

# MEDICAL STAFF

Huntington Hospital NEWSLETTER

VOLUME 49, NUMBER 12 December 2011

## From The President



*Everyone thinks of changing the world, but no one thinks of changing himself.*

- Leo Tolstoy

*Procrastination is the art of keeping up with yesterday.*

- Don Marquis

Huntington Memorial Hospital is a participant of the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP). Currently, there are over four hundred hospitals enrolled in the program, out of over five thousand hospitals nationwide. There are some thirty participating hospitals in California.

In the mid 1980's, the Department of Veteran Affairs came under great public scrutiny concerning the quality of surgical care at the one hundred thirty-three VA hospitals. At issue were the operative mortality rates and the perception in Congress that these rates were significantly above the national (i.e., private sector) average. In response, Congress passed law 99-166, which mandated the VA to report its surgical outcomes annually, on a risk-adjusted basis, and compare them to national averages. However, no national averages existed.

By the early 1990's, knowing there was no national database, nor risk-adjusted models for the various specialties, VA surgeons realized their own infrastructure, which included advanced information systems and a centralized organization, provided a

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## Summary of the Minutes for MEC

### Executive Committee 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 November 7, 2011 and by the Governing Board on December 15, 2011.

#### PRESIDENT'S REPORT

Dr. James Buese presented the October 2011 event report. There were six events reported during this period. One case has been referred for peer review, and two cases have been closed. Disposition of the remaining three cases is pending.

#### ADMINISTRATIVE REPORT

##### Report from the President/Chief Executive Officer:

Mr. Steve Ralph, President/CEO reported on the following items:

- Survey Participation

He thanked the members of the Medical Executive Committee for their participation in the recent Joint Commission survey. He noted that overall the hospital did very well with only minimal deficiencies.

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# Summary of the Minutes

## Executive Committee Meeting

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- Stroke Survey

He reported that The Joint Commission returned last week to conduct the survey for Stroke Center certification. The results of the survey were very favorable.

- Trauma Survey

Representatives from the American College of Surgeons surveyed the Trauma program on November 8<sup>th</sup>. The exit conference was scheduled for Wednesday, November 9<sup>th</sup>.

### **Report from the Vice President, Quality and Performance Improvement/CMO:**

Dr. Paula Verrette, reported on the following items:

- Survey Participation

Dr. Verrette acknowledged the commitment exhibited by the Medical Staff leadership during the recent Joint Commission survey.

### **Report from Director of Healthcare Services:**

Ms. Gloria Gomez reported on the following items:

- Staffing

A new Medical Staff Coordinator has been hired, Ms. Heather Mullen Peraza, CPMSM, who brings over thirty years experience as a Medical Staff Professional.

- Medical Staff Meeting Assignments

Ms. Gomez, presented a listing of the current Medical Staff meetings and the new coordinator assignments. She noted that she has revised the meeting assignments to provide each coordinator with some exposure to the various types of medical staff meetings. In 2010, efforts were made to reduce the number of meetings supported by the Medical Staff Coordinators, by 10%. Due to change in leadership, the meetings continued to be supported through 2011 to allow proper assessment. Effective 2012, the 10% reduction will take effect. Proper notification will be given to each Committee Chair.

- Meeting Attendance Rewards

Ms. Gomez reported that the raffle winners for the month of October were:

- ▶ Gloria DeOlarde, MD – Plastic Surgery
- ▶ Andres Falabella, MD – Anesthesiology

- October Medical Staff Meeting

Ms. Gomez reported that the October Medical Staff meeting was well received. The Emeritus members expressed appreciation for the recognition they were given as well as for the canes.

- National Medical Staff Services Week

Ms. Gomez reported that November 7<sup>th</sup> through November 11<sup>th</sup> is National Medical Staff Services Week. Ms. Gomez suggested that the MEC members take this opportunity to thank their coordinators for their hard work and dedication.

## **ADMINISTRATIVE POLICIES AND PROCEDURES**

Please go to SharePoint -> Medical Staff Services -> Board Approved Items -> 2011 and select November.

## **ORDER SETS**

- Sedation Order Set
- Maternity Vaginal Delivery; Recovery/Postpartum Orders
- Labor and Delivery Admission Orders
- Maternity Cesarean Section; Recovery/Post-op Orders

## **FORMULARY MANAGEMENT**

- Ticagrelor (Brillanta) – Formulary addition

## **OTHER MISCELLANEOUS ITEMS**

- Critical Care Section – 2011 Peer Review Indicators
- Plans for new dosing instruction for Tylenol products
- FDA Modified dosing recommendations for Erythropoiesis-stimulating agents

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# Summary of the Minutes

## Executive Committee Meeting

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### DEPARTMENTAL POLICIES AND PROCEDURES AND ORDER SETS

#### Medicine Department:

##### Emergency Medicine Section:

- Care of Patients in Legal Custody
- Admission, Triage and Medical Screening Exam of Patients
- Diagnostics/Use of Ancillary Services in the ED
- Discharges/Transfers from the Department of Emergency Medicine
- Immunization
- Storage of Group “O” RBC’s in the ED Refrigerator
- Sudden Infant Death Syndrome (SIDS)
- Basic Department of Emergency Medical Records
- Census/Daily log
- Change of Shift Report/Patient Flow Coordinator
- Outside Agency References
- Limb Replantation and Revascularization
- Animal Bite Reporting
- Blood Alcohol and/or Drug Content Drawing for Law Enforcement
- Police Notification
- Emergency Equipment Crash Carts/Defibrillators
- Emergency Supplies
- Lending Equipment
- Patient Safety
- Orientation of New Employees
- Emergency Department Infection Control
- Emergency Department Standard Staffing and Scheduling
- Consent Form for Telemedicine Services
- RETIRE – Performance Improvement ED

##### Neurology Section:

- Intrathecal Baclofen Trial Protocol

##### Cardiology Section:

- Treatment Protocol for Cardiac Rehab Patients with Increased Level of Care

##### Pulmonary Section:

- Bronchoscopy Procedure Note

##### Surgery Department:

- Order Set Review:
  - Robotic Prostatectomy Orders
  - Thoracotomy Post-Operative Orders
  - Orthopedic Post-Operative Orders
  - Generic Post-Operative Orders
  - Critical Care Admit Post-Cardiac Surgery Orders
  - Transfer – Adult Post Cardiac Surgery Orders

### IRB STUDIES

#### New Study Approvals:

- 1) HMH 2011-019: A Phase III Clinical Trial Comparing Trastuzumab Given Concurrently with Radiation Therapy and Radiation Therapy Alone for Women with HER2-Positive Ductal Carcinoma In Situ Resected by Lumpectomy (NSABP: B-43) (PI: Ruth Williamson)
- 2) HMH 2011-020: Safety of rt-PA + Transcranial Emission of Low-Energy Lasers for Acute Stroke Recovery (StELLA) (PI: Arbi Ohanian)

### MEDICAL STAFF APPOINTMENTS

- Barry Blum, MD – Internal Medicine
- Wanda Brady, MD – Obstetrics & Gynecology
- Ara Keshishian, MD – General Surgery
- Victor Morales, MD – Obstetrics & Gynecology
- Anya Rose, MD – Obstetrics & Gynecology

### MEDICAL STAFF RESIGNATIONS

- Theodore Burdumy, MD (Emeritus – effective 4/30/12)
- Jen Chow, MD (Effective 12/31/11)
- Richard Zeiss, MD (Emeritus – effective 12/31/11)

#### James Shankwiler, MD

Secretary/Treasurer, Medical Staff

## From *The President* continued from page 1

unique opportunity to create these data models. As a result, the VA embarked upon the National VA Surgical Risk Study (NVASRS), using forty-four of their hospitals. The foundation for their work was Iezzoni's "algebra of effectiveness," which states that outcomes of health care can be described by the equation: Patient Factors + Effectiveness of Care + Random Variations = Outcome. For this equation to have practical application, the VA needed to build a statistically reliable database of patients' preoperative risk factors and post-operative outcomes. They also needed to create a method for accurate risk adjustment and to account for random events.

During this period, a dedicated nurse in each of the forty-four medical centers collected pre-op, intra-op, and thirty day outcome variables on a total of one hundred seventeen thousand major operations. Using this data, NVASRS was able to develop risk models for thirty-day morbidity and mortality in nine surgical specialties. Additionally, they found that the risk-adjusted outcomes produced by the model matched the quality of the systems and processes in the forty-four hospitals. This work allowed, for the first time, a comparative measurement of the quality of surgical care in the nine specialties.

By 1994, the success of the NVASRS study encouraged the VA to establish programs for monitoring and improving the quality of surgical care in all VA medical centers, and thereby gave birth to the National Surgical Quality Improvement Program. Each year, over one hundred ten thousand major surgical cases were added to the database, creating over one million cases in the VA system.

At the close of the 1990's, the private sector became interested in NSQIP. Specifically, they wanted to know if the methodology used in the VA system was applicable outside of the VA, and

if the risk-adjusted model would hold true for the more heterogeneous private sector patient population, as compared to the male-dominant VA patient population. A pilot study began in 1999, which included Emory University, University of Michigan and University of Kentucky. The three institutions found, after the first complete year of analysis, that both the data collection methods and the predictive and risk-adjusted models of NSQIP were applicable to the private sector.

In 2001, The American College of Surgeons (ACS) began to take an active interest in NSQIP and its results in reducing surgical morbidity and mortality. ACS, founded in 1913 with the aim of improving the care of surgical patients, applied for an Agency for Healthcare Research and Quality (AHRQ) grant to expand NSQIP into the private sector. With funding received, fourteen new medical centers were added, including Massachusetts General Hospital, University of Virginia, and New York Columbia Presbyterian Hospital. NSQIP functioned well in the private sector hospitals, and, in October 2002, the Institute of Medicine named NSQIP the "best in the nation" for measuring and reporting surgical quality and outcomes.

By 2004, over five years of private sector experience demonstrated the effectiveness of NSQIP as a quality improvement tool and a source of new clinical knowledge. ACS then developed a business plan to offer the program to interested hospitals. Initially, only general and vascular surgery was available for analysis. By October of that year, ACS began enrolling new private sector hospitals that met minimum participation requirements, completed a hospital agreement, and paid an annual fee. The number of participating hospitals has grown from one hundred twenty one in 2005, to four hundred twelve members presently. There are thirty-some participating hospitals in California, including Huntington Memorial, fourteen Kaisers,

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## From *The President* continued from page 4

Stanford, UC Davis, UC Irvine, UC San Diego, UC San Francisco, and USC. Note the many absences, such as Cedars-Sinai and UCLA.

NSQIP focuses on systems at its participating centers, not on individual providers of surgical care. There are several types of “packages” which ACS offers participating hospitals, which vary in detail and expense. Several types of surgical cases are excluded from data collection: less than eighteen years old, trauma, transplant, donor, and concurrent cases with two surgical procedures by two different surgical specialties.

Huntington Memorial enrolled in NSQIP in January 2007. Statistically, relevant data began returning by July 2007. Huntington is enrolled for general surgery, colorectal surgery and vascular surgery, as well as eight subspecialties (Cardiac, Gynecologic, Neurosurgery, Orthopedic, Otolaryngology, Plastic, Thoracic and Urology). The areas measured include mortality, morbidity, cardiac complications, pneumonia, unplanned intubation, ventilator greater than forty-eight hours, DVT/PE, Renal Failure, UTI, and Surgical Site Infection.

Huntington has performed quite well since first enrolled: we have gained “exemplary” status in three overall main categories (Morbidity, Surgical Site Infection, and UTI), which only twenty-six of the over three hundred participating hospitals nationwide have achieved. We also received exemplary designations for gynecologic, neurosurgical, orthopedic and urologic surgery morbidity rates. In addition, new “parsimonious” evaluation of data has shown Huntington exemplary in 30-day DSM (Death or Serious Morbidity) in all patients, 30-day DSM in patients older than 65, and UTI.

This is great news, and reflects the excellent work by the medical staff and hospital employees. This type of performance will anneal our ability to weather the vexations and challenges of the unknown landscape of healthcare reform. Moreover, this bodes well for our patients, and reflects well on our medical staff.

In closing, I would like to wish everyone the best during this holiday season.

**Jim Buese, MD**  
*President Medical Staff*

## From the Health Sciences Library

### New Library Guide: Off-Site Access to Library Resources

Maybe you already knew that HMH physician’s have access to library e-journals, e-books and databases from off-site, however, did you know that **hospital employees** and **patients** can also access selected resources from off-site too? The newly created **Off-Site Access to Library Resources** guide will tell you the “what” and the “how” of accessing the library’s health-related e-journals, e-books and databases from the comfort of your own home. Find the guide on the **Health Sciences Library** Sharepoint site under the **FIND INFORMATION** section. Refer to the appropriate section – Physicians, Hospital Employees, or Patients – to find out what is available and how to access it. Contact the library staff for assistance at extension 5161 or [library@huntingtonhospital.com](mailto:library@huntingtonhospital.com).

FIND INFORMATION
Bioethics Information Resources (NLM)
Complementary & Alternative Medicine (CAM) Resources
Cancer Resources
CME & Meetings
Emergency Medicine Resources
Health Reform Source
<i>Basics, Research &amp; Analysis, Pu Opinion and more</i>
<b>Off-site Access to Library Resources</b>
<i>Learn which resources can be accessed from off-site and how.</i>

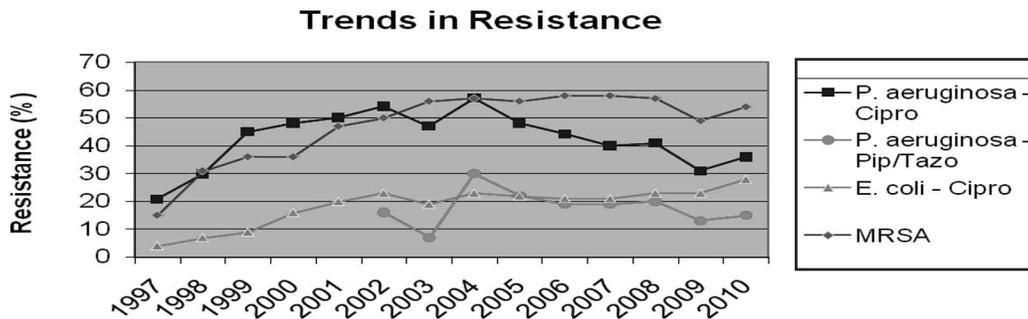


# From the Pharmacy

## Trends in Huntington Hospital Antibigram

by Emi Minejima, PharmD

Annie Wong-Beringer, PharmD



Every year, the Huntington Hospital (HH) antibiogram is updated by the microbiology laboratory with data on the antibiotic susceptibility for organisms isolated from patients at HH. The antibiogram can be accessed through Sharepoint under Clinical Sites and selecting Clinical Laboratory Information where the Antibiogram tab will be in the left column. Starting from 1997, we have used this data to track the rates of resistance development and thus make empiric antibiotic recommendations and Formulary decisions accordingly.

Since the removal of levofloxacin from the HH Formulary in 2006, extended-spectrum cephalosporins such as ceftriaxone has been the recommended empiric treatment for infections in which non-*Pseudomonas* gram-negative pathogens are suspected. *E. coli* is the most frequently isolated gram-negative pathogen at HH. *E. coli* susceptibility decreased slightly towards ceftriaxone last year, from 98% to 92% but remains far superior than ciprofloxacin (72%) and TMP/SMX (65%). Notably, a significant decrease (>15%) in ceftriaxone susceptibility was observed for, *E. aerogenes* (66%) and *Serratia*

*marcescens* (77%), which are less frequently isolated nosocomial gram-negative pathogens. Inducible  $\beta$ -lactamases are likely responsible for the reduced susceptibility in the latter organisms towards ceftriaxone; 90-99% of those isolates remain susceptible to cefepime. As such, cefepime should be considered in place of ceftriaxone for empiric coverage of gram-negative pathogens acquired nosocomially, while ceftriaxone remains an empiric choice for urosepsis or intraabdominal infections in which *E. coli*, *K. pneumoniae* or *P. mirabilis* are likely pathogens acquired from the community.

The carbapenems (imipenem or meropenem) are often reserved as last resort to treat infections caused by multidrug-resistant gram-negative pathogens. However, of grave concern is the emergence of carbapenem resistance among Enterobacteriaceae across the United States, with *K. pneumoniae* being the most common organism to possess the carbapenem resistant gene. These strains are often resistant to almost all antibiotic classes, except for colistin, tigecycline, and fosfomycin. A few cases acquired outside of HH causing primarily urosepsis have been encountered here.

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## *From the Pharmacy* continued from page 6

Notably, over the past year, we have observed an overall trend of decreasing susceptibility for all agents against *Pseudomonas aeruginosa*, the second most frequently isolated gram-negative pathogen at HH. The most significant decrease was seen with imipenem (from 84% to 76%). Piperacillin-tazobactam plus tobramycin remains the recommended empiric antipseudomonal regimen with susceptibility maintaining at 85% and 90% respectively, compared to 82% for ceftazidime and 64% for ciprofloxacin. It is important to recognize that even a modest 5% decrease in ciprofloxacin susceptibility can negatively affect activity of other antipseudomonal agents, likely due to the over-expression of bacterial efflux pumps induced by fluoroquinolone over exposure. The pumps are capable of extruding other structurally-unrelated compounds along with the fluoroquinolones, thereby resulting in the selection for multidrug-resistant strains. Thus, the observed overall trend of decreasing susceptibility in 2010 with *Pseudomonas* signals an immediate need to cutback use of ciprofloxacin in order to limit further development of resistance in *Pseudomonas*.

With respect to gram-positive pathogens, *Streptococcus pneumoniae* remains highly susceptible to ceftriaxone (93% for blood isolates and 100% for respiratory isolates) and is recommended as first line empiric therapy for community-acquired pneumonia. On the other hand, the prevalence of methicillin-resistant *Staphylococcus aureus* (MRSA) has maintained at 54%, underscoring the importance of stringent infection control practice. According to the 2011 treatment guidelines from the Infectious Diseases Society of America, vancomycin is a recommended first line agent for empiric treatment of suspected MRSA infections. Vancomycin dosage targeting trough levels between 15-20  $\mu\text{g/ml}$  are recommended for bloodstream infections or pneumonia caused by MRSA isolates with elevated

MIC  $>1 \mu\text{g/ml}$ . Concern for risk of nephrotoxicity with high vancomycin doses has prompted us to conduct a prospective observational study using the new more sensitive diagnostic criteria for acute kidney injury to facilitate early identification in vancomycin-treated patients (published in *Antimicrob Agents Chemother*, July 2011). ICU admission, history of malignancy, low baseline GFR, and prior episode of AKI were identified as the strongest risk factors for developing AKI by multivariate regression analysis. Interestingly, higher trough levels or use of other nephrotoxic agents were not significant predictors.

In summary, the HH empiric antibiotic guidelines remain unchanged. The gram-negative antibiogram trend supports the continued use of  $\beta$ -lactam antibiotics over fluoroquinolones for empiric coverage of suspected gram-negative infections such as urinary tract infections and intra-abdominal infections. The overall trend of slight increase in resistance in Enterobacteriaceae against beta-lactams is a strong reminder for the need to de-escalate and discontinue empiric treatment where appropriate. Fluoroquinolones should be avoided whenever possible due to its continued high resistance profile with gram-negative organisms. The increasing resistance profile of carbapenems with *Pseudomonas aeruginosa* and *K pneumoniae* makes them less reliable for empiric use where multidrug-resistant strains are suspected and requires concerted cutback on their use in order to preserve their utility. Vancomycin remains the first line empiric therapy for MRSA infections; therapy should be promptly discontinued upon culture and sensitivity reports negative for MRSA, in order to decrease any risk for nephrotoxicity. Anti-MRSA alternatives such as linezolid and daptomycin should be reserved for when the patient cannot use vancomycin due to nephrotoxicity risks or if the MRSA isolate has elevated MICs to vancomycin.

# From Physician Informatics

## Ambulatory Information Services and Physician Informatics

2011 has been a very busy year and we have enjoyed every minute of working with our physicians and their office staff.

### A Look Back at Activities and Services 2011...

- ❖ Conducted three physician seminars attended by several hundred physicians and office staff on EHR adoption, federal incentives and penalties.
- ❖ Continued rollout and support of Huntington Rx (ePrescribe), adding 68 physicians in 2011, bringing our current total to 163 and 386 of their office staff. Many physicians who adopted HuntingtonRx last year qualified for – and RECEIVED – their ePrescribing bonus checks from CMS in August – October this year. We expect many of our physicians to qualify for the bonus again this year and receive their checks in fall of 2012.
- ❖ Developed 40 Physician Documentation (PD) templates for various areas, including ED2, Pulmonary/Critical Care, CDRC, and Inpatient Rehab.
- ❖ Went LIVE with CPOE in Maternal Child Health, which included training 60+ Pediatricians and OB/Gyn Physicians.
- ❖ Rolled-out Huntington Health eConnect Collaborate Portal to our pilot physician and office staff pilot testers to several physician practices. We are working on loading HMH history and adding new features based on pilot tester feedback and will shortly be rolling out to physicians in our community.
- ❖ Went live with Huntington Health eConnect delivering lab results into Huntington Medical Foundation's new EHR (Allscripts Enterprise). HMF physicians have seen results of lab tests they have ordered available within their patient's electronic chart within 4 minutes of the test being completed by Huntington Hospital's Laboratory.

- ❖ Working with other EHR vendors selected by our medical staff, to deliver results/reports directly into theirs as well.
- ❖ Provided information and assistance to physicians registering for hardship to avoid 2012 penalties for not meeting the ePrescribing requirements.
- ❖ Conducted 20 Readiness Assessments representing 50 physicians, providing information on evaluating and selecting electronic health records for their private practices.

### Some of the things to look forward to in 2012...

- ❖ Implement HuntingtonRx in Huntington Hospital Emergency Department
- ❖ Roll out HHeC to physicians in our community and continue to work with Electronic Health Record vendors to deliver results and reports directly into selected EHRs, provide integration and visibility into the Community Patient Record and facilitating communication between patient care teams.
- ❖ Working with physicians to help them qualify for EHR Meaningful Use incentives and providing education and awareness of anticipated Stage 2 meaningful use requirements.
- ❖ Addressing physician and section requests to build additional physician documentation templates to improve ease of use and patient care documentation within Meditech.

**All of us in the Physician Informatics Office would like to thank you for being a member of our medical staff and look forward to assisting you in 2012!**

*Vera, Becky, Joe and Rebecca*

**Wishing you a Happy Holiday season!**

**Physician Informatics Office: 626-397-2500**

# From Quality Management

## Read What is New with SCIP – Surgical Care Improvement Project

### Surgical Care Improvement Project

➤ **Changes effective January 1, 2012**

➤ **Beta blocker calls for two doses to be given:**

- For surgery patients on a beta blocker prior to arrival:
- two doses of a beta blocker should be given.

- **1<sup>st</sup> dose – Anesthesia's responsibility – determine if patient took beta blocker on the day prior to Or give beta blocker the day of surgery (currently included in SCIP measures)**

- **2<sup>nd</sup> dose – Surgeon's responsibility – to be given on POD 1 Or POD 2**

- \* Unless reasons for not administering the medication were documented.

### **Surgeon needs to:**

- Communicate with anesthesia to determine if the patient is on a beta blocker.
- If anesthesia documents: The pt states they are not on a beta blocker, there is no need for further beta blocker orders.
- If anesthesia indicates that the patient is on a beta blocker:
  - Either:  
Order the beta blocker on POD 1 **Or** POD 2.
  - Or:  
Document on Physician Orders on POD 1 **And/Or** POD 2: "No beta blocker" and include a reason for not administering.  
Example: Potential risk for Bradycardia and/or Hypotension.

- Cannot accept documentation on POD 0 (zero) of a contraindication or reason not to give the beta blocker.
- The contraindication must be documented on POD 1 **And/Or** POD 2.

### **Surgeon's shortened version:**

⇒⇒ **On POD 1 And POD 2: Either write an order for the beta blocker to be given or write an order for the beta blocker not to be given and include a reason/contraindication.**

### ➤ **Additional changes:**

- Laparoscopic cases will be included in the SCIP measures. **Laparoscopic appendectomy and cholecystectomy are excluded.**
- Foley catheter measure: Patient refusal to have the foley removed will be an acceptable reason to continue the catheter. Patient refusal must be documented on POD 1 or POD 2.

### **Urological/perineal procedures are excluded.**

Source: Specifications Manual for National Hospital Quality Measures Discharges 01-01-12 (1Q12) to 06-30-12 (2Q12).

For additional information please contact Susan Czirmay, RN, BSN at Quality Management, extension 3784.

# MEDICAL STAFF

## NEWSLETTER

December, 2011

### CME Corner



#### UPCOMING FIRST THURSDAY:

No First Thursday for December.

#### UPCOMING MEDICAL GRAND ROUNDS:

**Topic:** Delirium in the ICU  
**Date:** December 2, 2011  
**Time:** Noon  
**Place:** Research Conference Hall  
**Gap Analysis:** Delirium is a frequent contributor to death in the ICU, and is preventable with prompt diagnosis and treatment. This program will allow providers to prevent, identify, and treat delirium sooner and more effectively.

**Objectives:**

1. Understand the recent literature and apply it in practice.
2. Learn updated treatment approaches and diagnostic tools.

3. Apply information to decrease delirium rates in the ICU.
4. Outline the various components of cultural/linguistic diversities that relate to patient demographics, diagnosis, and treatment.

**Audience:** Primary Care Physicians, Critical Care, and Surgeons

**Methods:** Lecture

**Evaluation:** Post-activity evaluation form

**Speaker:** Mike Wang, MD, USC

**Credit:** 1 *AMA PRA Category 1 Credit*<sup>TM</sup>

#### UPCOMING MEDICAL GRAND ROUNDS:

No Grand Rounds for December.