001 Hospital Drive  
Cheverly, MD 20785

## CDS DocuMentor

### HIV & AIDS

Human Immunodeficiency Virus (HIV) & Acquired Immune Deficiency Syndrome (AIDS) are major health care concerns. There are a myriad of conditions associated with HIV infection. CDS Nurses and Coders look for confirmation of HIV infection and if the patient is asymptomatic or has conditions/complications associated with the HIV infection.

### Documentation we look for associated with HIV & AIDS

- Candidiasis of esophagus
- Retinopathy due to AIDS-like disease
- Pneumocystis carinii

- Acute lymphadenitis due to ARC
- Kaposi's sarcoma
- Agranulocytosis due to HIV infection

### Coding

Code 042 is assigned to all types of HIV infections described by terms such as: AIDS, AIDS-related complex (ARC), AIDS-related conditions, AIDS-like disease or illness, HIV disease. Asymptomatic Human Immunodeficiency Virus infection is assigned code V08.

### What you should do:

Always document and link any conditions present in your patient that you feel may be associated with HIV or AIDS.

*Christine Mobley, RN CDMP Director 86507; Teresa Butler Washington, RN 86268; Emily Wilcox, RN 82788*

## Your Hands, Your Patient's Health

### ***“What are the most deadly weapons in the hospitals?”***

The answer would be “HANDS” as they cause more harm than any other lethal weapons combined such as “guns” or “drugs” or “knives.” Hands have been identified both as a healer and transmitter of infections – which side we want to use? Semmelweis applied epidemiologic methods to test this hypothesis when microorganisms were not yet recognized as a cause of infection. Hand hygiene (HH) is an old cultural heritage of human civilization. Perhaps the easiest, effective and lowest-technology way to prevent the spread of organisms, but even the highest-tech hospitals can't seem to get their healthcare workers (HCW) to do it enough.

In 1990 an MRSA outbreak occurred in an area hospital involving 19 neonates. Aggressive infection control measures were instituted which were not effective in slowing the outbreak. The single additional measure of changing the hand washing soap was associated with immediate termination of the acute phase of the outbreak, attesting to the effectiveness of the HH program. From 1961 to 1987 there were 25 reported *S. aureus* outbreaks in United States' nurseries. Epidemiologic evidence documented hand carriage by the HCW was the most likely mode of transmission. Another study reported carriage of organisms on the hands has been implicated in more than 40 outbreaks. A temporal relationship between improved HH compliance and reduced healthcare associated infections (HAI) was reported in seven studies from 1977 to 1999. A Swiss study showed that boosting the compliance rate from 48% to 66% reduced HAI rates in half over a four-year period. It has been reported that hospitals probably would see a significant reduction in HAI if they could maintain an 85% HH compliance rate.

The objective of HH is to remove extraneous substances including sweat, skin lipids, epithelial debris, transient and a small part of resident flora. This will reduce microbial release from hands to an extent that will prevent hand borne infections. HH includes hand washing with soap and water and use of alcohol foam. Transient flora cause most infections and must be eliminated to render hands safe for the next patient contact. Hand washing eliminates

transient flora by their mechanical and detergent effect and exerts sustained antimicrobial activity on resident flora. Alcohol-based hand rubs are active against clinically important bacteria, viruses, yeasts and fungi. Wash hands when hands are visibly soiled and use alcohol foam when hands are dry such as in between patient contact. When using alcohol foam, apply it to the palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. We are always on the go, running from room to room, patient to patient and alcohol foam is suitable in most of the circumstances.

We are busy doing things that are all important for the patient and most of us just don't see HH as a priority, allowing it to slip down on that list. Surgeons would consider it absolutely unacceptable if fellow surgeons didn't do a scrubbing before a procedure. Then why do we accept low HH compliance in other areas of the hospital? Why is the message not consistently translated into clinical practice? Why is adherence to recommended practice unacceptably low? How can we completely stop the locomotion power of microorganisms? How can we change our behavior? What can we all do to make PGHC, HAI free? How can we remind ourselves of the “inverse relationship between HH and HAI”? What is our role and moral obligation to achieve this goal? We can make significant inroads by increasing our vigilance in HH compliance. CDC and WHO issued guidelines. Joint Commission encourages us to talk to patients about it, which will help us to be more compliant. Recently we joined the MD Healthcare Commission HH Collaborative and now we will be more scrutinized in our practice. We need to take ownership of our compliance and begin self-monitoring. The time has come to shout from the roof tops that HH promotion should be a priority for us. The adverse effects of HAI's are well known, impacting the healthcare system every day. As a HCW, it behooves us all to maintain high standards of the single most important, yet single most neglected, fundamental rule of healthcare practice, that of simple “HAND HYGIENE”.

Abdul B. Zafar MBBS, MPH, PHD  
Director, Infection Control and Employee Health, DHS

# PGHC Formulary Updates – 2009

## ADDITIONS

DRUG	INDICATION/RATIONALE
• Aripiprazole (Abilify®)	Atypical antipsychotic
• Budesonide/formoterol (Symbicort®)	Maintenance of asthma and airway obstruction in COPD
• Cinacalcet (Sensipar®)	Calcimimetic for treatment of 2° hyperparathyroidism in patients with chronic kidney disease on dialysis
• Clevidipine (Cleviprex®) injection **Other agents should be considered 1st line therapy when appropriate**	Injectable dihydropyridine calcium channel blocker, specific arterial vasodilator for reduction of blood pressure when oral therapy is not desirable
• Collagenase (Santyl®) ointment	For debriding chronic dermal ulcers and severely burned areas
• Duloxetine (Cymbalta®)	Selective serotonin (5-HT) and norepinephrine reuptake inhibitor for MDD, generalized anxiety disorder, diabetic peripheral neuropathy, and fibromyalgia
• Fenofibric Acid (Trilipix®)	For mixed dyslipidemia, severe hypertriglyceridemia, and primary hyperlipidemia.
• Ferric Gluconate (Ferrlecit®)	For iron replacement in patients with iron deficiency anemia in hemodialysis patients in conjunction with erythropoietin
• Insulin Detemir (Levemir®)	Longacting insulin for treatment of adults and pediatric patients with Type 1 diabetes and adults with typ2 diabetes who require basal insulin for control of diabetes
• Lamotrigine (Lamictal®)	Adjunct for generalized seizures, primary tonic-clonic seizures and partial seizures in adults and children
• Methimazole (Tapazole®)	Treatment of hyperthyroidism
• Nitrofurantoin (Macrobid®)	Antibacterial for treatment of UTI caused by susceptible organisms; dosed twice daily
• Oxcarbazepine (Trileptal®)	A derivative of carbamazepine, 2nd generation antiepileptic for mono or adjunctive treatment of partial and generalized seizures in adults and children
• Ranolazine (Ranexa®)	For treatment of chronic angina
• Repaglinide (Prandin®)	An oral hypoglycemic used as an adjunct for Type 2 diabetes
• Selenium	Trace element included in antioxidant protocol for risk reduction in both hospital and ICU length of stay

## DELETIONS

DRUG	INDICATION/RATIONALE
• Abciximab (ReoPro®)	Similar efficacy with formulary IIb/IIIa inhibitor eptifibatide (Integrilin®)
• Papain/urea (Accuzyme®) ointment	Removed from the market; formulary alternative Santyl® ointment
• Aprotinin (Trasylol®)	Patient safety initiative
• Benzocaine (Hurricane®) Spray	Patient safety initiative; safer formulary topical anesthetics available
• Beractant (Survanta®)	Similar efficacy with formulary Poractant alpha (Curosurf®)
• Colchicine/Probenecid (Colbenemid®)	Similar efficacy with formulary alternatives to treat gout
• Fluticasone/Salmeterol (Advair®)	Similar efficacy with formulary alternative Budesonide/formoterol (Symbicort®)
• Gemfibrozil (Lopid®)	Safer formulary alternative Fenofibric Acid (Trilipix®)
• Granisetron (Kytril®)	Similar efficacy with formulary ondansetron (Zofran®)
• Insulin glargine (Lantus®)	Similar efficacy with insulin detemir (Levemir®)
• Iron Dextran (Dexferrum®, INFeD®)	Safer formulary alternative ferric gluconate (Ferrlecit®)
• Metaproterenol (Alupent®)	Similar efficacy with formulary Albuterol (Proventil®)
• Nitrofurantoin (Macrobid®)	Similar efficacy with Nitrofurantoin (Macrobid®)
• Pindolol (Visken®)	Similar efficacy with formulary beta blockers
• Piroxicam (Feldene®)	Similar efficacy with formulary NSAIDs
• Probenecid (Benemid®)	Similar efficacy with formulary drug to treat gout
• Promethazine (Phenergan®) Injection	Patient safety initiative; safer IV formulary alternative available
• Salsalate	Similar efficacy with formulary NSAIDs
• Thioridazine (Mellaril®)	
• Thiothixene (Navane®)	
• Trifluoperazine (Stelazine®)	
• Triazolam (Halcion®)	Safer formulary alternatives for insomnia
• Urokinase (Abbokinase®)	Similar efficacy with formulary Alteplase (Activase®)