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APRIL PHOTOGRAPHER OF THE MONTH:
Douglas Alexander
Technical Specialist Clinical Lab Scientist
in the Chemistry Section of the Core Laboratory at CRMC

I thought I would share photos of two of California’s closest National Parks to Fresno, Death Valley and Yosemite. Each has its own beauty and are easily accessible by the general public for most of the year. All of these photographs were taken a few years ago when ample winter rains had occurred. Most people when they think of Death Valley, think of one hundred twenty plus temperatures and desolate salt flats. But, there is nothing quite so beautiful as a stroll on the valley floor on a cold December evening as a snow shower falls on your head. Or, as beautiful as the vista of carpets of yellow desert sunflowers, with intermittent purple phacelia and desert five spot flowers in early March after a wet winter. Or, the reflection of snow capped Telescope Peak and the Panamint Mountains in a pool of salt water at Badwater, the lowest point in the United States. Yosemite, on the other hand, normally is green and filled with water. Everyone has seen Half Dome and El Capitan and Yosemite and Bridalveil Falls. But, just a few yards off the main road are views of Mt. Watkins reflecting in Mirror Lake, El Capitan and Yosemite Falls reflecting in the Merced River, and Vernal and Nevada Falls on a trail behind Half Dome in Yosemite Valley. Polly Dome reflecting in Tenaya Lake, Mt. Dana and Mt. Gibbs reflecting in a roadside pond, and Mammoth Mountain and The Kuna Crest reflecting in Tioga Lake are other beautiful vista points in the Tuolumne Meadows area of the Park. I encourage you to see these Beauties of Nature; but, when you do, get out of your vehicle and walk, hike, bike, or ride a horse off the beaten path and see these other spectacular views.

The photographer has been a Clinical Laboratory Scientist in the CRMC Clinical Laboratory for almost 37 years. He enjoys travelling to beautiful places and taking photographs.

ON THE COVER:
Yosemite, Half Dome from Yosemite Valley

Deadline to submit articles for the May 2015 issue of Physicians’ Edition is Friday, April 17.
Becker’s Healthcare listed Community Medical Centers in its 2015 edition of “150 great places to work in healthcare.”

Hear what Community employees said about their workplace shortly after winning a 2013 award from the Advisory Board for employee engagement. It was the first of two recognitions from the Advisory Board for employee engagement.

Community, the largest private employer in Fresno County, with 7,600 employees, was recognized for being among the top 10% for employee engagement in 2014 among 300 hospitals surveyed by the Advisory Board. Becker's noted that besides offering comprehensive benefits, including retirement planning classes and wellness events, Community encouraged employees to grow their careers within the hospital system. Community invested $18.5 million last fiscal year to provide access to in-house leadership training, outside seminars, free professional certifications, online continuing education, scholarships, tuition reimbursements, and tuition discounts at University of Phoenix for bachelor's and master's degrees.

Community’s largest hospital campus in downtown Fresno houses a 6,000-square-foot fitness center equipped with various weightlifting equipment and exercise machines that’s free to all employees and hospital volunteers. The system also offers employees numerous retail discounts made available through its group purchasing organization and provides a concierge service to run errands and provide convenience for clinical staff working 12-hour shifts.

“Becker's recognition validates our efforts to be the employer of first choice,” said Peg Breen, senior vice president of Human Resources. “We are continually listening to our employees and responding to their feedback on how we can improve Community to make it a great place to work and provide care for the region's families. I’m proud of the HR team and the leaders who helped us achieve this honor.”

Becker's Healthcare is the leading source of cutting-edge business and legal information for healthcare industry leaders through its five trade publications. The just-released 2015 Becker's list includes healthcare providers, along with healthcare technology companies, consulting firms and professional organizations. Employers were chosen for their benefits offerings, wellness programs, commitment to diversity and inclusion, professional development opportunities and environments that promote employee satisfaction and work-life balance. Many of these organizations have been recognized by national, state or local organizations for their workplace culture or employee satisfaction scores.

Erin Kennedy reported this story. Reach her at: MedWatchToday@communitymedical.org.

On March 11, the financial rating service Standard & Poor’s announced a two-notch, bond credit rating upgrade for Community Medical Centers, from “BBB” to “A-” with a “stable” outlook.

This upgrade is highly significant. It's expert affirmation that Community is a financially sound, well managed, and well-positioned organization. And the higher rating means that when Community again needs bond financing for future expansion, Community will enjoy more advantageous terms.

In its full report, S&P noted these key strengths for Community:

- An excellent and growing market position.
- A track record of performing well to budget and carefully managing debt.
- Maintaining a steady supply of cash on hand, despite recent costs for the Clovis expansion project.
- A strengthened financial profile and improving balance sheet.
- A stable leadership core with a history of operational execution.
- And recent initiatives to strengthen our capabilities for the evolving healthcare environment, such as establishing Community Care Health Plan for our employees and expanding use of our Epic electronic health record.

“This is a huge team achievement – at a time of much transition and financial challenges in healthcare – and it has important implications for our future,” said Community CEO Tim Joslin. “This again affirms Community is a solid, advancing place to work and obtain care, for years to come.”

Mary Lisa Russell reported this story. Reach her at: MedWatchToday@communitymedical.org.
How To Beat Burnout: 7 Signs Physicians Should Know

Excerpted From AMA Wire® March 4, 2015

Editor’s Note: Physician Well Being is always a vital topic for our readers. This month we feature a recent AMA publication that emphasizes pre-disposing factors and warning signs and has some linked resources.

If constant stress has you feeling exhausted, detached from patients, or cynical, take notice. You may be in danger of burnout, which studies show is more prevalent among physicians than other professionals. But how can you avoid it? Learn the signs of physician burnout and what you can do to stay motivated on the job.

Mark Linzer M.D., Director of the Division of General Internal Medicine at Hennepin County Medical Center in Minneapolis, has studied physician burnout since 1996. He said he understands why many physicians eventually feel exhausted practicing medicine, but this problem is avoidable.

“Burnout doesn’t have to be highly expensive to fix,” Dr. Linzer said. “The problem is that no one is listening. People always want to say that physician wellness and performance measures will cost a lot of money, but preventing burnout can actually save money in the long run on recruiting and training new practice staff.”

If physicians want to keep burnout at bay, Dr. Linzer said there are some serious signs they should never ignore. Here are seven ways to know if your practice is getting the best of you – and when to finally do something about it:

You have a high tolerance to stress. Stress consistently ranks as the number one predictor for burnout among physicians, Dr. Linzer said. “Please don’t ignore the stress, even if you can take it,” he said. Physicians who consistently operate under high stress are at least 15 times more likely to burn out, according to his research.

Your practice is exceptionally chaotic. A quick glance around your practice will let you know if you or your colleagues may cave to stress. “People tend to think it’s the patients that always stress doctors out, but actually, it’s the opposite,” Dr. Linzer said. “Caring for patients keeps doctors motivated. What burns them out is caring for patients in a high-stress environment. Change the environment and you’ll change the overall quality of care.”

You don’t agree with your boss’ values or leadership. This one is particularly tricky to identify but “necessary to prevent burnout,” Dr. Linzer said. Whether at a large hospital or private practice, physicians need to feel as if the people leading them also share their values for medicine and patient care. Otherwise, their motivation can slowly wane.

You’re the emotional buffer. Working with patients requires more than medical expertise. “Often, the doctor acts as an emotional buffer,” Dr. Linzer said. “We will buffer the patient from our own stressful environment until we can’t take it anymore.”

Your job constantly interferes with family events. Spending quality time with loved ones helps physicians perform better. “When they can’t do those things, it’s all they think about during the day and the patient suffers,” Dr. Linzer said, citing work-life interference as one of the most common predictors for burnout among physicians in his studies.

You lack control over your work schedule and free time. When work demands increase, but control over your schedule doesn’t, stress can kick in and spark burnout. That’s why Dr. Linzer often tells practices, “If you standardize, customize” – a medical mantra to suggest that if physicians must work a long standardized set of hours each week, practices should at least customize their schedules to flexibly fit changes or needs in their daily lives.

You don’t take care of yourself. When was the last time you enjoyed a nice bubble bath or morning run? If you continually neglect yourself, you may neglect your patients, too. “As physicians, we want to be altruistic but one of the keys to altruism is self-care,” Dr. Linzer said.

Readers may wish to look at Dr. Linzer’s study for tips and recommendations that may fit your practice. Editor’s Note: Print readers can find it by searching: Organizational Climate, Stress, and Error in Primary Care: The MEMO Study (Linzer et all).

Preventing physician burnout is a priority for the AMA’s Professional Satisfaction and Practice Sustainability initiative, which partners with physicians, leaders and policy makers to reduce the complexity and cost of practicing medicine so physicians and continue to put patients first. Editor’s Note: Print readers can find this by on line search. Interestingly the main specific projects of the Initiative are directed to improving the EMR experience for physicians.
Attention Medicare FFS Physicians
Senate Delays Vote On SGR Fix After House Passes Bipartisan Bill

By James Michael Cole, Director
Government Reimbursement

On Friday, March 27 the Senate delayed a vote until next month on H.R.2 – Medicare Access and CHIP Reauthorization Act of 2015. Until then, physicians will continue to be paid at their current payment levels. Various news outlets are quoting Senate Majority Leader Mitch McConnell (R-KY) as saying “I think there’s every reason to believe it’s going to pass the Senate by a very large majority.”

As currently drafted, the H.R. 2 provides for:

- Keeping physician payments unchanged through June 30, 2015
- Annual increase in payments of 0.5 percent for five years through the end of 2019
- A zero percent update for the following six years through the end of 2025; and,
- Payments to increase one percent a year beginning 2026 if physicians achieve a new “qualifying alternative payment model conversion factor” but only 0.5 percent if they do not.

This legislation is aimed to incentivize physicians to move to risk-based, alternative payment models (ACOs, bundled payment, capitated patients centered medical homes). If the policy remains intact, by 2018 physicians will choose between staying in Medicare fee-for-service, which will include performance risk under a revamped value-based purchasing program, or move to a risk-based alternative payment model and receive a 5% Medicare pay bonus.

If the Senator McConnell is correct, we should be able to bring you in next month’s Newsletter the Bill’s final provisions on future physician payment methodologies and rates.

Resources:
- Text H.R. 2 (pdf) found here: https://www.congress.gov/114/bills/hr2/BILLS-114hr2eh.pdf
- A summary is in progress. When completed it will be posted here: www.congress.gov/bill/114th-congress/house-bill/2?q=%7B%22search%22%3A%22%22%7D

Initial Appointment to the Medical Staff effective March 12, 2015

New Medical Staff Members Approved by the Medical Executive Committee and the Board of Trustees

- Oren Erlichman M.D.
  Department: Surgery
  Specialty: Anesthesiology

- Laju Kumar M.D.
  Department: Family Medicine
  Specialty: Family Medicine

- Ahamed Raza M.D.
  Department: Surgery
  Specialty: Anesthesiology

- Lidia Rodriguez-Carranza M.D.
  Department: Medicine
  Specialty: Internal Medicine/Palliative Care

- Jagroop Basraon D.O.
  Department: Cardiology
  Specialty: Cardiology

- Frederick Comrie M.D.
  Department: DOCS
  Specialty: Physical Medicine & Rehabilitation

Initial Appointment to the Medical Staff effective March 12, 2015

New Allied Health Professionals Approved by the Medical Executive Committee and the Board of Trustees

- Lindsay Cornwell P.A.-C
  Department: Surgery
  Specialty: Neurosurgery

- Angela Fisher-Weaver P.A.-C
  Department: Emergency Medicine
  Specialty: Emergency Medicine

- Charise Sullivan P.A.-C
  Department: Surgery
  Specialty: Neurosurgery
Did you know that CMC has a new order set for treatment of hyperosmolar hyperglycemic state (HHS)?

The treatment of this condition is similar to diabetic ketoacidosis (DKA), but differs in several important ways, mainly blood glucose goals and resolution parameters.

**Considerations in determining whether your patient has DKA or HHS:**

<table>
<thead>
<tr>
<th></th>
<th>DKA (Glucose &gt; 250 mg/dL)</th>
<th>HHS (glucose &gt; 600 mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial pH</td>
<td>7.25 – 7.30</td>
<td>&lt; 7.00</td>
</tr>
<tr>
<td>Serum Bicarbonate</td>
<td>15-18</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Serum ketone</td>
<td>Positive</td>
<td>Positive</td>
</tr>
<tr>
<td>Urine ketone</td>
<td>Positive</td>
<td>Positive</td>
</tr>
<tr>
<td>Serum osmolality</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Anion gap</td>
<td>&gt;10</td>
<td>&gt;12</td>
</tr>
<tr>
<td>Mental status</td>
<td>Alert</td>
<td>Alert/drowsy</td>
</tr>
<tr>
<td>Target glucose</td>
<td>150 – 200 mg/dL</td>
<td>250 – 300 mg/dL</td>
</tr>
</tbody>
</table>

*Comparison of the treatment of DKA versus HHS:*
- Start with an insulin IV bolus of 0.1 units/kg, then initiate continuous IV infusion at 0.1 units/kg/hr.
- Recheck blood glucose levels in 1 hour and adjust based on the following nomogram:

<table>
<thead>
<tr>
<th>BG Change from Previous Value</th>
<th>Insulin infusion rate change</th>
</tr>
</thead>
<tbody>
<tr>
<td>BG Increases</td>
<td>Increase by 0.1 unit/kg/hr and call physician</td>
</tr>
<tr>
<td>BG Decreases by less than 50 mg/dL in 1 hour</td>
<td>Increase by 0.1 unit/kg/hr</td>
</tr>
<tr>
<td>BG Decreases by 50 – 75 mg/dL in 1 hour</td>
<td>No change</td>
</tr>
<tr>
<td>BG Decreases by 76 – 99 mg/dL in 1 hour</td>
<td>Reduce by 25%</td>
</tr>
<tr>
<td>BG Decreases by 100 mg/dL or more in 1 hour</td>
<td>Reduce by 50%</td>
</tr>
</tbody>
</table>

Once blood glucose levels reach <200 mg/dl in patients with DKA or <300 mg/dL in patients with HHS, decrease rate to 0.05 units/kg/hr and proceed to:

<table>
<thead>
<tr>
<th>Titrations Instructions Once at Goal Blood Glucose (BG)</th>
<th>Insulin infusion rate change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 200 mg/dL</td>
<td>Increase infusion by 50%</td>
</tr>
<tr>
<td>Greater than 300 mg/dL</td>
<td>No change</td>
</tr>
<tr>
<td>150 – 200 mg/dL</td>
<td>Decrease infusion by 50% and call physician</td>
</tr>
<tr>
<td>200 – 300 mg/dL</td>
<td>Stop insulin infusion, repeat stat to confirm. Call MD. Give 50 ml of 50% Dextrose in Water and recheck BG every 15 minutes until BG is greater than 150 mg/dL, then resume every 1 H BG measurements. Once BG is greater than 150 mg/dL, restart insulin infusion at 50% of previous rate.</td>
</tr>
<tr>
<td>70 – 150 mg/dL</td>
<td></td>
</tr>
<tr>
<td>70 – 200 mg/dL</td>
<td></td>
</tr>
</tbody>
</table>

**Resolution of DKA:**
- Venous pH > 7.3
- Bicarbonate ≥ 15 mEq/L
- Blood glucose < 200 mg/dL
- Anion gap < 12
- Able to eat

**Resolution of HHS:**
- Blood glucose < 300 mg/dL
- Normal mental status
- Normal serum osmolality
- Able to eat

Once patient meets these criteria, can start subcutaneous insulin. Continue insulin drip for 2 hours after starting subcutaneous insulin to prevent hyperglycemic rebound and/or return of ketoacidosis.

The Quality Performance and Quality Management Departments periodically feature a corporate and/or facility performance improvement initiative that the organization is focusing on to encourage physician involvement in understanding the opportunities and in seeking solutions. This month the focus is sepsis management. This was selected as a corporate initiative based on a Clinical Opportunity Analysis report from Premier® that identified sepsis mortality and readmission as an area of opportunity for all Community Medical Centers (CMC) acute care facilities.

**What is Premier®?**

Premier® is a healthcare performance improvement alliance that aims to improve the health of communities. It provides a comprehensive database including data on 1 in every 3 US hospital discharges. Premier® focuses on best practices and cost reduction strategies. In addition, CMC is a participant in Premier®’s Quality, Efficiency, Safety and Transparency (QUEST®) Collaborative that allows data resource sharing with other hospitals. Approximately 350 hospitals participate in the QUEST® Collaborative.

**What is our current sepsis management performance?**

The sepsis mortality and readmission baseline measures for fiscal year 2014 (September 1, 2013-August 31, 2014) for Clovis Community Medical Center (CCMC), Community Regional Medical Center (CRMC), and Fresno Heart Surgical Hospital (FHSH) are listed in Table 1. The baseline measures include average length of stay, mortality rate, readmission rate, and average cost per case by facility and as an organization. The goal is to achieve an observed to expected (O/E) ratio of 1 or less.

**What efforts are being performed to improve sepsis management?**

Past efforts have included revision to the Sepsis order set (Early Goal Directed Therapy-6 Hour) and a one week Sepsis Best Practice Alert pilot in the CRMC Emergency Department. In order to formalize efforts across the organization, a multidisciplinary Sepsis Steering Committee and Sepsis Management Workgroup have been formed. Each organization is focusing on to encourage physician involvement in understanding the opportunities and in seeking solutions. This month the focus is sepsis management. This was selected as a corporate initiative based on a Clinical Opportunity Analysis report from Premier® that identified sepsis mortality and readmission as an area of opportunity for all Community Medical Centers (CMC) acute care facilities.

**Table 1. Sepsis Fiscal Year 2014 Baseline Measures**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Case Count</th>
<th>ALOS</th>
<th>ALOS O/E Ratio</th>
<th>Mortality Rate</th>
<th>Mortality O/E Ratio</th>
<th>Readmission Rate</th>
<th>Readmission O/E Ratio</th>
<th>Average Cost per Case</th>
<th>Cost per Case O/E Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRMC</td>
<td>1,550</td>
<td>9.25</td>
<td>1.52</td>
<td>17.9%</td>
<td>1.26</td>
<td>19.9%</td>
<td>1.31</td>
<td>$26,620</td>
<td>1.81</td>
</tr>
<tr>
<td>CCMC</td>
<td>529</td>
<td>8.91</td>
<td>1.50</td>
<td>17.4%</td>
<td>1.24</td>
<td>13.3%</td>
<td>1.03</td>
<td>$24,535</td>
<td>1.63</td>
</tr>
<tr>
<td>FHSH</td>
<td>10</td>
<td>11.80</td>
<td>1.76</td>
<td>22.2%</td>
<td>1.31</td>
<td>0.0%</td>
<td>0.00</td>
<td>$61,501</td>
<td>3.21</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2,089</td>
<td>9.17</td>
<td>1.51</td>
<td>17.8%</td>
<td>1.26</td>
<td>18.10%</td>
<td>1.24</td>
<td>$26,259</td>
<td>1.77</td>
</tr>
</tbody>
</table>

ALOS = average length of stay; O/E = observed/expected
Anticoagulation Guidelines for Epidural/Spinal Procedures Now Accessible from the Medication Administration Record

Available on:
- Heparin (SQ and IV)
- Enoxaparin
- Warfarin
- Rivaroxaban
- Apixaban
- Dabigatran
- Fondaparinux

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**CMC Anticoagulation Guidelines for Epidural/Spinal Procedures**

**Guidelines to prevent spinal hematoma following epidural/spinal procedures (including intrathecal procedures and lumbar punctures)**

- These guidelines are not intended to replace critical clinical judgment. Please evaluate and document the necessity of an epidural/spinal procedure and any deviations from these recommendations. Please also consider the degree of trauma associated with the epidural/spinal procedure when assessing risk/benefit of concomitant anticoagulation therapy. Administration of more than one medication that affects hemostasis increases risk of spinal bleeding and is generally not recommended.

- Recommendations to be used as a general guideline, physician to review individual patient parameters and medication regimens. In selected patients, the risk/benefit of using “CONTRAINDICATED” anticoagulation with recent or concomitant epidural/spinal procedure may still be warranted.

<table>
<thead>
<tr>
<th>Medication</th>
<th>BEFORE Epidural/Spinal Procedure Minimum time between last dose of anticoagulant and epidural/spinal injection or catheter placement</th>
<th>DURING Epidural/Spinal Catheter Use Restrictions on use of anticoagulants in patients with epidural/spinal catheters in place</th>
<th>AFTER EACH Epidural/Spinal Procedure Minimum time between completion of epidural/spinal injection or catheter removal and next anticoagulant dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Dose Prophylactic Heparin (5,000 units SQ Q24H)</td>
<td>No restrictions</td>
<td>No restrictions</td>
<td>No restrictions</td>
</tr>
<tr>
<td>High dose Prophylactic Heparin (5,000 units SQ Q24H)</td>
<td>8 hours</td>
<td>NOT RECOMMENDED</td>
<td>2 hours</td>
</tr>
<tr>
<td>Once Daily Prophylactic Low Molecular Weight Heparin (Enoxaparin* 40mg SQ Q24H or Dalteparin (Fraxiparin*) 5,000 units SQ Q24H)</td>
<td>12 hours (longer in renal impairment)</td>
<td>May be used with following precautions: Must wait 6-8 hours after catheter PLACEMENT before giving dose.</td>
<td>4 hours</td>
</tr>
</tbody>
</table>

**Anticoagulants for Thromboembolic Prophylaxis**
On April 22, we will be upgrading to Epic version 2014. Approximately every 18-24 months Epic develops a new version with a focus on enhancing the electronic medical record and addressing end-user concerns surrounding the current version. By implementing these updated versions Community Medical Centers is able to take advantage of these improvements and enhancements. Although there will be some significant changes, you should still see many similarities. To help prepare you for the most substantive changes, we are providing online educational videos to describe and demonstrate these enhancements and familiarize you to the new look before the go-live. This material is now available, is required, and needs to be completed by May 22, 2015. If not completed within the timeframe outlined, you will not have access to the Epic system. Most users will be able to complete the education videos in less than 30 minutes.

Here are some of the key changes you will see:

**EpicCare Inpatient**
- Chart Search – Epic 2014 now makes it possible to search a patient’s chart for any word, phrase, or test using one search field.
- Collapsible Notes and Smart links – Minimize note bloat by collapsing information that has been copied from other parts of the chart.
- Orders Not Requiring Reconciliation – Certain types of orders can now be excluded from Order Reconciliation, saving time and minimized errors.
- User Version Order Sets – With 2014, you are now able to save multiple versions of an order set, tailored to individual groups of patients.
- Inline Dose Warnings – Dose related warnings can now be managed when ordering a medication, to minimize how often medication related warnings appear.

**Emergency Medicine (ASAP)**
- Orders Quick List – Improve ordering efficiency by rapidly placing complaint driven order panels.

**Ob/Gyn (Stork)**
- Enhanced OB history documentation – To make documentation more consistent with the deliver summary and more user friendly.

**Anesthesia**
- Enhanced procedure documentation – Improved documentation of procedure performed outside of the operating room.
- Vitals at a glance – Abnormal vital signs will now be highlighted to draw attention to them, and will align better for trend comparison.

**Ambulatory**
- Enhanced Physician Productivity – 2014 provides many tools to improve efficiency by minimizing click.

The educational modules will highlight all of these key changes, and other key enhancements within the 2014 version, and are available through Community’s online learning tool, HealthStream Learning Center (HLC). The link can be found on the Forum homepage, and some computers may also have an icon on the desktop to take you straight to the training modules. If the HLC link from the forum does not work, look for this icon.

Click the HLC link and follow the logon process:
- Log on using your CMC Network Log on credentials (same as Epic)
- Click on the “My Learning” tab – there will be Epic 2014 modules to complete
- Click on the first Epic 2014 module – Epic Overview to complete – required for everyone. Once you have successfully completed the module, you will be taken back to the “My Learning” tab to complete the other modules assigned to you by specialty.

For any questions regarding logging in please contact the Help Desk – (559) 459-6560 / ext. 56560 (Rev. March 27, 2015).
Your Community At Work:
Good Stewardship

By John G. Taylor, Director
Public Affairs, Community Medical Centers

The April edition of “Your Community at Work,” the Community Medical Centers corporate social responsibility report, includes stories about examples of so-called “community benefits” provided by Community. These include care and services for which Community is not paid. Among them: our long-time medical education partnership with the University of California, San Francisco; the mother’s resource center and Specialty Health Center, serving HIV/AIDS patients, both at Community Regional Medical Center; and the California Cancer Center's patient support services. Since 1996, Community has provided $1.4 billion in community benefits.

“Your Community at Work” began publication last year. It runs monthly in The Fresno Bee. It’s also published in the Business Journal and the California Advocate, and its contents are available through Community’s website, public affairs newsletter and elsewhere.

This type of report, sometimes referred to as an “advertorial,” has become an important communications tool for corporations around the world. It allows industry leaders to report back to stakeholders on how well they are meeting their mission, acting ethically and being good stewards of financial and human resources. Given that Community is a locally owned non-profit health system, we are in a real sense reporting to our owners.

CMC’s content will fit under these six categories: making care accessible, building relationships, advancing clinical quality, shaping patient care, stewarding our resources, and caring for our workforce. John Taylor, Community’s public affairs director, serves as primary editor.

Here’s a link to the Web page that contains the April report as well as previous editions:
Print readers can find it at www.communitymedical.org > News and events > Facts, reports and publications > Your Community at Work April 2015

Ensure Your Communications are HIPAA-Compliant

TigerText is HERE!
The TigerText Application Is Being Rolled Out To All CMC Physicians Starting in April Making Your Communications More Secure

This new mobile application helps Community Medical Centers and physicians comply with HIPAA Security Standards and allows you to communicate with other clinicians about your patients’ care safely and simply using secured text messaging. TigerText can be used anywhere, delivers messages immediately via any type of smartphone or tablet, and has many features that will be of interest to physicians. Look for on-site visits from Corporate Information Services in your hospital physician lounges during April!

For more information, contact Gayle Christner in Information Services at (559) 459-2715 or gchristner@communitymedical.org
A Very Public Commentary On Electronic Medical Records

Submitted by David L. Slater M.D.
Physician Editor of Physicians Edition

Many readers will recognize the name Robert Wachter M.D. He is Professor of Medicine at UCSF and Chief of the UCSF Hospitalist Program. Dr. Wachter is one of the world’s leading experts in patient safety and healthcare quality, and – it will be of no surprise to those of you who know what great faculty we secure – a speaker at one of Community’s early-days Winter Symposiums (we are due to invite him back). Dr. Wachter is also author of “The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine’s Computer Age.” His highly informative blog is “Wachter’s World” – seek it out.

Dr. Wachter recently wrote an entertaining, sobering, but ultimately optimistic New York Times Op-Ed piece entitled “Why Health Care Tech Is Still So Bad”. The points will resonate with users of hospital and office Epic (and other EMRs of course). It is of interest that our “Well Being” article this issue makes note that the main initiative of the AMA’s project to improve the physician practice experience, is to make EMRs better. Clearly the relationship between providers and EMRs will continue to evolve and mature. Dr. Wachter outlines some priorities needed to make that a positive story.

Here is the link to Dr. Wachter’s NY Times piece. Print readers can easily search for it (Opinion: Why Health Care Tech Is Still So Bad, by Robert M. Wachter). Access is free.

Survey Ranks California Counties On Current, Future Health Outcomes

One of the important annual nationwide health surveys is the County Health Rankings and Roadmaps program. Published by the Robert Wood Johnson Foundation in collaboration with the University of Wisconsin Population Health Initiative, it rates the health of nearly every county in the nation.

The Rankings look at these and many other Health Outcomes indicators:
- Percentage of adult reporting poor or fair health;
- Average number of “physically unhealthy days” experienced in the last month;
- Average number of “mentally unhealthy days" experienced in the last month; and
- Percentage of life births with low birth weight.

The Rankings also consider many Health Factors, among them:
- Health behaviors, such as smoking;
- Clinical care, such as the percentage of population under 65 without insurance;
- Social and economic factors, such as the percentage of adults 25 to 44 with some college education and income inequality; and
- Physical environment, such as air pollution and commute measures.

The 2015 California County Health Rankings was just published. Print readers can easily find it on line. It will not be surprising that Central Valley counties fared poorly in both the Health Outcomes and the Health Factors portions of the survey. Still, please realize that your dedicated patient care and Community Medical Centers’ mission to improve the health of its community are vital to our region’s health factors and outcomes. You should be proud of your contribution.

The survey also ranks California’s measures against national medians. There are some favorable comparisons (fewer Californians smoke or are obese) and some weaknesses (drinking water violations, severe housing problems, shortage of mental health providers).

For further information, visit: www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2015_CA_0.pdf
The important question of whether older RBC units have adverse clinical effects compared to “fresh” RBC has received much attention in recent years. After many observational studies, some of which found that older RBC (definition of which also varied) had poorer clinical outcomes, 3 randomized controlled studies have now been reported. The most recent was just published in New England Journal of Medicine (March 17, “Age of Transfused Blood in Critically Ill Adults”):

Researchers in Canada and Europe looked at 1211 critically ill patients randomized to receive either only RBC less than 8 days of age or “standard issue” RBC (mean age 22 days; similar to our supply at CMC, though RBC may be used up to 42 days of age). All RBC were leukocyte-reduced (same as our supply at CMC). The study had a numerous primary endpoint of 90-day mortality and numerous secondary morbidity end points. The conclusion: “…Transfusion of fresh red cells, as compared with standard-issue red cells, did not decrease the 90-day mortality among critically ill adults. …There were (also) no significant between-group differences in any of the secondary outcomes (major illnesses; duration of respiratory, hemodynamic, or renal support; length of stay in the hospital; and transfusion reactions) or in the subgroup analyses.”

This trial joins two other large randomized and controlled trials in finding no adverse effects of aged RBC. One looked at very low birth-weight infants (JAMA 2012;308:1443-51) and one looked at elective cardiac surgery patients (Transfusion 2014;54:Suppl:15A).

So is the long-standing matter of “Fresh vs Old” RBC now put to rest? Most likely not, since chemical changes (such as depletion of nitric oxide leading to impaired vasodilation) and RBC deformity leading to cell sludging in the microcirculation, are undeniably associated with older RBC. But insofar as the “bottom line” is comparison of clinical outcomes, the best science to date does NOT suggest that age of RBC is an important concern, even in very small infants.

Another contentious thing (Blood bankers look relaxed but they thrive on conflict) has been the optimal ratio of RBC, plasma and platelets for massive transfusion of trauma patients. Typically, blood components in this situation are issued in “packs” of defined composition. A major study reported in JAMA (Feb 3 issue, “Transfusion of plasma, platelets and red blood cells in a 1:1:1 ratio vs a 1:1:2 ratio and mortality in patients with severe trauma: the PROPR trial”) looked at 680 severely injured patients treated at 12 North American level one trauma centers. Data to date have not conclusively supported the 1:1:1 ratio (which is what we have used at CRMC for at least 3 years), and there have been concerns that its greater plasma exposure can produce unintended adverse outcomes.

Interested readers will want to review the article, but here are the conclusions:

“Among patients with severe trauma and major bleeding, early administration of plasma, platelets, and red blood cells in a 1:1:1 ratio compared with a 1:1:2 ratio did not result in significant differences in mortality at 24 hours or at 30 days. However, more patients in the 1:1:1 group achieved hemostasis and fewer experienced death due to exsanguination by 24 hours. Even though there was an increased use of plasma and platelets transfused in the 1:1:1 group, no other safety differences were identified between the 2 groups.”

And:

“Given the lower percentage of deaths from exsanguination and our failure to find differences in safety, clinicians should consider using a 1:1:1 transfusion protocol, starting with the initial units transfused while patients are actively bleeding, and then transitioning to laboratory-guided treatment once hemorrhage control is achieved.” (At CRMC this means our ROTEM testing).

So does this study put the Trauma Ratio issue to rest? Most likely not, since although there was no increase in transfusion-associated adverse effects in the more aggressive arm (important information, yes), there was also no survival advantage. And in the end, patients in the more aggressive arm got twice as many platelets as those in the 1:1:2 arm. But so long as platelets and plasma can be reliably supplied, the 1:1:1 ratio (transitioning to targeted transfusion) is preferred.
Sepsis and SIRS Documentation

Submitted by Sandra Sidel RHIA, CCS

Avoid Queries for clarification by documenting specific terms for Sepsis and SIRS. Enhanced documentation for Sepsis and SIRS = assigning codes that accurately reflect the patient’s severity of illness and risk of mortality.

In ICD-10-CM, SIRS due to infectious source does not code to sepsis. Also, sepsis syndrome and urosepsis are not codable, as neither of these terms is synonymous with sepsis.

Terminology that should be utilized to accurately reflect the patient’s condition:

- Sepsis (Must be stated instead of SIRS in order for sepsis to be coded)
- Sepsis due to pneumonia
- Sepsis due to UTI
- Sepsis due to urinary catheter
- SIRS due to non-infectious source (e.g., pancreatitis, trauma, burn)

If you would like more information or have any questions, please do not hesitate to contact Sandra Sidel: email ssidel@communitymedical.org or (559) 459-6003/Ext.: 56003.

Tips to a Successful ICD-10 Transition

Submitted by Sandra Sidel, RHIA, CCS, HIM Coding Educator

<table>
<thead>
<tr>
<th>Current ICD-9 Documentation</th>
<th>Improved ICD-10 Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 year old female with hypotension &amp; tachycardia. SIRS criteria met, presumably infectious.</td>
<td>75 year old female with hypotension &amp; tachycardia. Sepsis, possibly due to pneumonia, cultures grew Pseudomonas.</td>
</tr>
</tbody>
</table>

The following documentation improvements are needed for ICD-10: Source, Organism, Underlying cause (e.g., due to urinary catheter), Acuity (e.g., severe sepsis)


**Poison Prevention Week Review**

*Submitted by Rais Vohra M.D.*
CRMC Emergency Medicine
California Poison Control System

Poison prevention week is an annual event organized nationally each March, to help highlight these issues as well as the importance of poison control efforts to patients as well as to health care providers. According to the Centers for Disease Control (CDC), in 2008 over 41,000 people died as a result of poisoning, and poisoning became the leading cause of injury death for the first time since at least 1980. The poisoning death rate nearly tripled over the past 30 years and the percentage of poisoning deaths that were caused by drugs increased from about 60% to about 90%. In 2008, nationally, about 76% of poisoning deaths were unintentional, 16% were suicides, and 8% were of undetermined intent. Surpassing trauma from vehicular accidents, poisoning is now the leading cause of death from injuries in the United States, as reported by the Centers for Disease Control and Prevention, National Center for Health Statistics.

Currently, 57 regional poison centers serve the US. Poison centers handled 2.3 million human poison exposures in 2011, but this figure does not reflect the magnitude of poison-related injury and death in the United States because many poisonings do not involve a call to the poison center. In 2010 there were 42,917 deaths attributed to poison yet poison centers were consulted in 1,730 poisoning fatalities – only 4%! The CDC estimated that there were 1,098,880 poisoning injuries in 2010 that resulted in a visit to an emergency department. However, poison centers were involved in only 601,197 cases that involved treatment at a health care facility, indicating that poison centers are not consulted for many poisoning-related ED visits. Poisonings also go unreported when people do not realize they have been exposed, choose not to seek medical treatment or advice, do not have access to medical care, or do not know about poison center services.

The infographics on these pages state the case eloquently, but it’s up to all of us to ensure that patients and kids are kept safe from the hazards that may be lurking in their homes. Please consider spending an extra few minutes with your at-risk patients (parents of young children, teens and older

See *Tox Tidbits* on page 16
Prepare & Prevent

A room-by-room guide to help prevent unintentional poisonings in the home.

About 90,000 children are seen in emergency departments each year due to unintentional poison exposures. Think outside of the box—beyond the medicine and kitchen cabinets—when it comes to poison prevention.

Kitchen and Bath

Think "On Tight and Out of Sight."

Most poisonings in the home are associated with commonly used medicines and household cleaners.

☐ Keep medicines and household cleaners in original child-resistant packaging. Re-secure lids after each use.

☐ Place medicines and household chemicals up high and out of sight.

☐ When high storage is not an option, store medicines and household chemicals in locked or latched cabinets with child-resistant locks/latches.

Laundry Room

A New Product Brings New Hazards.

Single-load laundry packets look like candy or a teething ring, but they can be poisonous.

☐ Store all laundry products up high and out of sight.

☐ Leave laundry products, such as highly concentrated single-load laundry packets, sealed in their original packaging.

Bedrooms, Living & Family Rooms

Coin Cell-Size Danger.

In addition to a choking hazard, a swallowed coin cell battery in the throat can release hydroxide in as little as two hours, resulting in dangerous chemical burns.

☐ Keep remotes, keyless entry controls, gaming devices and other small electronics with small, coin cell-size batteries out of a child's reach.

☐ Use tape to help secure a battery compartment that does not have a screw.

☐ Keep spare batteries out of the reach of children.

Basement, Garage, Attic

Be on the Lookout for the "Invisible Killer."

Carbon monoxide is a colorless, odorless gas and if you have fuel-burning appliances, a car and/or a portable generator, take note.

☐ Install CO alarms in the hallway near bedrooms/sleeping areas. Test alarms frequently and replace dead batteries.

☐ Have heating system inspected and serviced annually by a trained service technician.

☐ Operate portable generators outdoors and 20 feet away from open doors, windows and vents.
adults on multiple medications) to make sure they understand the specific hazards in their own home environments, and instruct them on how to store or dispose of these safely. Most important of all, each and every patient that we see program their cell phone to have ready access to toll-free, all hours Poison Center Hotline number, 1-800-222-1222. A room by room checklist is also provided to share with patients and parents who can use these tips to make their home safer from poisoning hazards.
17th in Our Series of Specialty Recommendations for “Choosing Wisely”

Editor’s Note: This issue’s Choosing Wisely list addresses common and major cancer diagnostic and cancer management choices. Important principles at work: Care planning and communication about care as a team, Patient and family engagement, Optimizing value of cancer surgery and cancer follow-up, and Prevention of complications from major cancer surgery.

As a reminder, readers can access the entire library of Choosing Wisely lists (which include supplemental literature citations supporting each entry and information on the organization that submitted that list) at: Choosingwisely.org

See Choosing Wisely on page 18
Choosing Wisely

Continued from page 17

Don’t use surgery as the initial treatment without considering presurgical (neoadjuvant) systemic and/or radiation for cancer types and stage where it is effective at improving local cancer control, quality of life or survival.

- In many cancer types, presurgical chemotherapy, hormone/endocrine therapy and/or radiation therapy followed by surgery is better than surgery as the first treatment. This often shrinks the cancer, allowing more limited surgery that maintains organ function, reduces the chances of cancer recurrence and spread and improves the quality of life.
- For example, presurgical therapy may make mastectomy unnecessary with breast cancer, a colostomy unnecessary with rectal cancer, voice-sparing surgery possible with laryngeal cancer and amputation unnecessary with extremity soft tissue sarcoma.
- When used appropriately, there is no evidence that the cancer spreads during presurgical therapy and that cancer survival is the same or better as with initial surgery.
- Despite its known advantages, many people are not provided the advantages of presurgical therapy.
- Disease sites where this should be considered include:
  - Clinical Stage IIB and IIIA Non Small Cell Lung Cancer
  - Clinical T2-4a; Any N positive esophageal cancer
  - Clinical T3 and T4 rectal cancer
  - Clinical T2, T3 or Stage III breast cancer
  - Head and Neck cancer
  - Resectable pancreas cancer
  - Extremity soft tissue sarcomas where resection may affect functional outcomes

Don’t perform major abdominal surgery or thoracic surgery without a pathway or standard protocol for postoperative pain control and pneumonia prevention.

- Uncontrolled pain and pneumonia after major abdominal and thoracic surgery are factors that lead to other serious complications and prolonged hospitalization.
- Coordinated care efforts and established care pathways to control pain and prevent pneumonia reduce the frequency of complications and reduce length of hospital stay and should be in place.
- Fewer pulmonary complications occur when adequate analgesia is provided making postoperative pain control and pulmonary plan as essential elements of care.
  - Facilities that conduct flow analyses in patients with lung cancer have improved quality care.
  - Institutions or hospitals in collaboration with the surgeon and other medical staff should develop these pathways, standard protocol or procedures and assure their implementation.
  - Improvement efforts need to address documentation and standardization of process of care.

Don’t initiate cancer treatment without defining the extent of the cancer (through clinical staging) and discussing with the patient the intent of treatment.

- Treatment intent may be diagnostic, curative, maintenance or palliative.
- Many patients, especially those with advanced or metastatic cancer, do not have a full understanding of the intent of cancer treatment – they identify that treatment may be curative when in fact it is given only with palliative intent. They often do not understand the costs, risks and potential side effects of the treatment.
- Palliative therapy may provide relief of symptoms or short-term prolongation of survival, but often can cause substantial toxic effects and can interfere with the patient’s quality of life.
- This directive should be applied to all phases of cancer treatment from initial therapy to treatment for recurrent and metastatic cancer.
- Clinical staging should be performed and documented using information from history and physical examination, relevant biopsy and appropriate imaging based on the type and stage (extent) of the cancer.
On March 27, UCSF Fresno’s Global Health Curriculum hosted a breathtaking exploration about High Altitude Illness Research on Mount Everest in the Nepal Himalayas. Dr. Thomas Kim, a 4th year resident in Emergency Medicine at UCSF Fresno, spent five weeks in the villages leading to the Mt Everest base camp in Northeastern Nepal, assessing and researching the best preventions and treatments for altitude-related illnesses.

Dr. Kim was closely involved with the Himalayan Rescue Association in conducting multiple research studies. He investigated the pharmacologic prevention of Acute Mountain Sickness (AMS), measuring rates of AMS after trekkers used ibuprofen, acetaminophen, or placebo. His team also analyzed the use of positive pressure ventilation for the treatment of high altitude pulmonary edema, and surveyed the incidence, prevalence, and associated factors of hemodynamic changes at altitude and its relationship to essential hypertension.

These pictures demonstrate Dr. Kim’s picturesque experiences on the high slopes of the mountainous terrain of Eastern Nepal. He described his Nepal trip as an ideal, real-world complement to the lessons of the UCSF Global Health Research Scholars program, which gives a unique, long-term perspective on global health: “Global health is best served by thinking about the consequences and predefined goals of the environment you are serving. How do you want to change it? Long term changes are best because they provide sustainability and have the greatest impact from your intervention.”

While conducting the research studies, Dr. Kim mentioned that he was very appreciative that over 600 subjects in Nepal were willing to participate in the research studies. “It was difficult because we had to make sure the subjects were from out of the country… and were willing to partake in continuous monitoring of factors including their blood pressure and response to different medications.”

A progressive increase in altitudes leads to less available oxygen content. At the peak of Mount Everest, the oxygen level is at 33% compared to sea level. Acute Mountain Sickness is one of the most common diagnoses of high altitude gain in subjects. According to Dr. Kim, individuals with the highest risk factors are those who have a prior history of Acute Mountain Sickness, have a steep rate of ascent, and sleep at high altitudes. Results indicate that

See International Insights on page 20
age, gender, and race do not carry any significance. Dr. Kim mentioned that one important pearl for those who climb to high altitudes is “climb high, sleep low.” The process of acclimatization typically takes at least 1-2 days to occur, and if there is an onset of AMS symptoms, it is important to not ascend until symptoms have been resolved.

This raises the question: How can we prevent symptoms associated with high altitude sickness? While Dr. Kim’s research study is ongoing, there is preliminary data to suggest that certain medications may be helpful. Acetazolamide and dexamethasone are the most established preventative measures for AMS. However, the non-prescription NSAID ibuprofen has also been found to be almost equally effective in preventing high altitude sickness and acute mountain sickness, and was shown to be much more effective than the placebo when testing subjects. Dr Kim’s research focused on comparing ibuprofen with acetaminophen for their preventative efficacy.

Dr. Kim’s engaging stories and photos from contemporary Nepal, with its many modernizing influences on centuries-old ethnic populations of the high Himalayas, depicted why global health is such a dynamic and fascinating field which touches on many other specialties such as wilderness, austere, and altitude medicine. If you would like to get involved in a global health opportunity, you can contact Dr. Rais Vohra (Director of UCSF Global Health at UCSF Fresno). For our next UCSF Fresno Global Health Curriculum meeting, there will be an upcoming lecture on April 24 at 4 PM entitled, UCSF Global Health Innovations in Education. This will be a very exciting lecture so make sure to mark your calendars!

Lastly, there are many additional workshops and events coming up which you can hear about by joining our mailing list! Email rvohra@fresno.ucsf.edu.

Or find the UCSF Fresno Global Health Curriculum on the Facebook: www.facebook.com/groups/368994383236895

International Insights

Continued from page 19
Community Hospital's Medical Library has recently added a number of print textbooks and several new electronic journals. JAMA Oncology, Neurosurgery, and Journal of Burn Care & Research can be found on the Medical Library homepage: The Forum/Learning Opportunities/Medical Library. For Neurosurgery and JBC&R you can access electronically published articles ahead of print and have off-campus access as well.

Some of our new print textbooks include:
- Comprehensive Clinical Nephrology
- Fanaroff & Martin's Neonatal-Perinatal Medicine
- Nuclear Medicine and PET/CT Technology and Techniques
- Genograms-Assessment and Intervention
- Ministry with Persons with Mental Illness and Their Families
- Management and Legal and Ethical Issues in Nursing
- Hospital Readmissions: Complexities, Reduction Efforts, and Analyses of Hospital-Acquired Conditions

Spotlight on E-Book Resources:
Clinical E-book Collection

If you’ve never had occasion to investigate the 1900+ titles in the Clinical e-book collection I invite you to do so. Health and Medicine has the largest clinical selections but many interesting titles can be found in all categories:
- Adults with Childhood Illnesses: Considerations for Practice 2011
- Decision Making in Spinal Care 2013
- Food Allergies: Symptoms, Diagnosis and Treatment 2011
- The Essentials of Hospital Medicine: A Practical Guide for Clinicians 2013
- Inherited Metabolic Epilepsies 2013
- Substance Abuse in Adolescent and Young Adults: A Manual for Pediatric and Primary Care Clinicians 2013
- Principles and Practices of Lasers in Otorhinolaryngology and Head and Neck Surgery 2014
- A Clinician's Guide to Helping Children Cope and Cooperate with Medical Care 2014
- A Guide to Board Certification in Clinical Psychology 2013
- Addictive States of Mind 2013
- Pharmacy on a Bicycle: Innovative Solutions to Global Health and Poverty 2013

These books are in pdf format but can also be downloaded by creating a personalized account with EBSCOhost. A personalized account will allow you to save your preferences, save and retrieve your search history, save and share your folders with others, create email alerts, and access your saved research remotely.

Search Tips
Your search results can be refined by using the box on the left side of the page. Boolean operators are the “AND”, “OR”, “NOT” words that allow you to narrow or broaden your search focus. “AND” narrows your search, “OR” broadens your search, and “NOT” excludes. For example, in a search for pediatric oncology articles or books you can type in “oncology” which comes up with 190 results. Typing in “oncology” AND “pediatric” will only give those articles or books that include both terms: 47 in this case. The same terms using “OR” will result in those books/articles that have either term or both: 469 results. To exclude neonates from the list you would type in “oncology” AND “pediatric” NOT “neonates”. This retrieves 43 items.

Please don’t hesitate to call us at 459-3968 for assistance. You can also fill out a literature request form on the left side of the Medical Library Homepage and it will reach me at the library.

A THOUGHT FOR WELL BEING:

“Never interrupt someone doing something you said couldn’t be done.”

– Amelia Earhart, aviator
**Pediatric Lecture Series**

Title: “Drug Allergy”  
Date: Tuesday, April 7, 2015  
Speaker: John Kelso M.D.  
Time: 12:30-1:30pm  
Place: CRMC-10 West Conference Room  
CME: 1 CME

Title: “Recognition and How to Approach Acute Respiratory Failure and ARDS in Pediatrics”  
Date: Thursday, April 16, 2015  
Speaker: Thianchai Bunnalai M.D.  
Time: 12:30-1:30pm  
Place: CRMC-10 West Conference Room  
CME: 1 CME

Title: “Acid-Base Physiology”  
Date: Tuesday, April 28, 2015  
Speaker: J. Anthony Reid M.D.  
Time: 12:30-1:30pm  
Place: CRMC-10 West Conference Room  
CME: 1 CME

**CCMC Presents:**

Title: “Experiences of Mothers Who Exclusively Breastfed Their Children Until 6 Months in the Central Valley”  
Date: Tuesday, April 14, 2015  
Speaker: Amy Evans M.D.  
Time: 6:00-7:00pm (dinner provided)  
Place: H. Marcus Radin Conference Center – Clovis Community Campus  
Contact: Jessica Lipsius, (559) 324-4002 or jlipsius@communitymedical.org  
CME: 1.0 hrs

**Perinatal M & M**

Title: “Twin to Twin Transfusion Syndrome”  
Date: Wednesday, April 15, 2015  
Speaker: Drs. Elizabeth Woods, Cynthia Curry, Nathalie Nguyen and Steve Elliott  
Time: 12:30-1:30 pm  
Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 136  
Contact: Bernadette Neve, (559) 459-7059  
CME: 1 CME

**University Centers of Excellence Presents**

Title: “2015 Dermatology Symposium”  
Date: Thursday, April 16, 2015  
Speakers: Drs. Greg Simpson and Leslie Storey  
Time: 6:00-8:00pm (dinner provided)  
Place: Limon – 9455 N. Fort Washington, Suite 101, Fresno, CA 93730  
Contact: Allison Hernandez, (559) 453-5256 by April 9  
CME: 1 CME

Title: “Update in NeuroSurgery: Stroke, Brain Tumors and Cerebral Vascular”  
Date: Thursday, April 16, 2015  
Speakers: Drs. Amir Khan, Yu Hung Kuo and Armen Choulakian  
Time: 6:30-8:00 pm (dinner provided)  
Place: Palms, 7550 North Palm Ave., Fresno, CA 93711  
Contact: Denise Jennings, (559) 459-3136 or djennings@communitymedical.org  
CME: 1 CME

Title: “Multidisciplinary Breast Care from Diagnosis to Survivorship”  
Date: Tuesday, April 21, 2015  
Speakers: Drs. Elizabeth Woods, Cynthia Curry, Nathalie Nguyen and Steve Elliott  
Time: 6:30-8:00 pm (dinner provided)  
Place: Bella Luna, 350 W. Main St, Merced, CA  
Contact: Denise Jennings, (559) 459-3136 or djennings@communitymedical.org  
CME: 1 CME

**Save The Date**

Title: High Sierra Wilderness and Travel Medicine Conference  
Join us for UCSF Fresno’s 7th Annual Wilderness Medicine Conference  
Date: Wednesday, Thursday and Friday, April 29-May 1, 2015  
Speakers: Various  
Place: Pines Resort at Bass Lake, CA  
Register: [www.ucsfcmec.com/2015/MMC15025/info.html](http://www.ucsfcmec.com/2015/MMC15025/info.html)  
Contact: Mary Swenson, (559) 499-6443 or mswenson@fresno.ucsf.edu

Please also see the enclosed individual flyers for more on these & other upcoming local CME activities to meet your CME needs.
Save The Date
Title: “21st Annual Hispanic Medical Conference”
Date: Saturday, May 2, 2015
Speakers: Drs. Ignacio Guzman, Mario Ochoa, Juan G. Bautista, Carlos Santibanez, Luis G. Bautista and J. Luis Bautista
Time: 8:00 am-1:30pm (lunch provided)
Place: Belmont Country Club, 8253 E. Belmont Ave. Fresno, CA
Register: No Fee for Attendees
Contact: Yolanda or Laura, (559) 266-8300
CME: 5 CME Applied for

Save The Date
Title: “Central California Trauma Symposium”
Date: Wednesday, May 13, 2015
Time: 7:00 am-5:00 pm (breakfast, lunch and afternoon snack)
Place: UCSF Fresno MERC, 155 N. Fresno St., Fresno, CA
Register: $75/person www.Treffresno.org or (559) 459-5130
CME: 7 CME

Save The Date: Perinatal M & M
Title: “Resurgence of Congenital E. coli Sepsis”
Date: Wednesday, May 20, 2015
Speakers: TBA
Time: 12:30-1:30 pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 136
Contact: Bernadette Neve, (559) 459-7059
CME: 1 CME

Save The Date
Title: “2015 10th Annual Cardiology in the Valley Symposium”
Date: Saturday, May 16, 2015
Speakers: Drs. Teresa Daniele, Ryan Berg, Ralph Wessel, John Ambrose and Sundararajan Srikanth
Time: 8:00 am-1:30 pm (Continental breakfast and lunch provided)
Place: UCSF Fresno MERC, 155 N. Fresno St., Fresno, CA
Register: www.fresno.ucsf.edu/conferences/cardiology2015 Pre-registration is required. Registration is on a first-come, first-served basis. Early registration is recommended, as seating is limited
CME: 5 CME

Save The Date: Perinatal M & M
Title: “Cord Blood Banking”
Date: Wednesday, July 15, 2015
Speakers: TBA
Time: 12:30-1:30 pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA
Contact: Bernadette Neve, (559) 459-7059
CME: 1 CME

April 2015 Guest Photographer of the Month:
Douglas Alexander
See page 2 for details.

Tioga Lake, Mammoth Mountain and the Kuna Crest, Rock, Log
APRIL 2015 GUEST PHOTOGRAPHER OF THE MONTH:
DOUGLAS ALEXANDER
See page 2 for details

Artist’s Drive, Artist’s Pallette

Sand Dune and Ripples and the Grapevine Mountains

Furnace Creek Wash near 20 Mule Team Canyon
Capacity Determinations

**WHO CAN DETERMINE CAPACITY?**

As a mental health professional and a member of the Community Medical Centers Ethics Committee, I frequently encounter situations which indicate a lack of clarity among members of the Medical Staff regarding the role of physicians in assessing a patient’s capacity to make informed consent and/or basic decisions about their healthcare. A review of the literature on this topic supports the position that the patient’s primary physician is best suited to make the capacity determination. However, in the hospital, the primary physician might not be the attending physician. In such cases it is generally considered best, and most appropriate, for the inpatient attending physician to determine capacity. It is common for there to be an expectation that a psychiatrist should perform the evaluation to determine capacity. A psychiatric consultation may be helpful if the patient has or is suspected to have a psychiatric disorder. However, any licensed physician who undertakes the task can determine a patient’s capacity to make healthcare decisions. Furthermore, the UCSF School of Medicine website Ethics page states, “the attending physician is ultimately responsible for determining whether the patient has decision-making capacity”. Thus, a psychiatric consultation is neither always required nor always appropriate to determine capacity.

*What is “capacity?”*

An adult is presumed to have capacity for making their own healthcare decisions unless determined otherwise. Both legally and ethically Western culture favors an individual patient’s autonomy and right to self-determination. The principle of autonomy requires that a physician respect the authority of a patient to make decisions, even when the decisions appear to be unwise. Restricting this autonomy requires a clear and convincing assessment that a patient’s decision regarding care will result in *unintended*, irreparable harm. However, it is important to recognize that autonomy is only possible when the patient possesses the ability to make relevant health decisions. If individuals lack decision-making capacity they may make decisions that are contrary to their best interests and thus need to be protected from harm.

Physicians assess the decision-making capacity of their patients at every clinical encounter even if a concern regarding capacity is not at issue. This reinforces that any licensed physician undertaking the responsibility may determine a patient’s capacity. When a concern regarding capacity presents itself, a directed clinical interview can assist in the assessment process. Such assessments by nature will always contain a subjective element. Generally, the following should be explored with the patient:

- Ability to understand information and respond to questions about proposed diagnostic tests and/or treatments
- Ability to appreciate the impact of treatment versus non-treatment on their situation
- Ability to appreciate the nature, risks and benefits of any reasonable alternatives
- Display a use of reason in making their decisions
- Ability to clearly communicate their choices

If a physician determines that a patient lacks decision-making capacity, the medical team will need to look to advance directives and/or surrogate decision-makers to help make healthcare decisions for the patient. The physician will also need to document the determination in the medical record, and should include the factors taken into account in reaching the determination.

If you have any questions about a particular case, you may contact the Ethics Committee for assistance.

*(Prepared by: Richard Adams, PhD; Clinical Psychologist; Community Behavioral Health Center)*

3/31/2015
Ensure your communication is HIPAA compliant

TigerText is HERE!

The TigerText application is being rolled out to all CMC physicians starting in April making your communications more secure.

This new mobile application helps Community Medical Centers and physicians comply with HIPAA Security Standards and allows you to communicate with other clinicians about your patients’ care safely and simply using secured text messaging. TigerText can be used anywhere, delivers messages immediately via any type of smartphone or tablet, and has many features that will be of interest to physicians. Look for on-site visits from Corporate Information Services in your hospital physician lounges during April!

For more information, contact Gayle Christner in Information Services at 459-2715 or gchristner@communitymedical.org
Training to prepare you for key changes in Epic

The educational modules will highlight all of these key changes, and other key enhancements within the 2014 version, and are available through Community’s online learning tool, HealthStream Learning Center (HLC). The link can be found on the Forum homepage, and some computers may also have an icon on the desktop to take you straight to the training modules. If the HLC link from the forum does not work, look for this icon.

Click the link and follow the logon process

1. Log on using your CMC Network Log on credentials (same as Epic)
2. Click on the “My Learning” tab - there will be Epic 2014 modules to complete
3. Click on the first Epic 2014 module – Epic Overview to complete – required for everyone. Once you have successfully completed the module, you will be taken back to the “My Learning” tab to complete the other modules assigned to you by specialty.

For any questions regarding logging in please contact the Help Desk – 459-6560 / ext. 56560

EpicCare Inpatient –
- Chart Search – Epic 2014 now makes it possible to search a patient’s chart for any word, phrase, or test using one search field.
- Collapsible Notes and Smart links – Minimize note bloat by collapsing information that has been copied from other parts of the chart.
- Orders Not Requiring Reconciliation – Certain types of orders can now be excluded from Order Reconciliation, saving time and minimized errors.
- User Version Order Sets – With 2014, you are now able to save multiple versions of an order set, tailored to individual groups of patients.

Emergency Medicine (ASAP) – Orders Quick List – Improve ordering efficiency by rapidly placing complaint driven order panels.

Ob/Gyn (Stork) – Enhanced OB history documentation: To make documentation more consistent with the deliver summary and more user friendly.

Anesthesia –
- Enhanced procedure documentation – Improved documentation of procedure performed outside of the operating room.
- Vitals at a glance – Abnormal vital signs will now be highlighted to draw attention to them, and will align better for trend comparison


This material is now available, and is required and needs to be completed by May 22, 2015. If not completed within the timeframe outlined, you will not have access to the Epic system.
CME Dinner Lecture
Little Incisions for Little Patients
Advanced Endoscopic Surgery for Neonates

SPEAKER: Holly Williams, M.D.
Pediatric General Surgeon

DATE/TIME: April 7, 2015, Tuesday
6:30 pm – 8:30 pm

ATTENDEES WILL:

1. Gain better understanding of the newest techniques in the evolution of endoscopic surgery for children "and utilize in one’s practice".

2. Will be able to list at least two principles and benefits of endoscopic surgery for children and the impact on patient outcomes.

3. Learn better, understand and incorporate into patient care the knowledge of how to select cases eligible for endoscopic surgery identify two measureable outcomes.

LOCATION:
Ruth’s Chris Steakhouse
7844 N. Blackstone Ave.
Fresno, CA

CME 1.0
Dinner provided (Vegetarian options available)

TARGET AUDIENCE:
Pediatricians, Obstetricians, Primary Care Physicians, Internal Medicine and Family Practice, RN's and all Allied Health Professionals who work in Primary Care field.

RSVP to Business Development Outreach Dept., Denise Jennings, Admin Sec. at (559) 459-3136; Email: DJennings@Communitymedical.org

Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians.

Community Medical Centers designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This credit may also be applied to the CMA Certification in Continuing Medical Education.

Disclosures: Speaker Holly Williams, M.D. and event planner Kimberly Goldring, Ric Morales and Louis Triana have no disclosures to make.

www.CommunityRegional.org
EXPERIENCES OF MOTHERS WHO EXCLUSIVELY BREASTFED THEIR CHILDREN UNTIL 6 MONTHS IN THE CENTRAL VALLEY – RESULTS FROM RESEARCH

SPEAKER:
Amy Evans, MD, FAAP, CLEC, FABM

DATE:
Tuesday, April 14, 2015
6:00 pm - 7:00 pm
Dinner will be provided

LOCATION:
H. Marcus Radin Conference Center
The Palm Room

ATTENDEES WILL:
1. Become more familiar with the recommendations for exclusive breastfeeding to 6 months by many medical societies and see how we are doing in the Central Valley.
2. Become more aware of the barriers mothers encountered while trying to exclusively breastfeed to 6 months stemming from the hospital, to the doctor's office, to the family at home.
3. Learn how to work with nursing mothers to help them achieve their breastfeeding goals as modeled by our local doctors who participated in this study with specific recommendations targeted for doctors, doctor education and community outreach.

TARGET AUDIENCE:
All physicians, nurses and allied health professionals.

CME: 1.0

RSVP:
Jessica Lipsius at:
(559) 324-4002
jlipsius@communitymedical.org

www.ClovisCommunity.org

Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. Community Medical Centers takes responsibility for the content, quality and scientific integrity of this CME activity. Community Medical Centers designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)**. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

Disclosures: Speaker and Activities Director Amy Evans, MD has no Commercial Disclosures to make. Planner Jessica Lipsius has no Commercial Disclosures to make.
Perinatal M & M Presents:

"Twin to Twin Transfusion Syndrome"

Wednesday, April 15th, 2015 from 12:30pm – 1:30pm

UCSF – Fresno, Room: 136
155 N. Fresno Street, Fresno, CA 93701

Case Presentation
Obstetrics: Dr. Nathalie Nguyen
Neonatology: Dr. Steve Elliott

Principal Discussants
Perinatology: Dr. Elizabeth Woods
Genetics: Dr. Cynthia Curry

Target Audience
Any staff physician, resident physician, nurse, nurse practitioner, nurse midwife, physician assistant, or allied health professional working with the perinatal, neonatal, and/or pediatric population.

Objectives
At the end of the session, attendees will be able to:

1) Apply to practice, current clinical evidence and guidelines relating to twin to twin transfusion syndrome.
2) Gain insight into the potential problems related to twin to twin transfusion syndrome, thereby improving patient safety & outcomes.
3) Identify ethical concerns that apply to the clinical situation and anticipate barriers that may adversely impact outcomes if not addressed across a diverse population.

1 CME or CE will be offered
RSVP is not required
Lunch will be provided

Drs. Elliott; Nguyen; Woods; Curry and program Director Dr. K. Rajani; and Program Planner Bernadette Neve have no relevant commercial relationships to disclose.

This is an activity offered by Community Medical Centers, a CMA-accredited provider.
Records of attendance are based on sign-in registration and are maintained only for Community Medical Centers staff members who are credentialed as an MD, DO, CNM, NP, or PA.

Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMO/CMA) to provide continuing medical education for physicians.

Community Medical Centers designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.
University Centers of Excellence presents

2015 Dermatology Symposium

Greg Simpson, M.D.
Medical Director, University Dermatology Associates
Assistant Clinical Professor, UCSF at UCSF Fresno
General Dermatology and Pediatric Dermatology

Leslie Storey, M.D.
Assistant Clinical Professor, UCSF at UCSF Fresno
Mohs/Dermatological Surgery and General Dermatology

Sheila Mayo, PA-C, MMSc & Margot Ceglieski, NP

Thursday, April 16th, 2015 • 6 PM

Limon ▼ 9455 N. Fort Washington, Suite 101 ▼ Fresno, CA 93730
6:00 - 6:30 PM Complimentary Dinner
6:30 - 8:00 PM Dermatological Manifestations of Chronic Disorders

Please submit your RSVP to Allison Hernandez at 559.453.5256 by April 9th, 2015.

Participants will be able to:
1. Identify dermatology resources and use that knowledge to communicate with patients available options to improve patient care, patient safety and outcomes.
2. Recognize dermatological manifestations of chronic disorders increasing physician competency, provide more effective care and achieving better patient outcomes.

Target Audience:
Pediatricians, Internists, Family Practitioners, General Practitioners, Physician Assistants and Nurse Practitioners

Program director: Dominic Dizon, M.D., Speakers: Leslie Storey, M.D., Greg Simpson, M.D., Sheila Mayo, PA-C, Margot Ceglieski, NP, and Planners Allison Hernandez and Stephen Esqueda have no relevant commercial relationships to disclose. This CME activity has no commercial support associated with it. Food or refreshments provided by University Dermatology Associates. Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. Community Medical Centers designates this live activity for a maximum of 1.5 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.
CME Dinner Lecture
Update in NeuroSurgery: Stroke, Brain Tumors, and Cerebral Vascular

SPEAKERS: Amir Khan, MD, Yu Hung Kuo, MD and Armen Choulakian, MD
UCSF Neurosurgery Associates

DATE/TIME:
April 16, 2015 • Thursday, 6:30pm to 8pm

ATTENDEES WILL:
1. Attendees will know how to identify patients eligible for treatment with IV TPA endovascular stroke interventions and/or Neuro-ICU management and be able to add this knowledge to one’s practice.
2. Gain competency to discuss acute stroke intervention treatment options with patients and patient families and/or caregivers improving patient care.
3. Better understand the goal of surgical resection in brain and spinal metastases treatment in order to improve patient outcomes.
4. Will know how to identify the indications for radiosurgery and will be able to add this competency to ones practice.
5. Gain a better understanding the role of the neurosurgeon as part of a multidisciplinary team.
6. Gain competency in clinical identification of cerebral aneurysms and their early management, including diagnostic tests and referrals.
7. Learn to identify patients that are good candidates for endovascular coiling of aneurysms and for surgical clipping of aneurysms. Learn to apply this to achieve better patient outcomes.

TARGET AUDIENCE:
ER Physicians, Primary care physicians, Internal Medicine, Family Practice, and Oncologist, PA-C’s, NP’s, RN’s and all Allied Health Professionals who work in primary care field.RSVP to Business Development Outreach Dept. Denise Jennings, Admin Sec. at (559) 459-3136 Djennings@communitymedical.org

LOCATION:
Palms
7550 North Palm Ave., Fresno, CA 93711
CME 1.0
Dinner provided (Vegetarian options available)

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Community Medical Centers designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This credit may also be applied to the CMA Certification in Continuing Medical Education.

Disclosures: Speaker Amir Khan, MD, Yu Hung Kuo, Armen Choulakian and event planner Ric Morales, Kimberly Goldring and Louis Triana have no disclosures to make.
CME Dinner Lecture
Multidisciplinary Breast Care from Diagnosis

SPEAKER: Ibironke Adelaja, MD
Board Certified General Surgeon,
Fellowship Trained Breast Surgeon

DATE/TIME: April 21, 2015
Tuesday, 6:30 pm to 8 pm

ATTENDEES WILL:
1. Competency in delivering care will improve in: Describing management of benign breast disease and identifying surgical candidates for efficient referral.

2. Describing current management guidelines of high risk breast pathology and invasive breast cancer.

3. Formulating a plan for management of high risk and heredity patients for early detection of breast cancer.

LOCATION: Bella Luna
350 W. Main St.
Merced, CA

CME 1.0
Dinner provided, (Vegetarian options available)

TARGET AUDIENCE:
Physicians-General Practitioners, Nurse Practitioners, Physician assistants, Oncology Nurse, Oncology Social Worker, Oncology Nutritionist

RSVP to Business Development Outreach Dept.
Denise Jennings, Admin Sec. at
(559) 459-3136
E-mail: Djennings@communitymedical.org.

Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians.

Community Medical Centers designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This credit may also be applied to the CMA Certification in Continuing Medical Education.

Disclosures: Speaker: Ibironke Adelaja, MD and event planner Ric Morales, Kimberly Goldring and Louis Triana have no disclosures to make.
The UCSF Fresno Global Health Curriculum represents a group of dedicated providers associated with the UCSF Fresno Medical Education Program. Our events highlight local connections to international medical projects and overseas clinical opportunities. Attendance is open to healthcare staff and clinical providers from all departments and disciplines.

Join the mailing list: rvohra@fresno.ucsf.edu

Find us on FaceBook: https://www.facebook.com/UCSFFresnoglobalhealth/info?tab=page_info

Website: http://www.fresno.ucsf.edu/global_health/
Save the Date
Saturday, May 2, 2015

21st Annual Hispanic Medical Conference
Targeting Health Issues Affecting The Hispanic Community

Topics will include:
◆ COPD
◆ Gout & Rheumatoid Arthritis
◆ How to Avoid a Medical Lawsuit
◆ Infectious Diarrhea
◆ Suicide & Burnout Among Doctors
◆ Weight Loss & Obesity in Primary Care
(Topics subject to change)

Time: 7:30 am - 1:30 pm
Location: Belmont Country Club
8253 E. Belmont Avenue
Fresno, CA  93727

To register please call Yolanda or Laura
@ (559) 266-8300; No charge to attendees

Community Medical Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians
(5 Hours of Category 1 Credit)
SAVE THE DATE

2015
10th Annual
Cardiology in the Valley Symposium
“Controversies in Cardiology”
Course Director: John A. Ambrose, MD, FACC

Saturday, May 16, 2015
8:00AM–1:30PM

UCSF Fresno Center for
Medical Education and Research
155 N. Fresno Street
Fresno, CA 93701

CME: 5 AMA PRA Category 1
CREDITS (APPLIED FOR)
FEES: No Charge

Continental Breakfast & Lunch
will be provided

TOPICS:
- Approach to Women with Coronary Artery Disease
  Teresa Daniele, MD
- Cardiology Clearance & Perioperative Risk Assessment
  Ryan Berg, MD
- NOACS vs. Coumadin
  Ralph Wessel, MD
- How, When, and What to Do for STEMI, NSTEMI
  John Ambrose, MD
- Management of CAD Patients with Stage 4 Renal Dysfunction
  or on Dialysis
  Sundararajan Srikanth, MD

COURSE OBJECTIVES:
At the conclusion of this activity, participants will be able to:
1. Better understand how to diagnose and treat chronic and acute coronary events to provide better patient care in both men and women.
2. Risk-assess patients with heart disease who are undergoing non-cardiac surgery.
3. Proficiently manage patients with severe renal dysfunction and heart disease.
4. Better manage patients requiring anticoagulation with Coumadin as well as the new anticoagulation drugs.

TARGET AUDIENCE:
Cardiologists, hospitalists, family and internal medicine physicians, physician assistants, nurse practitioners, and allied healthcare professionals with an interest in cardiology.

DISCLAIMERS:
Presenters Drs. Teresa Daniele, Ryan Berg, Ralph Wessel, and Sundararajan Srikanth, Program Director Dr. John Ambrose, and Planners Renee Amavizca and Virginia Coningsby have no commercial disclosures to make. All potential conflicts of interest will be resolved prior to this event.

ACCREDITION:
Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. Community Medical Centers designates this live activity for a maximum of 5.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

Pre-registration is required. Registration is on a first-come, first-served basis. Early registration is recommended, as seating is limited.

REGISTER ONLINE AT:
www.fresno.ucsf.edu/conferences/cardiology2015

For more information, call (559) 459-6299
Save the Date
Perinatal M & M Presents:

“Resurgence of Congenital E-coli Sepsis”
Wednesday, May 20th, 2015 from 12:30pm - 1:30pm
UCSF - Fresno, Room: 136

“Cord Blood Banking”
Wednesday, July 15th, 2015 from 12:30pm - 1:30pm
UCSF - Fresno, Room: 143 Auditorium

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Tuesday, April 7, 2015
12:30-1:30 p.m.
“Drug Allergy”
John Kelso, M.D.

Thursday, April 9, 2015
12:30-1:30 p.m.
“Disorder of Solium in PICU”
Linda Keele, M.D.

Tuesday, April 14, 2015
12:30-1:30 p.m.
“Heterotaxy – A New Update on An Old Approach”
James Pierce, M.D.

Thursday, April 16, 2015
12:30-1:30 p.m.
“Recognition and How to Approach Acute Respiratory Failure and ARDS in Pediatrics”
Thianchai Bunnalai, M.D.

Tuesday, April 21, 2015
12:30-1:30 p.m.
“Transfusion Medicine”
Tara Lemoine, M.D.

Thursday, April 23, 2015
12:30-1:30 p.m.
“Drowning”
Harry Kallas, M.D.

Tuesday, April 28, 2015
12:30-1:30 p.m.
“Acid-Base Physiology”
J. Anthony Reid, M.D.

Thursday, April 30, 2015
12:30-1:30 p.m.
“Status Epilepticus”
J. Anthony Reid, M.D.
April 2015

April 2nd
Resident Spring Retreat – NO GRAND ROUNDS

April 9th
No Grand Rounds

April 16th
“Neurocognition of Hoarding Disorder”
Carol Mathews, MD
Professor in Residence
Psychiatry
School of Medicine, University of California, San Francisco

April 23rd
No Grand Rounds

April 30th
“The Damnation of Benzodiazepines: Part 2”
Robert Hierholzer, MD
Associate Chief of Staff, Research and Education, VACCHCS
Health Sciences Clinical Professor, UCSF Fresno

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This credit may also be applied to the CMA Certification in Continuing Medical Education. Email: lsmith@communitymedical.org  P: 559-459-1777 F: 559-459-1999
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As of 3/25/15
Agenda

8:00 – 8:30  Breakfast
8:30 – 8:45  Welcome and Stroke Mission
            By Program Director; Trilok Puniani, M.D.
8:45 – 9:30  What’s New in Stroke
            By Trilok Puniani, M.D.
9:30 – 10:15 TIA and Acute Stroke Clinical Practice Guidelines
            By Ann Bebensee, M.D.
10:15 – 10:30 Break
10:30 – 11:15 Intracranial Hemorrhage and Management
            By Tina Lin, D.O.
11:15 – 12:00 Stroke in Young Adults
            By Haider Chaudhry, M.D.
12:00 – 12:15 Break – Lunch
12:15 – 1:00 Clinical Cases
            By above listed speakers (w/lunch)
1:00 – Adjourn

Objectives:
1. Discuss the different types of strokes and stroke rehabilitation.
2. Review the standardized measures for Primary Stroke Center.
3. Improve efficiency in administering TPA to patients with acute ischemic strokes.

NO CHARGE TO ATTEND

RSVP by calling 448-3319 or e-mail
Marie.L.Smithey@kp.org
Deadline for RSVP’s 4/13/15.

Statement of Disclosure
The speakers for this program do not have affiliations with any corporate organizations that may constitute a conflict of interest with this program.
Kaiser Permanente does not endorse any brand-name products.
Fresno-Madera Medical Society

JustWalk! Walk with a Doc

River Center – San Joaquin River Parkway

11605 Old Friant Road, Fresno

5 miles NE of Woodward Regional Park
North on Friant Road, left on Old Friant Road – FREE entry/parking

Saturday Mornings

Registration 7:15 am/Walk Event 7:30 am - 8:30 am

April 18, 2015
(Stress Awareness/Public Health)

May 16, 2015
(Arthritis/High Blood Pressure/Osteoporosis/Stroke Awareness/Women’s Health)

June 20, 2015
(Men’s Health/Migraine & Headache/Physical Fitness)

July 18, 2015
(Kidney/Colorectal Cancer)

August 15, 2015
(Kidney/Colorectal Cancer)

September 19, 2015
(Childhood Obesity/Cholesterol/Healthy Aging/Prostate Health)

Registration 8:45 am/Walk Event 9:00 am - 10:00 am

October 17, 2015
(Children’s Health/Bone & Joint Health/Health Literacy/Breast Cancer Awareness)

November 21, 2015
(Alzheimer’s/Diabetes/Lung Cancer)

December 19, 2015
(Influenza Vaccination/Healthy Holidays)

Information: FMMS (559) 224-4224/ www.fmms.org/ dchaparro@fmms.org