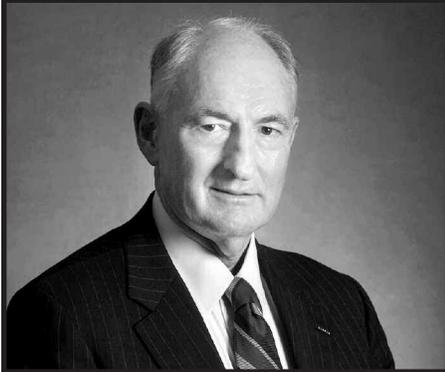


MEDICAL STAFF

Huntington Hospital NEWSLETTER

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From The President



“If the doctor has treated a gentleman for a severe wound with a lancet of bronze and has caused the gentleman to die, or has opened an abscess of the eye for a gentleman and has caused the loss of the gentleman’s eye, one shall cut off his hands.” -Hammurabi Code (circa 2000 B.C.)

“Judge not, that ye be not judged. For with what judgment ye judge, ye shall be judged; and with what measure ye mete, it shall be measured to you again.” -Matthew 7:1.

How are adverse events identified, categorized, evaluated, re-evaluated and finally adjudicated at Huntington Hospital? How does our system materially affect individual members of the medical staff? It may be best to step back a moment and consider our position. The purpose of medicine is to serve the community by continually improving health, health care, and quality of life for the individual and the population by health promotion, prevention of illness, treatment and care and the effective use of resources, all within the context of a team approach. This emphasizes a series of key issues, including the focus on patients, health and quality of life, the use of resources, and the team approach. Physicians are held to a high standard of ethics, and rightly so. There is increasingly greater scrutiny of professional practice, and standards are now openly discussed in the media and public forums.

The medical profession should have nothing to fear from such public discussions and should avoid appearing defensive or secretive. But how do we realistically deal with errors when they unavoidably occur, and how should we counsel our fellow physicians when mistakes happen? What is our process for maintaining clinical standards, evaluating outcomes, and assessing effectiveness?

The system of peer review has evolved over decades of trial and error. In theory, the peer review process exemplifies professionalism by determining and maintaining standards of conduct and practice in concert with ethical principles and accountability to patients and to the profession itself. Details of Huntington’s Peer Review are outlined under Medical Staff Policy and

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Summary of the Minutes



Executive Committee Meeting

The August MEC and the Board was dark however, a special MEC meeting was held August 19th to approve credentialing activity and will be reported in the October newsletter.

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Procedure, Policy # 710.030.4 and were last updated in December 2008.

The Joint Commission renamed “peer review” to be termed “Focused Review of Practitioner Performance” in 2004. The current term is now Focused Professional Practice Evaluation. If an organization's current "peer review" process includes the criteria to be used for identified performance issue, defined triggers that indicate the need for performance monitoring, focused professional practitioner evaluation covered by TJC requires that organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified. The triggers that indicate the need for performance monitoring can be single incidents or evidence of a clinical practice trend. There is a somewhat fine line between criteria and triggers but triggers are the very obvious issues, e.g., infection rates, sentinel events, perhaps complaints, etc.

Cases considered for Peer Review are referred from numerous sources, including variance from hospital indicators, occurrence events, risk management cases, physician referral, patient/family complaints, and rarely, insurance carrier referrals. A complex series of steps is then initiated to evaluate the case. The majority of cases never go farther than screening by a quality management specialist. Once physician review is deemed necessary, the case is referred to the Section Chair, who may elect to table the matter or refer to committee. The Committee reviews the case in executive session and attempts to define the seriousness of the event and to determine whether standard of care was met. The “assignment” is next forwarded to the Quality Committee, and finally to the Medical Executive Committee for a final designation. The process is time consuming, often tedious, and difficult. The principal participants are your elected section, department, and Quality Committee chairs, who work very diligently to attain the goals mentioned above. Thanks to all those who have participated in the Peer Review Process: you have graciously devoted your time and expertise to an indispensable activity.

The process is highly structured, with lots of redundancy. Unfortunately, that does not always mean that all cases are adjudicated as the physician under review would like. Not infrequently, participation in a Peer Review conference leaves physicians frustrated and angry. A few of our own medical staff have told me they felt needlessly humiliated or embarrassed by the process. Others described their experience as a “kangaroo court.” There is the perception by some independent practitioners that large groups of doctors tend to be overly critical of individuals, while staunchly defending their own. Some physicians have expressed a lack of confidence in our current system.

There are a number of potential pitfalls in our Peer Review process. First, the process is slow and cumbersome. This is not altogether bad, as it pays to spend lots of time discussing problems, and often systemic problems are discovered that can be corrected, to the betterment of all. Second, the system tends to assign blame to individuals rather than search for systemic issues that led to the adverse event in the first place. In fact, systemic deficiencies are often encountered and addressed during the process; but not necessarily as the primary goal of peer review. Third, each section has its own unique concepts of what constitutes acceptable practice that can confound the assessment. As an example, consider a hypothetical case of a man who underwent recent robotic surgery that was complicated by postoperative renal failure resulting from inadvertent ligation of both ureters. Once the problem was identified, bilateral stent placement was attempted by an interventional radiologist; one ureter was injured by the procedure. The adjudication by the surgical section was that the adverse outcome of ureteral ligation was an expected complication of surgery and not a practitioner-specific problem. On the other hand, in an entirely different setting (Section of Radiology and Department of Medicine) the radiologist was assigned a “3” for placing the stent that resulted in an injured ureter.

Clearly the system is imperfect, but how can we improve on our current process?

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Stanley Rappoport, MD

7/21/1927 – 8/1/2010

It is with great sadness that the medical staff office reports the passing of Dr. Stanley Rappoport, pediatrician, serving the Pasadena and Arcadia area for over 50 years. He was a member of the medical staff here at Huntington for over 20 of those years. Dr. Rappoport died August 1st from complications of cancer. He was 83.

The medical staff offers the family and friends of Dr. Rappoport our sincere condolences.

The HSL Wants 2 Know...Do u Txt?

The health sciences library (HSL) is considering a text messaging (SMS) reference service for hospital staff. The service would allow staff to send short questions via cell phone text messaging to the library (e.g., Do you have X book? Is Y journal available electronically? What is the rate of breast cancer in the California? Are my articles ready for pickup? etc.)

If you are an SMS user, we'd like to hear from you! Please text us at (626) 344-0542 and let us know ("yes," "no," "maybe" or "I don't know") whether or not you would use this type of a service. Respondents will be entered into a drawing to win a \$5 Starbucks gift card!

Responses must be sent no later than September 30th, 2010 in order to be included in the drawing.

Correction: It was reported in the August newsletter in the Medical Staff Appointments, Joanne Asuncion, MD Pediatrics (Neonatology) is incorrect. Specialty is Pediatrics not in Neonatology.

3 New Resource Guides from the Library

Medical Images

Preparing for a talk and need a few good visuals to illustrate your point? Try our **Medical Images Resources** guide to quickly locate images, tables, graphs and videos. The guide has a synopsis of what you will find at each resource and any copyright/permissions issues that may apply.

Patient Education

Did you know that the Huntington Community Health Library (HCHL) subscribes to a variety of patient education electronic resources? Patients and community members can come to the library to access a host of authoritative consumer-tailored health databases, eBooks, magazines and encyclopedias to find out more about their health issues. Hospital staff can access our patient education resources from onsite networked computer workstations by going to the Library's MyAlliance webpage and clicking on the "**Huntington Community Health Library**" tab. Physician's can access our patient education resources remotely via Connect or Citrix. Additionally, patients and community members can request health information by phone at (626) 397-5161 or by email at library@huntingtonhospital.com. Our **Patient Education Resources** guide alerts you to all the library offers in the way of patient education. The library is open to patients and community members during staffed library hours, 8 am to 4 pm, Monday to Friday.

Electronic Health Records

Want to get up to speed with all the buzz about EHRs? Take a look at our **Implementing an EHR** bibliography. The bibliography provides a list of articles written from 2008+ (updated quarterly) that focus on EHR implementation especially for small physician practices. Many of the articles are available fulltext (denoted by the paperclip icon). Click on the "View" link to get the article attachment or click on the "OvidSP" link to order the article via Interlibrary Loan.

Wish the library had a guide that would point you to authoritative resources on a particular topic? Email your "guide idea" to library@huntingtonhospital.com.

*Library resource guides can be accessed via the Library's MyAlliance website. Click on the **LIBRARY RESOURCES** link from the main HH MyAlliance webpage.*

Troponitis and MIs: Separate But Not Equal

The past two decades have seen dramatic developments in the treatment of acute myocardial infarction (MI). One of the most important tools that we use to diagnose patients with heart attacks is the troponin assay. These are the enzymes that are released into the bloodstream when there is myocardial injury.

One of the problems with using the troponin assay is how to interpret them in various clinical settings. Frequently, patients with complex systemic illnesses (sepsis, renal failure, heart failure, etc.) are found to have an elevated troponin without clinical evidence of acute or unstable myocardial ischemia. If we respond by reflex and label this situation an acute MI, we are now being held responsible to rapidly initiate the same major interventions and therapeutics as if the patient was admitted with elevated ST segments and crushing chest pain. Clearly these situations are not the same. In order to discuss nuances we must first discuss some basic definitions.

Acute Coronary Syndrome, or ACS, encompasses several of the ischemic syndromes responsible for heart attacks. **Unstable Angina (UA)** is defined by ischemic discomfort with at least one of three features:

1. Occurring at rest or on minimal exertion and usually lasting more than 20 minutes (unless relieved by sublingual nitroglycerine).
2. Being severe and of new onset (within 4 to 6 weeks).
3. Occurring with a crescendo pattern.

ST Segment Elevation Myocardial Infarction (STEMI) is chest pain associated with ST segment elevation on the electrocardiogram usually secondary to plaque rupture and coronary thrombosis.

Non ST Segment Elevation Myocardial Infarction (NSTEMI) is unstable angina with elevated troponins with or without ST segment abnormalities such as ST depression or nonspecific ST-T wave changes (but not ST elevation).

Secondary Unstable Angina by the Braunwald classification is seen in patients with known coronary artery

disease where a supply/demand mismatch is precipitated by anemia, tachycardia, fever, hypertension, hypoxemia, or other processes that are not due to acute plaque rupture and coronary thrombosis. This is similar to the Type 2 MI described below, and are situations where troponin elevation are frequent but where treatment is quite distinct from STEMI and NSTEMI infarctions.

Due to confusion and controversy surrounding the definition of MI the Clinical Expert Consensus Document on the Universal Definition of Myocardial Infarction was published in Circulation (November 27, 2007). **They emphasized the need for integration of clinical information from the history and ECG in determining whether an elevation in troponin is due to myocardial ischemia.** Elevation of troponin may result from nonischemic mechanisms of myocardial injury such as myocarditis, heart failure, myocardial contusion, cardiotoxins, sepsis, hypoxemia, etc.

Following are the types of MI that were defined:

- Type 1. Spontaneous MI related to plaque rupture/thrombosis.
- Type 2. MI secondary to ischemia due to either increased oxygen demand or decreased supply, such as anemia, hypotension, severe hypertension, etc.
- Type 3. Sudden cardiac death, including cardiac arrest, associated with new ST segment elevation or coronary thrombus by angiography or by autopsy.
- Type 4a. MI associated with PCI (angioplasty or stent).
- Type 4b. MI associated with stent thrombosis.
- Type 5. MI associated with CABG.

The controversy that continues at Huntington Hospital pertains to the patients with elevated troponin but no overt or clinical heart disease (a Type 2 MI or secondary Unstable Angina). This has been referred to by some as **“troponitis.”** Troponins can be elevated in patients without overt ischemic heart disease in the following conditions: congestive heart failure, myocarditis, rhabdomyolysis with cardiac injury, pulmonary embolism, pulmonary hypertension, renal failure, acute stroke or subarachnoid hemorrhage, infiltrative diseases (amyloid, sarcoid, etc.),

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Troponitis and MIs ...continued

respiratory failure, sepsis, burns, and extreme exertion (Table 2, page 2638, *Circulation*, November 27, 2007). An elevated troponin does carry with it an increased risk for death and morbidity, but is distinct and separate from the troponin elevation seen in acute coronary thrombosis (a Type 1 MI).

How do we treat “troponitis”? Clinical judgment and common sense would dictate that we first treat the underlying cause, such as anemia, infection, hypoxemia, etc. Once the patient is stabilized and *if clinically appropriate*, then an ischemic workup can be performed, such as noninvasive stress echo, nuclear imaging or cardiac catheterization. If tolerated and clinically appropriate, then antiplatelet agents, beta blockers, statins, etc. should be considered as well.

We are under increasing scrutiny by the government and payers in the provision and quality of care that we give. Acute MI treatment is high on the radar screen since this is a high risk population with high costs. Door to balloon times (less than 90 minutes), aspirin on arrival to the emergency department, and beta blockers within 24 hours of admission are tracked and documented. There are high expectations that we will adhere to the guidelines and provide appropriate therapy to our acute MI patients.

Therefore, we need to be careful when writing “acute MI” or “nonSTEMI” in the medical record. The expectation that these patients will be taken to the cath lab emergently and given aspirin, beta blockers, and statins may be inappropriate and contraindicated. In the elderly patient with renal failure, sepsis, shock, and GI bleed without chest pain or ECG changes of acute ischemia, this is clearly not medically indicated nor appropriate. If the troponin is elevated in this situation, then the designation of “elevated troponin secondary to systemic illness” is perfectly reasonable.

Huntington Hospital has excelled in several measures of quality for acute MI patients, including Door to balloon times, administration of aspirin and beta blockers. We need to be accurate in our charting so that we may give ourselves every opportunity to show what a good job we are doing. I am open to all comments and suggestions.

R. Fernando Roth, MD
Director, Cardiac Catheterization Laboratory

From *The President*

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First and foremost, the system must be perceived as impartial and fair. Next, there should be a renewed focus on systemic issues that led to the adverse event, including “root cause” analysis, in order to seize the initiative and use the adverse event as an opportunity to prevent similar problems in the future. Next, physicians must be held accountable for what they do; but the process must take place in a constructive, respectful and collegial fashion. We must accept that every human being makes mistakes, and try our best to support our colleagues in their endeavors. The study of human cognition and decision making is simply fascinating. Recent studies on perceptual blindness and conspicuity have drastically altered our understanding of how mistakes occur, and almost everyone makes them, even when we are not overly distracted, fatigued, or stressed. (If you have never seen the “gorilla on the court” video, be sure to watch it.)

I am pleased to report that an *ad hoc* committee has been formed to re-examine our peer review process. Members of the committee include Dr. Edmund Tse, Dr. Sylvia Preciado, Dr. Bryan Jick, and Dr. Syeda Ali. I am grateful to these fine physicians for their dedication to this project, and hope that they will receive the acknowledgement and support of our medical staff in their endeavors.

Charles F. Sharp, Jr. MD
President, Medical Staff

SAVE THE DATE

Medical/Dental Staff Holiday Party
Friday December 3, 2010



Huntington Hospital

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MEDICAL STAFF

N E W S L E T T E R

September, 2010

Physician Informatics Corner

PHYSICIAN DESKTOP

Physician Desktop is tool within Meditech that enables physicians to manage patients through a single desktop portal.

Through this portal you can:

- Receive Admissions, Discharges, and Transfers Notifications
- Receive newly resulted ED, Inpatient or *Outpatient Result* Notifications
- Create and Print a Rounding List where you do not need to put in an “MD Add Patient to List” order
- View and Print a My Admitted List
- Access the EMR
- Electronically Sign Reports/Telephone Orders
- Set your own preferences of what type of notifications you would like to receive on the Desktop

Physician Documentation Templates

Selected Physician Progress Notes/Reports are currently being electronically documented directly in the Meditech system. Some additional generic templates are in the

process of being created. If you are interested in participating or have questions about the template notes available, please contact our office.

Electronic Signatures:

- 74 percent of telephone orders housewide have been electronically signed off within 48 hours. The goal is 90 percent.
- 89 percent of dictated reports were electronically signed. The goal is 100 percent.

Please contact Physician Informatics for any questions, issues or additional training.

If you have any questions call us at 626-397-2500 or email:

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