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SEPTEMBER PHYSICIAN PHOTOGRAPHER
DAVID SLATER M.D. FCAP

Pathologist and Medical Director
Community Regional Medical Center Laboratory

Pathologist David Slater M.D. traveled to the Mediterranean island of Corsica in October 2014. He found it a wonderful place very proud of its culture, its history, its food and wine, its self-sufficiency over many centuries, and its unspoiled natural beauty. Corsica spent centuries under Italian influence, enjoyed all of 4 years of independence in the mid 1700s and since then has been a Region of France. Corsica was front and center in both WW I and WW II, and one sees war time vestiges all over. Corsican people are a rugged and independent-minded lot, and there is strong autonomy sentiment there currently (the “Moor’s head with bandana” Corsican symbol being everywhere).

Corsica has a rugged mountainous interior with flowing water, chestnut and oak forests, small farms and villages, and vineyards everywhere it is humanly possible to plant and tend. The coast is spectacular and largely unspoiled as compared to most Mediterranean landscapes. Fall and Spring are ideal times to visit, avoiding the crush of summer’s beautiful people and tour groups.

On the Cover: The harbor town of Bonifacio, Corsica (also shown in some of the other photos in this issue) is ancient and dramatically situated on limestone cliffs. It lies just 7 miles from the Italian island of Sardinia. The citadel of Bonifacio dates form the 9th Century. It is is partly preserved and includes sheltered flights of steps around part of its perimeter.

Erratum:
Distinguished ENT physician and naturalist Dr. Marvin Beil informed us that the winged creature on the cover of the July-August issue is a White Lined Sphinx moth, not a hummingbird.
If we want to significantly grow the numbers of physicians the Valley sorely needs, then Congress must overhaul Medicare’s flawed payment program for graduate medical education (GME).

That was the message I conveyed this summer in my Washington testimony before the Health Subcommittee of the House Ways and Means Committee, and during the extensive questioning by committee members that followed.

I was invited to speak by Valley Rep. Devin Nunes who serves on the Ways and Means Committee. I was one of three hospital CEOs from around the nation chosen to discuss the challenges of rural healthcare. Whether or not lawmakers supported the Affordable Care Act, health reform has spotlighted not only physician shortages but the innovation-strangling nature of our government’s complex payment system for medical education.

I recounted to lawmakers the harsh, often unique socioeconomic environment that Valley caregivers know too well: entrenched poverty; chronic diseases; a vast agricultural landscape with scattered access points to care, mostly in urban centers and at safety-net facilities like Community Regional Medical Center; significantly fewer primary care physicians than statewide averages.

We need more than the relatively few physicians we now have, in order to address some of these problems. But even though the region’s problems have accumulated for many reasons over many decades, they have also been compounded by government constraints. Nearly 20 years ago – in 1997 – Medicare imposed a cap on how much money it would pay for GME. There have been minor reallocations of resources since then but only when existing teaching hospitals closed or ended their GME programs. And Community has been excluded from significant funding improvements. Our GME funding remains frozen at its 1997 level.

For twice that long – nearly 40 years – we’ve collaborated with the University of California San Francisco to support the education of graduate medical trainees in the Valley. We currently support some 250 medical residents studying in eight areas, including primary care and emergency medicine. We now support 50 fellows studying in 17 medical and surgical sub-specialties. Our GME program is a critical feeder to the entire region’s physician population, and we’d like to grow the program. Some 30% of physicians who have trained here as residents or fellows stay on to start a practice here.

We’ve chosen to expand this vital training program at our own expense, far beyond Medicare’s GME funding of it. We have invested well over $400 million in the last 10 years. But considering that Community Medical Centers now shoulders more than $180 million in uncompensated care costs each year, we have limited financial resources to expand the GME program on our own. And this, in turn, limits our ability to provide Valley residents access to healthcare now and in the future.

I told Federal lawmakers that two important policy decisions are needed. Certainly, GME needs to be expanded in general. But also the program’s policy goals would be better served if the geographic allocation system were altered to benefit safety-net, teaching facilities like ours. That change could significantly magnify the impact of what we’ve been doing and must continue to do: “grow our own” physicians, with the ultimate goal of providing efficient, effective care capacity in our mostly rural, desperately underserved region.

In their comments and questions, House committee members indicated they were receptive to identifying new ways to address the physician shortages and access-to-care challenges we face in our largely rural landscape.

Community has been working for years to make improvements in GME payment policy. My testimony is only the latest and most visible evidence of our longstanding efforts. The current policy is outdated, creating barriers rather than improving access, for area like ours.

We will continue to vigorously advocate for redesigning the current, flawed policy in ways that will accelerate quality medical education and enhance pathways to patient care. And I look forward to your continuing support.
By-laws Approved By Two Medical Staffs; We Are Now One Medical Staff

As you are aware, a ballot was submitted to the medical staff regarding the approval of the new bylaws and associated transition plan. Following a two week voting period, the required number of ballots was returned and the majority of the medical staff approved the new bylaws. The vote result was confirmed by the chair of the Board’s Professional Affairs and Quality Committee.

The medical staff results were presented to the full Professional Affairs and Quality Committee and then to the full Board of Trustees where they were ultimately approved. The new bylaws have taken effect as of September 1, 2015.

I would first like to thank all those who participated in the voting process. I was impressed by the number of thoughtful questions I received regarding this significant change in our medical staff organization. As I hope you will remember, the majority of the changes were necessary as the result of the combination of licenses of Fresno Heart and Surgical hospital and Community Regional Medical Center and will not affect the daily practice of the vast majority of our medical staff.

I would encourage the medical staff to read through the bylaws. Any time you wish, find them on the CMC Forum: Shortcuts and Tools < Polices and Procedures < Medical Staff < By Laws); or under the Workgroups menu: Physicians Forum < By Laws. Folks in the Medical Staff Office and I will be happy to clarify any questions. Finally, I encourage any member of the medical staff who may be interested in becoming more involved in governance and quality activities to contact any member of the Medical Executive Committee or the Medical Staff Office, for opportunity and direction.

Jeff Thomas
President, Medical Staff

THOUGHTS FOR WELL BEING:

Shared by a hospital lab colleague in Beijing, whose laboratory walks the talk (er, the math) in its own work.

\[1.01^{365} = 37.8\]
\[0.99^{365} = 0.03\]
## Initial Appointment to the Medical Staff effective August 13, 2015

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aysun Azimi D.O.</td>
<td>Pediatrics</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>Jaswant Basraon D.O.</td>
<td>Cardiology</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Stephanie Bauer D.O.</td>
<td>Emergency Medicine</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Brent Castle M.D.</td>
<td>Emergency Medicine</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Brandon Chalfin M.D.</td>
<td>Emergency Medicine</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Amir Fathi M.D.</td>
<td>Surgery</td>
<td>General Surgery</td>
</tr>
<tr>
<td>Akshatha Gowda M.D.</td>
<td>Medicine</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>Tegest Hailu M.D.</td>
<td>Family Medicine</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>Anjani Kolahi M.D.</td>
<td>Family Medicine</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>Jason Davis M.D.</td>
<td>Surgery</td>
<td>Orthopedic Surgery</td>
</tr>
<tr>
<td>Derek Meyer M.D.</td>
<td>Family Medicine</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>Anthony Montana M.D.</td>
<td>Family Medicine</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>Ankit Rathod M.D.</td>
<td>Cardiology</td>
<td>Cardiology</td>
</tr>
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</table>

## Initial Appointment to the Medical Staff effective August 13, 2015

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
<th>Specialty</th>
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<tbody>
<tr>
<td>Omid Saeed Tehrani M.D., Ph.D.</td>
<td>Medicine</td>
<td>Hematology/Oncology</td>
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<tr>
<td>Sandra Sands D.O, PhD</td>
<td>Family Medicine</td>
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</tr>
<tr>
<td>Amandeep Singh M.D.</td>
<td>Medicine</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>Michelle Storkan M.D.</td>
<td>Emergency Medicine</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Mark Ting M.D.</td>
<td>DOCS</td>
<td>Psychiatry</td>
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<tr>
<td>Binh Trinh M.D., Ph.D.</td>
<td>Surgery</td>
<td>General Surgery</td>
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<tr>
<td>Lyman Whitlatch M.D., Ph.D.</td>
<td>Surgery</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>Cong Zi Zhao M.D.</td>
<td>Medicine</td>
<td>Neurology</td>
</tr>
<tr>
<td>Christopher Key P.A.</td>
<td>Emergency Medicine</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Alice Jackson N.P.</td>
<td>Surgery</td>
<td>General Surgery</td>
</tr>
<tr>
<td>Katherine Kimbro N.P.</td>
<td>Surgery</td>
<td>Neurosurgery</td>
</tr>
</tbody>
</table>
ANNOUNCING UPDATED ORDER SETS BEING RELEASED

Submitted by Quality/Performance Improvement

Please see below for a list of Order Sets, or Modules, that were released into production between 06/23/2015-08/18/2015. If you identify a problem with one of the retired order sets or modules please follow the procedure for corrective action. The appropriate form may be found on the FORUM: Short Cuts & Tools > Clinical Tools > New Order Set Request/Modification.

<table>
<thead>
<tr>
<th>Epic PRL #</th>
<th>Order Set Name</th>
<th>Description of Change</th>
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<tbody>
<tr>
<td>1346</td>
<td>NICU Admit</td>
<td>Lab updates</td>
</tr>
<tr>
<td>1357</td>
<td>Bariatric Surgery Postoperative Z</td>
<td>Changes Intravenous to Intramuscular Phenergan</td>
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<tr>
<td>1367</td>
<td>Acute Ischemic Stroke/TIA</td>
<td>Standardization of Respiratory orders</td>
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<tr>
<td>1284</td>
<td>OMFS Pre Admit</td>
<td>Updated ASA guidelines hyperlink</td>
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<tr>
<td>1283</td>
<td>OMFS Pre Op</td>
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</tr>
<tr>
<td>1581</td>
<td>SUR Inpatient Pre-Op</td>
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<tr>
<td>1369</td>
<td>Pre Op Bowel Surgery Inpatient</td>
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<tr>
<td>1370</td>
<td>Pre admit Bowel Surgery</td>
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<tr>
<td>638</td>
<td>SUR Pre Admit GU Cystectomy</td>
<td>Updated ASA guidelines hyperlink</td>
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<tr>
<td>1476</td>
<td>Pre Admit GU Radical Prostatectomy</td>
<td>Updated ASA guidelines hyperlink</td>
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<tr>
<td>635</td>
<td>Pre Admit BU/BYN Urethral Sling</td>
<td>Updated ASA guidelines hyperlink</td>
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<tr>
<td>1522</td>
<td>Pre Admit Hysterectomy</td>
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<tr>
<td>4</td>
<td>Pre Admit Minor GYN Surgery</td>
<td>Updated ASA guidelines hyperlink</td>
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<tr>
<td>632</td>
<td>Pre Admit Prostate Seed Implant</td>
<td>Updated ASA guidelines hyperlink</td>
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<td>1478</td>
<td>Pre Admit Turp Orders</td>
<td>Updated ASA guidelines hyperlink</td>
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<tr>
<td>1536</td>
<td>Pre Admit/Admit Orthopedic Surgery</td>
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<tr>
<td>1390</td>
<td>Pre Op Anorectal Surgery</td>
<td>Updated ASA guidelines hyperlink</td>
</tr>
<tr>
<td>1614</td>
<td>Laser Lead Extraction Pre Op/Pre Admit</td>
<td>Updated ASA guidelines hyperlink</td>
</tr>
<tr>
<td>1587</td>
<td>Pre Op Except Cataract and Strabismus</td>
<td>Updated ASA guidelines hyperlink</td>
</tr>
<tr>
<td>1553</td>
<td>ENT Short Stay Pre Op Routine Admit</td>
<td>Updated ASA guidelines hyperlink</td>
</tr>
<tr>
<td>1446</td>
<td>Gyn Pre Op Short Stay Surgery</td>
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<td>1554</td>
<td>Pre Admit Retinal Re Attachment/Vitrectomy/Trabeculectomy</td>
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<td>1588</td>
<td>Pre Op Anorectal Surgery</td>
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<td>1485</td>
<td>Pre Op Cataract</td>
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<tr>
<td>1227</td>
<td>Pre Op Colostomy Closure</td>
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<tr>
<td>1445</td>
<td>Pre Op Hysterectomy Orders</td>
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<td>Pre Op Orthopedic Surgery</td>
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<td>Pre Op Podiatry</td>
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<td>Pre Op/Admit Short Stay Surgery</td>
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<tr>
<td>1606</td>
<td>Pre-Operative Anesthesia</td>
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<td>1475</td>
<td>Pre Op Radical Prostatectomy</td>
<td>Updated ASA guidelines hyperlink</td>
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<tr>
<td>637</td>
<td>Pre Op Radical Cystectomy/Node Dissection/Urinary Diversion</td>
<td>Updated ASA guidelines hyperlink</td>
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<tr>
<td>1435</td>
<td>Adult Hyperosmolar Hyperglycemic State</td>
<td>Admin and titration instructions added to Insulin Infusion order</td>
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</table>

The following order sets were released on 06/23/2015:

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<tr>
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<tbody>
<tr>
<td>256</td>
<td>Pre Admit Surgery/Procedure Z</td>
<td>Updates to ASA guidelines, Labs, and IV</td>
</tr>
<tr>
<td>1408</td>
<td>Pediatric Pentobarietal Coma Induction and Maintenance</td>
<td>New Order Set</td>
</tr>
<tr>
<td>1548</td>
<td>Endo IP Liver Biopsy</td>
<td>Biennial Review-Blue print to match Epic and Pharmacy modifications.</td>
</tr>
<tr>
<td>1441</td>
<td>General/Non-Surgical Indwelling Urinary Catheter Placement/Continuation</td>
<td>Order set name changed to: Urinary Catheter Placement/Removal (non-surgical)</td>
</tr>
<tr>
<td>1529</td>
<td>Partial Circulatory Assist Device</td>
<td>Modifications made to Cardiology Procedures and Weaning</td>
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The following order sets were released on 07/07/2015:

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<tr>
<td></td>
<td>Pre Admit Surgery/Procedure Z</td>
<td>Updates to ASA guidelines, Labs, and IV</td>
</tr>
<tr>
<td>1408</td>
<td>Pediatric Pentobarietal Coma Induction and Maintenance</td>
<td>New Order Set</td>
</tr>
<tr>
<td>1548</td>
<td>Endo IP Liver Biopsy</td>
<td>Biennial Review-Blue print to match Epic and Pharmacy modifications.</td>
</tr>
<tr>
<td>1441</td>
<td>General/Non-Surgical Indwelling Urinary Catheter Placement/Continuation</td>
<td>Order set name changed to: Urinary Catheter Placement/Removal (non-surgical)</td>
</tr>
<tr>
<td>1529</td>
<td>Partial Circulatory Assist Device</td>
<td>Modifications made to Cardiology Procedures and Weaning</td>
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Order Sets continued on page 7
### The following order sets were released on 07/21/2015:

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<tbody>
<tr>
<td>1334</td>
<td>Tracheostomy Insertion</td>
<td>Biennial review--Updated Diet and Respiratory Care</td>
</tr>
<tr>
<td>1191</td>
<td>Detoxification Orders</td>
<td>Biennial review--Modified Thiamine and Advanced Diet</td>
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<tr>
<td>1553</td>
<td>ENT SS Pre Op Admit</td>
<td>Biennial review--Order set will be retired based on no usage</td>
</tr>
<tr>
<td>566</td>
<td>Nonketotic Hyperosmolar Syndrome</td>
<td>Biennial review--Order set will be retired based on no usage</td>
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<tr>
<td>1306</td>
<td>Hypoglycemia Orders Neonatal</td>
<td>Biennial review--spelled out abbreviation of LGA</td>
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<tr>
<td>1311</td>
<td>Acute Pain Management</td>
<td>Biennial review--Order set will be retired based on no usage</td>
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<tr>
<td>1361</td>
<td>Metered Dose Inhaler (M.D.I.) Conversion Form</td>
<td>Biennial review--Order set will be retired based on no usage</td>
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<tr>
<td>607</td>
<td>Sexually Transmitted Disease Prophylaxis</td>
<td>Modification to Levonorgestrel</td>
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<td>1394</td>
<td>Adult Propofol to Benzodiazepine Conversion</td>
<td>Biennial review--Order set will be retired based on no usage</td>
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### The following order sets were released on 08/18/2015:

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<td>1086</td>
<td>Post Op Cardiac Cath</td>
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<tr>
<td>629</td>
<td>Adult Burn Service</td>
<td>Indwelling Urinary Catheter and mechanical ventilation order updated</td>
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<tr>
<td>1396</td>
<td>Post Colonoscopy/Polypectomy Orders</td>
<td>Biennial Review</td>
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<tr>
<td>304</td>
<td>Post Op Cardiothoracic Surgery</td>
<td>Head of Bed order updated</td>
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<tr>
<td>1571</td>
<td>Gen IP Holding Orders</td>
<td>Head of Bed order updated</td>
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<tr>
<td>1309</td>
<td>Extracorporeal Membrane Oxygenation/Extracorporeal Life Support</td>
<td>Head of Bed and Indwelling Urinary Catheter order updated</td>
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<tr>
<td>1472</td>
<td>General Medical Admission</td>
<td>Head of Bed order updated</td>
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<tr>
<td>1197</td>
<td>Rad Post Angiogram</td>
<td>Head of Bed order updated</td>
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<tr>
<td>1384</td>
<td>Transfer Cardiothoracic Surgery</td>
<td>Indwelling Urinary Catheter order updated</td>
</tr>
<tr>
<td>1369</td>
<td>Pre Op Bowel Surgery</td>
<td>Head of Bed and Indwelling Urinary Catheter order updated</td>
</tr>
<tr>
<td>1368</td>
<td>Post Op Admit Major Bowel Surgery</td>
<td>Head of Bed order updated</td>
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<tr>
<td>1245</td>
<td>Acute Intracerebral Hemorrhage Admission</td>
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<tr>
<td>1439</td>
<td>Post Op Surgery</td>
<td>Head of Bed order updated</td>
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<td>COPD Asthma</td>
<td>Head of Bed order updated</td>
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<td>Alte Admit Orders</td>
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<td>1525</td>
<td>Pediatric GI Admit</td>
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<tr>
<td>1523</td>
<td>Pediatric General Admit</td>
<td>Head of Bed order updated</td>
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<tr>
<td>1586</td>
<td>Ophthalmology Admission Orders CMC-Inpatient</td>
<td>Head of Bed order updated</td>
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<tr>
<td>1516</td>
<td>Ophthalmology Admission Orders</td>
<td>Head of Bed and Indwelling Urinary Catheter order updated</td>
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<tr>
<td>588</td>
<td>Complicated UTI/Urosepsis</td>
<td>Head of Bed order updated</td>
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<tr>
<td>1499</td>
<td>Universal Surgery Admit Z</td>
<td>Head of Bed order updated</td>
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<tr>
<td>365</td>
<td>Rad Post Biopsy</td>
<td>Head of Bed order updated</td>
</tr>
<tr>
<td>1583</td>
<td>COPD Module Z</td>
<td>Head of Bed order updated</td>
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<tr>
<td>630</td>
<td>Post Op Laparoscopic Nephrectomy</td>
<td>Indwelling Urinary Catheter order updated</td>
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<tr>
<td>633</td>
<td>Post Op Prostate Seed Implant SS Discharge</td>
<td>Indwelling Urinary Catheter order updated</td>
</tr>
<tr>
<td>700</td>
<td>Community Acquired Pneumonia Admission</td>
<td>Indwelling Urinary Catheter order updated</td>
</tr>
<tr>
<td>1547</td>
<td>Admission Orders Inpatient Leon S Peters Rehab Unit</td>
<td>Indwelling Urinary Catheter order updated</td>
</tr>
<tr>
<td>1600</td>
<td>Acute Renal Failure Module Z</td>
<td>Epic only lab order change</td>
</tr>
<tr>
<td>9</td>
<td>Radiology Post Line Placement</td>
<td>Indwelling Urinary Catheter order updated</td>
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<tr>
<td>1227</td>
<td>Pre-Op Colostomy Closure</td>
<td>Indwelling Urinary Catheter order updated</td>
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<tr>
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<td>Pre Op Colostomy Closure</td>
<td>Indwelling Urinary Catheter order updated</td>
</tr>
<tr>
<td>632</td>
<td>Pre-Op Prostate Seed Implant</td>
<td>Indwelling Urinary Catheter order updated</td>
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<tr>
<td>1317</td>
<td>Pre-Admit Neurosurgery</td>
<td>Indwelling Urinary Catheter order updated</td>
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How quickly time flies! I’ve been here officially for two months now. I am slowly learning my way around all our facilities, meeting people, getting involved and working on a number of focus areas.

One of the first items on my ‘to do’ list: redefine our clinical IT/Informatics governance structure to support streamlined decision-making. I’m hearing loud and clear the desire to realign the organization so operations (both clinical and business sides) are really front and center, making decisions about how to streamline processes, and to respond to operational needs and our corporate strategies. This will then create a need for our tools (technology, EPIC, IT infrastructure) to support those initiatives. While EPIC certainly is a big part of our care and business operations, it really has to move into a supporting role. Designing a governance structure to rapidly, efficiently, and effectively support that move will be crucial to CMC becoming nimble in today’s healthcare market.

The flip side to all this is a need for more operational staff to get involved to craft the redesign of processes, identify people/cultural changes, build accountability, and thoughtfully advance requests for support tools. Getting engagement from all corners of the organization through ‘service line’ workgroups will be a significant key to success.

The second item on my list is to build up our Informatics Division and provide experts who can ‘translate’ the operational and workflow changes and requests into change management requests for the clinical IT team. Dr. Hagop Afarian and David Boyd are now formally part of the Division; Dr. Afarian as Associate CMIO, David as CNIO. In October, Bonnie Brock, Kevin Barcelos and Bruce Kinder, along with their informatics teams, will become part of the Division as well. They will report centrally, but still be located at the facilities. This will help us develop even more synergy around corporate-wide initiatives.

The third focus area is to support development of an Analytics Division, while growing the organization’s data curiosity, awareness and availability. Working with the interim Director of Analytics, we are interviewing candidates for the permanent position, bringing together our reporting pockets into a central group, and prioritizing work efforts for data transparency. All this will take time, but the ultimate goal is to facilitate a level of self-service and knowledge within all areas of the organization. We must provide timely support for new report requests, whether resulting from regulatory requirements, process improvement or new operational initiatives.

ICD-0 is almost here – only five weeks away! Much is happening in that space, with ICD-10 training through online videos, focused efforts on documentation improvement to support ICD-10 coding and avoid physician queries, and keep a keen eye on the financial impacts if we don’t get it ‘right’ from the start on October 1.

The next page in this newsletter reminds readers of the required medical staff ICD-10 training.

For now, know that I’m working hard to become a vital member of Community Medical Centers and the Fresno/Clovis community. I am having fun getting to know everyone, and working to advance these initiatives and many others toward fruition. If I can be of any assistance, please don’t hesitate to reach out!

For questions, contact Dr. Judi Binderman, CMIO, 559-324-6894, office; or 559-259-8256, cell; or email at jbinderman@communitymedical.org.

Editor's Note: This may be stretching things a little, but you may want to recall this famous and profound quote as you conquer ICD-10 over the coming months...

“It is not the mountain we conquer but ourselves.”

~ Edmund Hillary
ICD 10 Arrives
October 1, 2015

Don’t be caught!

Learn how to
document correctly

Documentation is much more specific.

Training available online.

3 simple parts:
• Content
• Tools in EPIC
• Query process

1 CME will be offered

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

• Document to the appropriate level of specificity to communicate to other members of the team. Leading to improved patient care.

• Better manage a patient problem list to ensure all of the appropriate elements are being managed.

• Respond to and improve documentation from clinical documentation specialist evaluations.

YOUR ONLINE TRAINING...
Must be done by September 21

Complete your online training now!

> CMC is pleased to offer online training to unlock the mysteries of ICD 10 coding and documentation. Each physician has been assigned a curriculum of content most applicable to his/her specialty, plus modules on the tools available in EPIC, and a new electronic query process.

> Complete your training within HealthStream (HLC). Access HLC through the Forum, our intranet, whether you are in the hospital or not.

> Complete the curriculum before September 21 to be prepared and avoid EPIC restriction. The series takes just over an hour, and the information should be helpful for you both in the hospital and in your office. Avoid an avalanche of Clinical Documentation Improvement (CDI) queries by getting it right the first time!

> Reach out to your informatics team or the educators for assistance in getting into HLC.

> Work with the CDI specialists to improve your documentation.

This is an activity offered by Community Medical Centers, a CMA-accredited provider. Records of attendance are based on training completion 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 (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.

Questions?
Contact Dr. Judi Binderman – CMIO
jbinderman@communitymedical.org
559-324-6804 (office) or 559-259-8256 (cell)
All California physicians should support the current Medi-Cal Matters campaign, the We Care for California Coalition initiative to promote SB243 and AB366.

Your California Medical Association (CMA) forms the core of the effort. Partners beyond CMA include the California Hospital Association, Anthem Blue Cross, Blue Shield of California, California Primary Care Association, Dignity Health, Health Net, Kaiser Permanente, Molina Healthcare, SEIU-UHW, plus a further list of FIFTY entities.

We should appreciate the efforts of primary authors Assemblymen Rob Bonta and Jimmy Gomez, from Alameda and Los Angeles, as well as State Senator Ed Hernandez from West Covina. Besides these three, there are a total of SIXTY state legislators, including our local Assembly District 31 incumbent Henry Perea.

Currently Medi-Cal reimburses physicians perhaps a third of what Medicare does for basic office visits, the core service that forms the foundation of primary care. Some doctors do accept Medi-Cal, but a thinly-covered “secret” is that such practices have little choice save to schedule patients so densely that the doctor or PA/FNP can spend barely five or six minutes, which rarely allows for any sort of medical quality, surely not care that any private-paying patient would accept.

Cutting an office visit from fifteen minutes, already barely adequate for most continuing care, by 60% means that no adequate history can be elicited, physical examination becomes minimal and analysis nil. Also there’s no time for discussion or counseling. Doctors try to compensate by ordering more tests than needed, procedures which could be partly avoided by one simple physician action, thinking.

Aggravating the care encounter are long and unpredictable waits at a physician’s office. Patients who need to be at their job lose time from work, often unreimbursed. When a doctor sees seventy or more patients a day, it doesn’t take much to disrupt and retard an office schedule.

Worse than that are the patients with NO primary care physician, who when ill or injured, have no choice but to seek care at a hospital Emergency Department. The ED Director at one local hospital tells me that in recent months, the scenario just a few years ago of their admitting 25% of their patients has dropped, down to perhaps 15% or so, diluting their specialty mission. Without denigrating effort of my ED colleagues, we all understand that the ED is NOT an appropriate venue for primary care. Care so provided is costly, draining dollars that could and should be used for funding basic office care. Further secondary costs include excess in-patient costs of all sorts.

Tertiary costs include dollars expended for dealing with complications generated by care that is delayed or of poor standard. Most obviously, untreated hypertension and diabetes cause stroke, coronary artery disease, and peripheral arterial insufficiency, disabling those well under the usual retirement age.

Almost certainly, a fee-for-service structure for basic outpatient care has substantial limitations, including that with minimal if any deductibles, basic economic forces will not influence Medi-Cal utilization. Capitation may well better service this population, calculated at rates that covers all the usual office overhead, while leaving payment for the provider that reasonably compensates for the level of medical and postgraduate education.

One CANNOT reduce office overhead per hour below a certain level. Even at relatively low local salary levels for front and back office medical assistants, labor and related costs alone cost a primary care physician at least $35 per hour, without dealing with rent, utilities, administration, custodial, utilities and several other unavoidable costs.

Ideally, we should be able to integrate the Medi-Cal population into practices that cover a full range of economic circumstances. For now, that may not prove feasible, leaving the community with the less desirable “separate but equal” scenario. Even approximately “equal” would be far better than current care.

The very first step, regardless, remains to restore Medi-Cal reimbursements to a level that allows care of adequate quality, and in the process, moves patients out of our emergency departments. Medi-Cal does Matter. We must move beyond, well beyond, the false economies of the current scenario. Regardless of whether you do or do not see patients through this program, support We Care For California.

Author may be reached at Siriusguy@aol.com.
Medicare and Medicaid at 50 – History and Future Prospects

Much has been written in the medical and lay press in the past few months about these massive programs’ 50th anniversary. No matter what point you are at in your medical career, having an understanding of the past, present and potential future of these large programs is a vital “real-world” professional competency for American medical providers.

The best coverage of this topic we have seen is by the respected, non-partisan Kaiser Family Health Foundation (KFF). Below is one of the tables from its coverage, but readers are highly encouraged to visit the pages of the Kaiser Family Foundation web site that cover these anniversaries:

A particularly engaging topic is the early story of Medicare. Having witnessed in contemporary times the extreme controversy and ongoing acrimony surrounding today’s Affordable Care Act, one could wonder how, in 1965, it was even possible to initiate a then-radical program like Medicare. KFF has an engaging video tour with that story. NOTE: Print readers can find this coverage at kff.org. Look for “Medicare and Medicaid at 50” along the top of the home page.

A related note: Please find on page 10 of this issue a frank and honest appraisal of MediCal by Fresno Madera Medical Society Vital Signs Editor Dr Alan Birnbaum.
The CRMC and CBHC Diet Manual can be located on the Forum under Shortcuts and Tools. It provides a snapshot of each diet provided by the Food and Nutrition Services Department at CRMC. Centers for Medicare and Medicaid requires facilities to provide an EASY TO READ version of the diet manual that any physician or nurse can quickly scan to know the details of each type of diet order.

The snapshot includes a nutritional analysis, sample menu, how to order the diet, and any additional guidance needed to assure patients meet their DRIs adequately. Please note that the diet manual is different than the Manual of Clinical Nutrition Management, which is a clinical tool used to help support Medical Nutrition Therapy used by our Dietitians. For any questions, please feel free to reach out to Karissa Bouchie, Clinical Nutrition Manager at Kbouchie@communitymedical.org or 559-459-2882 (ext 52882).

Note: The CCMC Diet Manual is also on the Forum under Shortcuts and Tools, right above CRMC’s.
Some might expect Dr. Joseph C. Woo, Jr., at age 91, to consider slowing down, but fortunately, he doesn't plan on that happening soon. After all, as he says, “Life is full circle.”

“As a physician, from Day One, I have lived by the philosophy of giving,” Dr. Woo said recently. “Patients are the main reason I give. It’s a philosophy I’ve shared over 60 years of service. There are always opportunities to give and share.”

From the day he was born in the Burnett Sanitarium (precursor to Community Medical Center) Dr. Woo and Fresno healthcare have been inextricably linked. Especially when, at age 23, Dr. Woo obtained his M.D. from George Washington University and returned to Fresno to begin a lifelong practice in Internal Medicine and Cardiology.

Many years ago, Dr. Woo says, “I was honored with a gift in my name by the late Dr. Stein, who was my mentor and friend. He gifted to me $150,000 for research in cardiology. This gift overwhelmed me and I wanted to perpetuate what he started.”

Dr. Woo has once again stepped up for the community by providing UCSF Fresno with an $80,000 donation to fund cardiology research that will directly benefit generations of Central California patients.

“How fortunate we are to be affiliated with a UC (here in the Valley),” Woo said. “It’s something people don’t fully appreciate or think about.”

“UCSF Fresno is the main medical education system for the whole Valley,” Dr. Woo said. “To support this institution, it’s important to give back to it to carry it forward into the future. Doctors giving back – this has to be a culture that has to be developed with the younger doctors!”

The donation to fund UCSF Fresno cardiology research continues a lifetime of giving. “We have a great opportunity to change and improve the practice of medicine here in Fresno,” Woo said. “To be able to support something so great [as UCSF Fresno cardiology research] is a way to impact the future of healthcare in Central California.”

If you see Dr. Woo in downtown Fresno (he has, for years, lived just 4 minutes away) be sure to say hello, but don’t expect him to slow down. After all, he has patients to see, doctors to meet, and a generous spirit that knows no bounds.

“The spirit of giving needs to be instilled in all physicians,” Woo said. “It’s fortunate that we have the opportunity to work with UCSF Fresno. It’s important to support UCSF Fresno.”

UCSF Fresno Gets Ready to Celebrate Its Third Endowed Chair

Submitted by Cynthia Harris, Director of Development and Alumni Relations, UCSF Fresno

On Thursday, September 17, UCSF Fresno and Interim Associate Dean, Dr. Michael Peterson, will host an Investiture Ceremony to celebrate the official establishment of its third endowed chair, The Gene W. Kallsen Endowed Chair in Emergency Medicine. The holder of the chair will also be appointed to the Chief of Emergency Medicine, Dr. Greg Hendey.

This chair is named in honor of Dr. Gene Kallsen for his over 40 years of work and dedication in enhancing the practice of emergency medicine in the Central Valley and in the state of California. It is quite fitting as well that the holder of the chair will be Dr. Greg Hendey, who has continued to enhance emergency medicine in his over 22 years of practice.

This endowed chair will join the other two existing chairs at UCSF Fresno, which include the Valley Medical Foundation Professor Endowed Chair in Internal Medicine, held by Dr. Michael Peterson, and the Steven N. Parks Endowed Chair in Surgery, held by Dr. James Davis.

The importance of endowed chairs is twofold: they help attract the best and brightest faculty in a particular specialty area to the UCSF Fresno program, and they ensure the position and activities outlined in the endowed fund continue in perpetuity.

The financial goal of the Kallsen endowed chair is $1 million and there is only $235,000 left to complete the goal. All are welcome to join in the celebration in the atrium at UCSF Fresno on September 17 at 5pm, with formal remarks at 6pm. Please contact Terri Griffin at tgriffin@fresno.ucsf.edu or 499-6426 to RSVP or with any questions.

There is a wealth of TEDMED talks archived on-line, drawn from the annual live 3-day session. This year's TEDMED (which costs nearly $5,000 to attend) is in Palm Springs in November. TEDMED is becoming an influential cultural force in world medicine, and so we invite readers to explore its content (for free). This newsletter has previously featured a few of the 2013 and 2014 talks.

Here are several other 2014 TEDMED talks featuring intriguing topics and engaging experts. Talks range from less than 15 minutes to an hour or so:

Electronic readers can use these direct links. Print readers can easily find these by searching by title and TEDMED. Or next time you are cooling your heels at the airport or at home, go to www.TEDMED.com and browse the eclectic content, which is presented via excellent quality video.

**Placebo Effects make good medicine better.**
By Dr. Ted Kaptchuk, head who directs Harvard's Program in Placebo Studies and Therapeutic Encounter

**Choosing the least worst death.**
By bioethicist Peggy Battin

**Inside outside: harnessing nature's secrets.**
By Jeff Karp, who has many biomedical inventions based on biomaterials from other organisms and natural sources.

**What your doctor won't disclose.**
By physician, columnist and public advocate Dr. Leana Wen.

**Anesthesia and the dynamics of the unconscious mind.**
By MIT neuroscientist and anesthesiologist Dr. Emery Brown
Fresno Heart and Surgical Hospital (FHS) is celebrating its highest-star recognition from the Society of Thoracic Surgeons in the highly watched domain of heart surgery outcomes. It is so important to focus on quality, and the team of physicians and staff at FHS are committed to doing just that.

There are many other great things happening at the facility. I am pleased to share that the hospital merged licenses with Community Regional Medical Center (CRMC) effective September 1. We are truly blessed to be part of Community Medical Centers’ family of hospitals and care facilities, which share a mission to provide great care to all in need. Additionally, CMC leadership is committed to being an employer of choice, working closely with affiliated medical staff, being responsible stewards of resources and finances, and striving to accomplish all of these worthy initiatives in a collaborative fashion.

The license merger will result in FHS being a “remote location of the main provider (CRMC)“. In a memo to FHS staff and affiliated physicians back in February 3rd of this year, I shared this, which remains true: “it’s important that we utilize our staff and facility to the best and fullest extent. By joining under one license, we will be able to standardize certain processes and paperwork and more efficiently fill our beds. I will remain your CEO, and the rest of FHS leadership will remain the same. The license change will have minimal impact on existing hospital leadership, services, and day-to-day operations at FHS. The goal is to preserve our distinctive “service excellence” culture and brand that has always been a part of FHS. Please know that our management teams at both FHS and CRMC are here to support you in any way possible. You are our most valuable asset, and I’m proud to work alongside a team so firmly committed to our patients.”

With this license transition, and as a result of CRMC’s and Clovis Community Medical Center’s medical staff voting for the revised Bylaws, FHS medical staff governance model will experience amicable modifications including a standardized governance structure. “Advisory” committees at FHS will report up to CRMC’s Medical Executive Committee (MEC) and commensurate subcommittees, then to the Corporate MEC, and ultimately to the CMC Board of Trustees. FHS will have four physician representatives on the Corporate MEC. Change is often challenging, but I genuinely believe that this one is also “good”; and that this transition will result in positive outcomes.

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**Fresno Heart & Surgical Earns Top Quality Ratings Again**

Fresno Heart & Surgical Hospital was once again awarded a 3-star rating for open heart surgery from the Society of Thoracic Surgeons (STS)

The latest quality rating is one of several for the hospital this year, which was has been designated for the second year in a row as a “Top Performer” by the hospital accrediting agency, Joint Commission. It’s also the second year in a row the hospital got top marks from STS for coronary artery bypass graft surgery. The not-for-profit STS represents more than 6,800 surgeons, researchers and allied health care professionals dedicated to ensuring the best possible outcomes for patients.

Fresno Heart & Surgical’s STS performance rating was based on patient outcomes for coronary artery bypass surgeries performed between Jan. 1 and Dec. 31 in 2014. The composite rating consists of a weighted average of four categories: absence of operative mortality, absence of major morbidity, utilization of internal mammary artery and use of all evidence-based perioperative medications. Fresno Heart & Surgical’s performance in this area rates in the top tier of participating hospitals across the nation.

“Quality care and top patient experience is a continual focus among our staff and physician partners,” said Fresno Heart & Surgical CEO Wanda Holderman. “For our patients this kind of recognition is an assurance that expert surgeons, exceptionally skilled healthcare professionals and the highest standards of medical care are available close to home in Fresno.”

Fresno Heart & Surgical recently earned the top overall hospital safety score in a 5-county region from Consumer Reports. And Healthgrades, a nationally known healthcare ranking agency, has continually recognized Fresno Heart & Surgical for its surgical excellence and exceptional patient experience. In 2014, the hospital made Healthgrades “America’s 50 Best Hospitals for Vascular Surgery” list for aortic aneurysm repair, carotid surgery and vascular bypass surgery.

Healthgrades has also given top five-star and special excellence awards to the hospital for bariatric surgery, gastroin-
### OPEN ONCOLOGY CLINICAL TRIALS

**Revised 07/28/2015**

#### BREAST

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<tr>
<td>SWOG S1007</td>
<td>Phase III trial of adjuvant endocrine therapy +/- chemo in pt's with 1-3 (+) nodes, hormone receptor (+) and HER-2 neg with recurrence score of &lt;25. <strong>OncoType Dx testing PROVIDED if not covered by insurance</strong></td>
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<td>NRG-BR003</td>
<td>Phase III study of adjuvant therapy comparing AC followed by weekly Taxol +/- Carboplatin for node(+) or high-risk node(-) triple-negative invasive breast cancer. If pN0, tumor must be &gt; 3.0 cm</td>
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<td>NSABP B-51</td>
<td>Phase III study evaluating post-mastectomy chest wall &amp; regional nodal XRT and post-lumpectomy regional nodal XRT in pts w/positive axillary lymph nodes before neoadjuvant chemotherapy who convert to pathologically negative axillary lymph nodes after neoadjuvant chemotherapy.</td>
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<td>A011202</td>
<td>Phase II study evaluating the role of axillary lymph node dissection in breast cancer patients (cT1-3, N1) who have positive SLN disease after Neoadjuvant chemotherapy. <strong>(MUST PRE-REGISTER/CONSENT PRIOR TO SURGERY)</strong></td>
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<td>CALGB 8070</td>
<td>A Phase III Trial of 6 vs 12 treatments of adjuvant FOLFOX plus Celecoxib/Placebo for pts w/resected Stage III colon ca. <strong>Celecoxib/Placebo PROVIDED</strong></td>
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<td>N1048</td>
<td>Phase II/III study of Neoadjuvant FOLFOX w/selective use of combined modality Chemoradiation vs preoperative combined modality Chemoradiation for locally advanced rectal cancer pts undergoing low anterior resection w/total mesorectal excision</td>
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<td>N0577</td>
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#### PROSTATE

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<td>A Multi-institutional Registry for Prostate Cancer Radiosurgery sponsored by the Florida Robotic Radiosurgery Association</td>
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| A031201 | A Phase III Trial of Abiraterone and Prednisone +/- Enzalutamide for castration resistant metastatic prostate cancer. **Enzalutamide PROVIDED**  
  **Contact:** Bonnie Harkins, RN, CCRP at 451-3647 (x63647) or cell phone 283-2789 |

### Fresno Heart & Surgical

*Continued from page 15*

testinal care, coronary intervention, and general surgery. The hospital is one of the few nationwide recognized for eight consecutive years by Healthgrades for delivering care that patients rate as exceptional. Fresno Heart & Surgical is one of four acute-care hospitals in the Community Medical Centers’ healthcare system, which partners with UC San Francisco School of Medicine, among the nation’s top five medical schools.

Erin Kennedy reported this story. Reach her at MedWatchToday@communitymedical.org.
Ask A Blood Banker: Platelet Basics

By Chelsea Tooke-Barry M.D. CRMC Blood Bank Pathologist

Editor's Note: This article is the first in a planned series of articles intended to cover a variety of interesting and pertinent topics related to platelet transfusion. Questions from readers are welcomed and highly encouraged! To submit a question relating to platelet transfusion or to suggest a future transfusion topic, please contact Dr. Tooke by email at ctooke@communitymedical.org.

Q: I’ve heard there are different kinds of platelets – what does that mean, and what kind of platelets do we have in the CMC hospitals?

A: There are two main types of platelets: single donor platelets (SDP) and whole blood derived (WBD-PLT).

First, the platelets we use at Community: SDP (aka ‘apheresis platelets', which is how they are named in the Epic order set) are obtained from a single donor. The platelets are collected via a scheduled, automated apheresis procedure. Because apheresis allows us to return the red blood cells back to the donor and remove only the platelets (and some plasma), the volume of platelets that can be collected in this manner is relatively high. The average volume of a single unit of SDP is ~200 mL, and one unit of apheresis platelets constitutes a ‘standard’ adult dose. SDP are leukoreduced at the time of collection before the units arrive at CMC – this means that providers do not need to order special leukoreduction filters prior to transfusion. The vast majority of hospitals in the United States use SDP. The platelet inventory available at CMC hospitals is leukoreduced, single-donor apheresis platelets.

The second type of platelets (not available at CMC): WBD-PLT (aka ‘5 pack’ or ‘random donor platelets’). These units are prepared from one unit of whole blood drawn by manual phlebotomy; the unit is then centrifuged and the ‘platelet rich plasma’ layer is expressed into a separate bag as WBD-PLT. Because WBD-PLT constitute a small fraction of the unit of whole blood (and because there is a limit to how much whole blood can be drawn from a donor), the volume of a single unit of WBD-PLT is small – between 40-60 mL. Several WBD-PLT units from different donors (usually 4-6) are pooled together to create one adult dose. These units are often, though not always, leukoreduced during the processing procedure. Units that have not been leukoreduced prior to transfusion may require bedside leukoreduction filters. Currently, only a few blood suppliers in the United States distribute WBD-PLT, and only a handful of institutions use them.

Q: Is there any significant difference between WBD-PLT and SDP?

A: Clinical response to transfusion, measures of platelet function, and in vivo efficacy of both products is equivalent. The unit volumes and platelet counts are also roughly equivalent (each unit contains ≥3 x 10^11 platelets). WBD-PLT and SDP units undergo the same quality control and infectious disease testing. Importantly, as long as the WBD-PLT units have been leukoreduced (either during processing or at bedside), there is no difference in the rates of HLA alloimmunization or the incidence of febrile reactions.

Q: I notice that occasionally, platelets are in short supply. This doesn't seem to happen with other blood products. Can you explain why this occurs?

A: Unlike RBC (which are refrigerated for up to 42 days) and FFP/cryoprecipitate (which can remain frozen for up to 12 months), platelets must be stored at room temperature in order to maintain their functional properties. However, storage at room temperature also increases the risk for bacterial proliferation in the platelet unit – and therefore increases the risk of transfusion-transmitted sepsis. In order to reduce the risk of bacterial proliferation during room temperature storage, platelet units have a shelf-life of 5 days.

Because of this short shelf-life, changes in platelet supply and/or platelet demand can have a significant impact on platelet availability. Most commonly, these situations occur in the days following major U.S. holidays (Thanksgiving, Christmas, New Year’s) when many apheresis platelet donors are unavailable to keep their regularly scheduled donation appointments. Despite the unavailability of donors during this time, demands for platelet transfusion continue and shortages can occur. Because platelet shortages are most likely to occur in the 1-2 days following a major holiday, it is recommended that elective surgeries which have a reasonable See Platelet on page 18
change of platelet usage be scheduled later in the week, when any shortage is likely to have resolved.

**Q: As I plan my platelet orders – what is the standard dose to keep in mind?**

**A: The standard adult dose for platelet transfusion is one unit of SDP (apheresis platelets). Pediatric dosing for platelet transfusion is 5-10 mL/kg body weight. Randomized clinical trials comparing a standard one-unit dose to a 2 unit dose (“high dose”) have shown that a larger dose of platelets does not reduce the risk of bleeding in thrombocytopenic patients. (Interested readers may refer to: Blood. 2009; 113(7):1564 and N Engl J Med. 2010;362(7):600).**

This is particularly pertinent for CRMC, given the many multi-unit platelet requests that our blood bank receives. Recent data from the Strategic Blood Management group reflects this multi-unit ordering trend. When platelet usage at CRMC is benchmarked against platelet usage in other institutions nationwide (with similar MSDRGs), an “opportunity gap” becomes apparent. This opportunity gap (the number of units that could potentially have been saved through closer adherence to published transfusion guidelines) is 632 units of platelets over the course of 12 months (Jan 2014-Jan 2015). Closer adherence to our facility transfusion guidelines, and use of the standard one unit transfusion will help us to close this opportunity gap – and most importantly – will reduce the risks of transfusion-related morbidity for our patients.

**Q: How much can I expect the platelet count to increase following a standard one unit platelet transfusion?**

**A: On average, the standard one unit transfusion is expected to increase the platelet count by approximately 30,000/uL (range 20,000-50,000/uL). Most transfusion-naive patients can be expected to respond appropriately to platelet transfusion. However, certain patient populations (including parous women and multi-transfused patients) are at risk for suboptimal responses (also known as transfusion refractoriness). The topic of platelet transfusion refractoriness will be covered separately in an upcoming newsletter.**

**Q: When should I consider transfusing platelets to my patient?**

**A: Platelet transfusions are utilized to reduce bleeding-related morbidity and mortality and can be either therapeutic or prophylactic in nature. Indications include significant thrombocytopenia and/or platelet dysfunction. General guidelines are summarized below and are also reflected in CMC’s standard transfusion order set. For more comprehensive platelet transfusion guidelines, see CMC medical staff Transfusion Guidelines, AABB’s Clinical Practice Guidelines published November 2014 and the Platelet Transfusion section of uptodate.com serve as additional resources.**

- For actively bleeding patients with thrombocytopenia or for bleeding prophylaxis in patients who will be undergoing major non-neuraxial invasive procedures, platelet transfusion should be considered when platelet count is <50,000/uL.
- Platelet transfusion for patients with intracranial, pulmonary, or ophthalmic hemorrhage or patients who are undergoing invasive neuraxial procedures should be considered when platelet count is <100,000/uL. Co-existing coagulopathy may influence these thresholds. Platelets are a standard part of our Massive Transfusion Pack (5 RBC, 5 plasma, 1 PLT).
- For prophylactic transfusion due to therapy-induced hypoproliferative thrombocytopenia in patients who are otherwise clinically stable and not bleeding, transfusion should be undertaken when platelet count is <5,000-10,000/uL. (Certain risk factors may push this threshold higher).
- A variety of thrombocytopathies exist and can be congenital (Glanzmann’s thrombasthenia) or acquired (medication related, ECMO, cardiac bypass, uremia). Routine prophylactic transfusion is not indicated for patients with thrombocytopathy; instead, the decision to transfuse these patients should be based on the patient’s clinical status and should also take into account any planned invasive procedures.

As always, the benefits of platelet transfusion must be weighed carefully against the risks inherent to transfusion – and transfusion should always be based on best clinical judgment.
Medication Safety Practice Alert

Patient Safety: Use of Filter Needles/Straws with Glass Ampules

The purpose of this flyer is to warn you of the potential hazards of administering medications from a glass ampule without using a filter needle or filter straw.

Why is this an issue? I have never used a filter needle when drawing up medication from a glass ampule.

Glass fragments can enter the ampule when it is opened. If drawn up without a filter needle/straw, small glass particles can pass through into the syringe. These glass particles can cause damage to the liver, kidney, lungs and spleen. Glass fragments have caused adult respiratory distress syndrome, pulmonary artery granuloma in infants, impairment of microcirculation and phlebitis.

How do I properly open the ampule and use a filter needle/straw?

1. After proper hand hygiene and donning gloves, wipe the neck of the ampule with an alcohol swab. Allow the alcohol to dry (about 1 minute), use a gauze pad and grab the neck of the ampule, break the ampule (use quick and firm pressure). Proper aseptic technique is required to prevent microorganisms from entering the ampule.

2. Place the opened ampule on a flat surface.

3. Remove the cover from the filter needle, attach to a syringe and insert the needle/straw into the fluid. Pull back on the plunger and withdraw the medication. (NOTE: keep the tip of the needle/straw below the surface of the medication.)

4. Remove the filter needle/straw and administer the medication.

My area does not stock filter needles. How do I get them stocked?

The needles can be ordered through Materials Management using the following ordering codes:

- For filter needle (19 gauge) FN 5119
- For filter straw (4 inches long, used for larger ampules) FS 5000
It’s been quite an interesting summer, for many reasons, particularly if you follow the news. Although it is easy to get caught up in the endless stream of mass media and social media available at the tap of a screen, there is occasionally an informative, insightful, or just plain important development that crawls across the screen to warrant noting in real time. This is certainly the case with clinical toxicology, where a number of recent developments have caught the attention of not only the subspecialty but the public at large. Here are a handful of the news stories that gave us a glimpse of the diversity and current challenges in clinical toxicology.

**Man Takes Selfie with Snake – and Almost Loses Hand.** This story is still unfolding as I type, but the headlines are from right next door in Southern California's Lake Elsinore Region. The snake in question was indeed a rattlesnake, which injects a potent venom capable of destroying local tissues as well as inhibiting normal coagulation mechanisms. While the majority of these wounds heal eventually, and antivenom can be used to halt the progression of the injury, complications of necrosis, infection, and surgical emergencies such as fasciitis have been described following these envenomations. Ill-advised first aid maneuvers can also adversely impact the bite related injury, so it is critical to present to appropriate medical care as soon as possible after any animal bite especially in the wilderness. ([http://www.latimes.com/local/lanow/la-me-ln-lake-elsinore-snake-bite-20150826-story.html](http://www.latimes.com/local/lanow/la-me-ln-lake-elsinore-snake-bite-20150826-story.html))

**Poisonous Explosions Rock a Major Port City in China** – The industrial transportation hub of Tianjin, on China’s southeastern coast, was the site of a horrific duo of night-time blasts in mid-August. The resulting contamination of air, soil, and water has revealed high levels of sodium cyanide among other chemicals which were stored or transported at the damaged sites. Compounding the tragedy of deaths and injuries among those who lived and worked perilously close to these chemical stores is the frustration of citizens who lack a clear narrative about what happened and who was responsible for this horrific incident. The problem is not an isolated issue for China alone – poor oversight and lack of disaster planning plague many industrializing nations, and one hopes that this widely covered story will alert those in control over hazardous occupations to conduct future enterprises with a cautious regard for human safety. ([http://www.theguardian.com/world/2015/aug/16/tianjin-blasts-sodium-cyanide-on-site-may-have-been-70-times-allowed-amount](http://www.theguardian.com/world/2015/aug/16/tianjin-blasts-sodium-cyanide-on-site-may-have-been-70-times-allowed-amount))

**Abandoned Mine in the Southwest Floods a River with Heavy Metals** – Three million gallons of water were...
Tox Tidbits
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released when a poorly maintained dam at a mine abandoned in the 1920s was dislodged during a clean-up project. Quite suddenly, the plume of water contaminated with arsenic, lead, copper, aluminum and cadmium discolored the Animas River a metallic yellow, and affected waterways in the four corners-region states. Most surprising of all was that the responsible agency was not a private contractor, it was the EPA itself. To their credit, the EPA has done an admirable job in many other mine clean-up operations, and the mine and river in this particular case were chronically polluted areas to begin with. Fortunately, public health authorities were able to alert populations on the riverways to avoid swimming in or drinking the water in the short-term. However, the disaster has reminded everyone it clear that major accidents can and do happen with hazardous materials, with environmental impacts that can unfold for months or years. As with the China port disasters, this crisis provides many real-world lessons that will have ripple effects for a whole range of hazardous occupations and agency policies. (http://www.theatlantic.com/national/archive/2015/08/a-river-runs-yellow/401966/)

How Dry I am: Powdered Alcohol Is Raising Concerns – A product called “Palcohol” was released to delight of fraternities everywhere and the frustration and anger of just about everyone else. Many parents and physicians have raised questions about why the FDA did not take stronger measures to curb the release of yet another intoxicant aimed at young adults and teenagers, but this episode only reveals the many inconsistencies and loopholes that characterize our society’s complicated and industry-influenced relationships to intoxicating substances. The powder itself is not yet widely available, but the manufacturer plans to market it as a light weight alternative to carrying bottles of booze—you add water to the flavored powder once you arrive at the party destination. An accident waiting to happen, it is already clear that this product and others like it will appeal to underage consumers, just like e-cigarettes have, and potentially open the gateway to more dangerous habits. (http://www.forbes.com/sites/alicegwalton/2015/03/13/powdered-alcohol-palcohol-sounds-like-an-accident-waiting-to-happen)

Ecstasy, MDMA, and Molly – Whatever the form, the effects are still potentially fatal. Numerous articles and public health bulletins have been released in recent months about the advent of newer drugs of abuse and the resurgence of older ones. One of our own EM and toxicology faculty, Dr Patil Armenian, was quoted in the Washington Post in an update about the stimulant drug MDMA (3,4-methylenedioxymethamphetamine), now making the street rounds in the guise of purified, powdered substance called Molly (short for “molecule,” get it?). All biochemistry references aside, there are now reports aplenty of fatalities and severe complications due to the ravaging effects of this potent excitatory drug. High-grade forms of MDMA are difficult to detect with conventional toxicology assays, and yet they can impact a number of brain neurotransmitter systems like dopamine, serotonin, and norepinephrine. While users seek euphoria, hallucinations and enhanced energy from the drug, the toxic affects can quickly overwhelm and incapacitate the patient, resulting in cardiac ischemia, dysrhythmias, seizures, kidney injury, hepatitis, hypertensive complications, and rhabdomyolysis. Sadly, mass casualties are frequently reported because it is a party drug, and typically distributed online and at rave dance parties. Like amphetamine (which is the parent compound of the MDMA), this drug is creating havoc, and controlling its use will take careful coordination between young people, parents, health care practitioners, law enforcement personnel and public health agencies. In other words, don’t be tardy for the party—get informed, educate those you care for, and contact poison control or our in-house toxicology service for further guidance. (http://www.washingtonpost.com/national/health-science/molly-a-form-of-mdma-or-ecstasy-can-cause-fatal-reactions/2015/07/27/7962da10-111e-11e5-9726-49d6fa26a8c6_story.html)
CME Webinar: Medical Ethics and Physician-Patient Encounters

Editor's Note: The broad territory of Physician-Patient Encounters holds many elements for successful care outcomes but it also holds some of major ethical and moral hazards for Physicians. Quite simply, this is always a highly relevant topic for physicians at any stage in their career.

Please join NORCAL Mutual Insurance Company for a free live CME event presented by Senior Risk Management Specialist Josh Hyatt, DHSc, MHL, CPHRM. This CME webinar is for NORCAL Mutual policyholders and other interested physicians and healthcare providers. You do not have to be a NORCAL or Medicus policyholder to register for this webinar.

Learning Objectives
By reviewing common allegations and risk issues associated with ethics, this presentation will support your ability to:

- Differentiate and identify the behaviors that constitute ethical behavior, personal conflicts and professionalism.
- Identify and apply bioethical principles in healthcare settings.
- Apply ethical best practices to improve patient safety and reduce overall liability that focuses on identifying, responding to, investigating and monitoring ethical behaviors.

Register Now!

Tuesday
September 22, 2015
3:30 PM to 5:00 PM EST
Click here to register!

or

Tuesday
September 22, 2015
6:00 PM to 7:30 PM PST
Click here to register!

NOTE: Print readers can register at www.norcalmutual.com/risk-management-events

CME Information and Disclosure
NORCAL Mutual Insurance Company is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
NORCAL Mutual Insurance Company designates this live activity for a maximum of 1.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. The faculty for this activity, Josh Hyatt, has no relevant financial relationships to disclose. The planners for the activity Paula Snyder, RN (Regional Manager, Risk Management, NORCAL), Christina Cassady, RN (Regional Manager, Risk Management, NORCAL) and Jo Townson (CME Manager, NORCAL) have no financial relationships to disclose.
Editor’s Note: We have covered diagnostic error previously in this publication (and through CMC’s CME program), but this topic is evergreen for our readers. Diagnostic error continues to attract much attention from public policy experts, accrediting bodies, and the public. The influential Institute of Medicine will publish a report on diagnostic error later this year, which is sure to raise awareness to an even higher level.

The August issue of NORCAL Mutual’s Claims Rx publication featured several legal cases where diagnostic error was alleged. With permission we have excerpted some of it below. NORCAL Mutual policy holders can access the complete August ClaimsRX CME publication with case studies by logging into your account at norcalmutual.com.

It’s hard to measure how frequently diagnostic errors occur and how significantly they reduce patient safety. First, there is the problem of differentiating a diagnostic error from a thorny diagnostic process. Then, there is the challenge of identifying actual errors for analysis (with the aim of limiting or, ideally, eliminating them). Articles in medical literature have pointed out these difficulties, noting a number of ways to attempt studies of diagnostic errors, including using autopsy results, reviewing medical records, requiring incident reports for all potential errors and scrutinizing them, surveying physicians about errors, and extrapolating from outcomes of investigations using simulated patients. Assessment of medical malpractice claims data is identified in medical literature as another way to study diagnostic errors. Many studies of malpractice claims data find that diagnostic error is the most common reason a claim is filed and the most costly malpractice allegation.

Figure 1 summarizes NORCAL’s most recent 5-year experience of closed claims related to diagnostic error (2010-2014). Published studies on medical error claims in the US show similar findings (eg, BMC Health Sciences Research, 2013).

Behavioral scientists have long been fascinated by the mental slips and biases that drive cognitive error. As well, systems flaws frequently contribute to errors in complex environments. Health care providers are well advised to retain self-awareness of these predisposing factors and to develop strategies to counteract them. The NORCAL publication featured this excellent summary of cognitive and systems risk management strategies:

Risk Management Recommendations
Cognitive Strategies
- Be aware that all humans are subject to certain cognitive processing biases and that for physicians, these biases can contribute to diagnostic errors.
- Establish a differential diagnosis; develop a routine of asking yourself “what else might this be?” in diagnostic situations.
- Consider various alternatives for a patient’s symptoms, “even though you are sure of your first diagnosis.”
- Ask yourself what the worst possible diagnoses would be for a patient with the same symptoms.
- Consider that a patient may have comorbidities or multiple disease processes occurring at the same time.
- Consider less common diagnoses: One author offering tips for avoiding diagnostic errors advises that while “common disorders occur commonly,” physicians should also “consider (although not necessarily test for) less common disorders when evaluating a patient.”
- Document your analysis.
- Practice taking brief but reflective diagnostic “time-outs” to think about possible alternative diagnoses and to “get a second opinion from your own conscious mind.”

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Diagnostic Error

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- When faced with an ambiguous diagnostic situation, consider reexamining and questionering the patient, rereading the medical history and other medical record notes, and taking other steps to gather additional information.
- When a patient’s symptoms do not respond to treatment, continue to search for a diagnosis.
- If you are confused about a diagnostic situation or if you cannot reach a definitive diagnosis, consider referring the patient to another physician for assessment. Communicate well with the consultant physician by sending him or her pertinent clinical information and a summary of why the patient is being referred. Talk with the consultant on the telephone if there is a need to clarify any aspects associated with the referral.
- Use electronic health record (EHR) tools for diagnostic help if they are available. Diagnostic support logic, tools that help with development of differential diagnoses and information about evidence-based guidelines are often built into EHR systems.
- If you receive feedback that indicates you missed a diagnosis (from a morbidity and mortality conference, autopsy results, etc.), take steps to identify and address any knowledge or training deficits you have by reading articles, conferring with colleagues and participating in continuing medical education activities.

Systems Strategies

- Ensure there is an established, reliable follow-up process for managing tests and consults for your practice. If you are part of an organization, and you think the follow-up process for your organization is lax, be a “squeaky wheel” advocating for development of a better process.
- Realize that slack follow-up systems are widespread and are seen even in sophisticated and otherwise high-quality practices and organizations. (One study found that “failures to inform patients of clinically significant abnormal test results occurred in one of every 14 tests.”10) Establishing a set of dependable processes will boost patient safety.
- Bear in mind that relatively simple and low-cost measures will increase the effectiveness of test results management. For example, one article advocates incorporating these features: “(1) all results are routed to the responsible physician; (2) the physician signs off on all results; (3) the practice informs patients of all results, normal and abnormal; (4) the practice documents that the patient has been informed; and (5) patients are told to call after a certain time interval if they have not been notified of their results.”
- Use technology tools in EHRs to facilitate good follow-up.
- Remember that simply automating poor processes will not fix inherent process problems.
- As close in time as possible to each patient interaction, document completely and accurately the care and assessments you render. Document so that the assessments and analyses leading up to diagnoses are clear.

When the IOM Report on Diagnostic Error is published, we will provide coverage – though we suspect readers will soon be well aware of it as it will be of much interest to both professional and lay media outlets.

Choosing Wisely

An initiative of the ABIM Foundation

Our progress through the many specialty societies’ Choosing Wisely lists will resume next month. In the meantime nearly every physician and mid-level is guaranteed to find information relevant to your patients and your common and important practice choices at choosingwisely.org.
Melanoma: A Family’s Loss Leads to Advocacy for Melanoma Avoidance and Awareness

An Invited Essay by Sarah Siemens

The palliative care doctor entered my mother’s hospital room at Community Regional Medical Center. He had a certain air about him, somber but friendly – like he’d done this before. My 48-year-old mother was dying of stage IV metastatic melanoma and our goal had rapidly switched from helping her fight for her life to making her comfortable until the end of it. She died four days later.

My mother, Mary, was first diagnosed with melanoma skin cancer in December of 2012. Our family’s initial perception was that skin cancer was highly treatable, an accurate perception for certain types of skin cancer, but my mother happened to develop the exception to the rule. The doctors and specialists warned us of the dangers of the WebMD spiral. “Don’t google melanoma,” they advised. “You’ll be discouraged by the statistics and your mother is not a statistic.” Fair enough, I thought. But I was much too stubborn and curious to stay away from researching the disease that was now defining a piece of my family’s history. The phrase seemed to punch me in the stomach – skin cancer is the most preventable type of cancer. Yet, it’s the fastest growing in the United States.

Admittedly, my mother had spent her entire youth in the sun, enjoyed indoor tanning, and worked in the yard without a hat or sunscreen. But she had grown up in a time where larger society believed that that kind of sun and UV exposure provided certain health benefits, such as Vitamin D. We now know that we get plenty from a healthy diet and running our daily errands. However, I couldn’t help but wonder whether other melanoma patients and their families felt the same way as we had – as though lifesaving information had been withheld. What if we knew back then what we know now about UV exposure? Would we have been more responsible with the usage of sunscreen? Would we have said no to indoor tanning? It’s impossible and ultimately detrimental to look back with the hope of changing the past. We can only move forward with the information and experience we now have.

I awoke one morning in August 2014 with one thing on my mind: I needed to destroy the tanning bed that my mother had used. I purchased it within the next month with the help of family and friends. Print readers can search “Fresno Bee Fresno woman is on a sun safety mission”. And here is Ms. Siemens’ video plea to the public (including footage of that tanning bed being blown to bits). Print readers can search “Stay the hell away from tanning beds”.

At the same time this story was printed in the Bee, several sets of disturbing US melanoma incidence data were published. These are summarized in the next article. We asked Sarah Siemens to provide an introduction to our coverage of these studies. Accompanied by a photo that captures her mom’s love of life and one of the permanently “decommissioned” tanning bed, here’s what this daughter wants to tell us.
Melanoma

Continued from page 25

friends. Close to my mother’s 49th birthday, we gathered together to celebrate her life and make a statement about skincare and sun safety. The tannerite inside the tanning bed lit with a bang and sent the doors flying in different directions. We cheered knowing that one of the most carcinogenic machines would no longer be in service. You can see the full mini-documentary at www.sunblocked.org.

Now is the time for change and education. Ultimately, it’s the prerogative of each individual to choose how they will treat their skin. But there is no power to choose if we do not have the education. We are spending billions of dollars on melanoma treatment and the costs are only going to increase if we do not focus on preventative measures. The advances that the healthcare industry has made in skin cancer treatment is encouraging and my hope is to see the same advances in preventative care, thus reducing spending and suffering. As health care professionals, I urge you to make sun safety and skin cancer awareness a priority for your patients, your communities, and even for your own families. The most troubling statistic is that a person dying from melanoma loses an average of 20.3 years of life. That alone is staggering, but behind those statistics are the people we love whose lives are being cut short by the most preventable type of cancer. We owe it to ourselves and those we love to commit to a sun safe lifestyle.

Thank you to those of you who have dedicated yourselves to excellent medical care. I still remember the face of the nurse who held my mother’s hand as she died. You are involved in courageous work and it is not a small task. Let’s continue to push sun-safe education and skin cancer preventative care to the top of our lists.

More information on Melanoma on the next page

Editor’s Note: The health dangers posed by tanning beds have led many states and municipalities to restrict their use. The WHO categorizes tanning beds into its highest cancer risk category – “carcinogenic to humans.” FDA has stepped up regulation and requires a permanent black box warning on machines advising against use for minors. There is no “safe” tanning bed dose and youths are especially susceptible to their UV radiation.

Here is the current status of state tanning bed regulation, with California among those prohibiting tanning for minors:

State Tanning Device Restrictions

How Do You Measure Up?

Sources: Health Policy Tracking Service & Individual state bill tracking services

- State law prohibiting tanning for minors (under age 16) with no exemptions.
- State law prohibits tanning for those under 17 (NV, NJ, CT, PA), or under 16 (WA, IN). State law requires parental accompaniment for every visit for those under 18 (UT), allows for physical prescription under 18 (OR, WA), or prohibits tanning for under age 18 unless a signed parental permission slip is obtained for every two visits (RI).
- No state law regarding tanning (indicated with an *), state law prohibits those 14 or 15 or under, law allows for signed parental permission, or law requires parental accompaniment for every visit under 16 or younger.
New Data Show Disturbing Melanoma Trends

Editor’s Note: The preceding essay and photos from Sarah Siemens put a human face on melanoma. Many of our readers can do the same based on your own circle of family and friends. The trends are not favorable at the national level. Poignant personal stories about devastating outcomes from mostly preventable tumors are powerful, but population data should be even more compelling to professionals. If you are in a position to advise patients about sun and tanning safety and melanoma awareness, please join Ms. Siemens in that effort.

CDC’s June 5, 2015 Morbidity and Mortality Weekly Report documented a doubling of melanoma incidence rates between 1982 and 2011. The analysis went on to project that a comprehensive skin cancer prevention program in the US could prevent 20% of melanoma cases in the future – a total of 230,000 cases between 2020 and 2030. Here is that abstract and several of the figures:

Vital Signs: Melanoma Incidence and Mortality Trends and Projections United States, 1982-2030

By Gery P. Guy Jr. Ph.D.; Cheryll C. Thomas M.S.P.H.; Trevor Thompson; Meg Watson M.P.H.; Greta M. Massetti Ph.D.; Lisa C. Richardson M.D.

Abstract

Background: Melanoma incidence rates have continued to increase in the United States, and risk behaviors remain high. Melanoma is responsible for the most skin cancer deaths, with about 9,000 persons dying from it each year.

Methods: CDC analyzed current (2011) melanoma incidence and mortality data, and projected melanoma incidence, mortality, and the cost of treating newly diagnosed melanoma through 2030. Finally, CDC estimated the potential melanoma cases and costs averted through 2030 if a comprehensive skin cancer prevention program was implemented in the United States.

Results: In 2011, the melanoma incidence rate was 19.7 per 100,000, and the death rate was 2.7 per 100,000. Incidence rates are projected to increase for white males and females through 2019. Death rates are projected to remain stable. The annual cost of treating newly diagnosed melanoma was estimated to increase from $457 million in 2011 to $1.6 billion in 2030. Implementation of a comprehensive skin cancer prevention program was estimated to avert 230,000 melanoma cases and $2.7 billion in initial year treatment costs from 2020 through 2030.

Conclusions: If additional prevention efforts are not undertaken, the number of melanoma cases is projected to increase over the next 15 years, with accompanying increases in health care costs. Much of this morbidity, mortality, and health care cost can be prevented.

Implications for Public Health Practice: Substantial reductions in melanoma incidence, mortality, and cost can be achieved if evidence-based comprehensive interventions that reduce ultraviolet (UV) radiation exposure and increase sun protection are fully implemented and sustained.

The rising rate of melanoma in the young is particularly disturbing and was most recently documented in this ASCO (American Society of Clinical Oncology) Post from May 30, based on an abstract at the recent ASCO Annual Meeting:

ASCO 2015: Melanoma Rates Dramatically Increasing in Children and Young Adults

The incidence of melanoma has increased by more than 250% among children, adolescents, and young adults since

See Melanoma Trends on page 28
Melanoma Trends

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1973, according to research to be presented by Roswell Park Cancer Institute (RPCI) on June 1 at the 2015 ASCO Annual Meeting (Abstract 9058) in Chicago. The research has been recognized with an ASCO Merit Award.

“Given the epidemic rise of melanoma cases diagnosed among children, adolescents, and young adults, it is imperative that new research initiatives are implemented, genetic and environmental risk factors identified, and effective prevention and screening strategies employed,” said Demytra Mitsis, MD, lead author of the study and a Fellow in the Department of Medical Oncology at Roswell Park.

Study Findings

Analyzing Surveillance, Epidemiology, and End Results Program (SEER) data, Roswell Park scientists determined that the number of cases of melanoma diagnosed in children, adolescents, and young adults increased by 253% from 1973 to 2011. However, survival rates also have increased – from 80% for the period 1973 to 1980 to 95% in 2011. Female young adults appear to be at particular risk for melanoma, a trend that may be due to known risk factors such as the prevalence of tanning.

The SEER data analysis included 35,726 cases of melanoma identified among individuals younger than 40 years of age from 1973 to 2011. Dr. Mitsis and colleagues found that 98% of the melanoma cases were diagnosed among adolescents and young adults (aged 15–39 years), with a median age of 32 years. Females comprised 57% of reported cases from 1973 to 1980 and 65% of reported cases from 2001 to 2011. The evaluation revealed that the proportion of noninvasive, early-stage melanoma cases increased from 4% of cases for the period 1973 to 1980 to more than 20% of all melanoma cases in 2011.

“The reality is that melanoma is the third most common cancer in those 15 to 39 years old, and these numbers have been steadily increasing. This is a national problem that needs to be addressed, and it begins with awareness and effective prevention strategies,” added senior author Nikhil Khushalani, MD, Section Chief for Soft Tissue and Melanoma at Roswell Park.

Concerns regarding the well-being of physicians is garnering increased attention throughout the United States. The availability of articles and workshops on this topic is expanding. Doctor stress and burnout is a frequent area of discussion among medical staffs and residencies. We have a wonderful local opportunity for physicians to learn tools for coping with the pressures and demands of being an effective healer. I encourage members of the CMC Medical Staff to attend this meeting. See informational information on page 30.

– Rick Adams, PhD, Chair, CMC Medical Staff Well Being Committee

Physicians are at a higher risk than other professional to suffer from burnout and its serious manifestations. Community Medical Centers’ Physicians are no exception.

Below is an article, which describes the risk factors and key strategies to address this issue. Please find on page 30 of this issue an invitation to the Fresno Madera Medical Society’s September 24 evening seminar on Physician Well Being.

This article is reprinted from the AMA Wire Published August 7, 2015.

8 Things That Can Put You at Risk of Burnout

As a physician, you have a higher risk of burnout than your peers in other professions – in fact, nearly one-half of physicians say they feel burned out. Depending on your lifestyle, practice type and other factors, you may be at an even higher risk of developing burnout. Learn the risk factors, and what you can do to prevent burnout.

According to a free online module (www.stepsforward.org/modules/improving-physician-resilience), part of the AMA’s STEPS Forward website (www.stepsforward.org), evidence shows stressed, burned-out physicians have:

• Lower patient satisfaction scores
• Higher rates of medical liability suits
• Increased likelihood of leaving the profession
• Tendency to make more medical errors
• Greater likelihood of exhibiting disruptive behaviors

Who is more likely to be burned out? Physicians who feel high degrees of stress at work, often brought on by time pressure, lack of control, chaotic work environment or lack of values alignment with leadership, are at risk of burnout. Conversely even in high demand jobs, strong
Burnout

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support in doing the work and significant control over the work can protect against burnout.

Physicians who experience the following factors are more likely to be burned out:

1. Demanding workload
2. Number of nights on call
3. A partner who also is a physician
4. Children to raise
5. A medical error made recently
6. Midway through their medical career
7. Conflicts between work and home
8. Less than 20 percent of their time is spent on the most meaningful aspects of work

Delve deeper into burnout risk factors with the seven signs of added stress that physicians should know.

For male physicians, the risk of suicide is up to three times the risk of suicide for non-physicians, according to a consensus statement (www.ncbi.nlm.nih.gov/pubmed/12813122) on physician depression developed by experts on the subject. For female physicians, it’s even worse – this risk increases up to five times.

What can physicians do? There are two main strategies for combatting burnout: You can do so internally by improving your own resiliency. And you can do so externally by making changes at the practice level to improve efficiency and make time for the most important part of being a physician – caring for your patients.

Two modules in the AMA’s STEPS Forward series take on both sides of the problem:

The first module (www.stepsforward.org/modules/improving-physician-resilience) shows you how to improve your own resiliency. You’ll learn how to start small and gradually increase your hardness against stress, ultimately improving yourself and your practice.

The second module (www.stepsforward.org/modules/physician-burnout) explains how to prevent burnout in your practice. You’ll read real-life ways physicians across the country improved patient satisfaction, quality outcomes, and clinician recruitment and retention.

The modules also offer continuing medical education credit.

Preventing physician burnout is a priority for the AMA’s Professional Satisfaction and Practice Sustainability initiative, which aims to help physicians and their practices thrive so they can continue to put patients first. Stay tuned to AMA Wire® for more ways to improve your resiliency and prevent burnout in your practice.

Submit your ideas: Practice Innovation Challenge

These two modules on boosting resiliency and preventing burnout and the 14 others available on the STEPS Forward website are only the beginning. The AMA and the Medical Group Management Association are partnering to conduct the Practice Innovation Challenge (www.innovatewithama.com), which seeks the best proposals from physicians and entrepreneurs.

If you’re an out-of-the-box thinker, submit your ideas, experiences and learnings by Sept. 1. Submissions that are selected as easy-to-adopt, transformative medical practice solutions will be developed into future STEPS Forward modules and will be eligible to win one of several $10,000 prizes.

More than 25 modules are expected to be available by the end of the year.

Dr. Ron Workman had a distinguished career at Community Centers as a Pathologist and Laboratory Medical Director. Ron moved away some years back, and he recently passed away too young at age 68. It is fitting – in a Well Being context and in view of Ron’s many years of service at Community – to pass along this part of a note from his widow, Diana.

“Ron valued his professional friendships over the years and enjoyed his time in Fresno. He wants all of us to follow his life lessons: To always reach higher; to say kind and caring words; and to show more patience and generosity than expected.”
“Staying Sane, Satisfied and Effective in Medicine & Life”

All Physicians Invited
Thursday September 24, 2015
Fort Washington Country Club
10272 N Millbrook, Fresno
Required R.S.V.P. by Sept. 21
(559) 224-4224 ext. 118 or
csrau@fmms.org

Keynote Speaker
Linda Hawes Clever, M.D., MACP, is founder
and president of the not-for-profit RENEW
(www.renewnow.org), Clinical Professor of
Medicine at UCSF, and member of
the National Academy of
Medicine. She is
considered an
expert on the
well-being
and professional
renewal of
physicians and
other health care providers. She is author
of “The Fatigue Prescription: Four Steps to
Renewing Your Energy, Health and Life”.

“In order to do well, you have to be well.”

4-6 p.m. Leadership Workshop
“Life Preservers for Leaders”
(for Medical Staff Executive Committee members, Department Chairs, Well Being
Committee members, Hospital Administrators)

Dr. Clever will provide clarity and sound advice to those in leadership
positions in order to be at the top of their abilities.
- Establish effective and healthy clinical and administrative settings
- Evaluate situations in order to assure access to relevant information
- Explore the best approaches to dealing with competing demands

5-7 p.m. Exhibitor Reception & Networking

7 p.m. Physician Dinner Meeting & Keynote Presentation
“Staying Sane, Satisfied and Effective in Medicine & Life”

So much to do, so little time. Rarely enough time to relax and just be.
Or maybe even sleep. Always the possibility of making a mistake.
Relentless pressure and change. What kind of life is this? Is there
anything to do about it? Yes indeed.

Fresno-Madera
Medical Society

Co-Sponsored by
**Annual Lung Nodule Conference**

**Title:** “Diagnostic Reform in Lung Nodules”  
**Date:** Saturday, September 12, 2015  
**Speakers:** Daya Upadhya M.D., Michael Peterson M.D., Kathryn Bilello M.D., William Siveira M.D., Binh Trinh M.D. and Pravachan Hegde M.D.  
**Time:** 8am-1pm  
**Place:** UCSF Fresno Auditorium  
**Contact:** Kathy Norkunas RN, 559-224-5864 or E-mail: knorkunas@communitymedical.org  
**CME:** 4.75 hrs

**Pédiatric Lecture Series**

**Date:** Tuesday, September 15, 2015  
**Title:** “Interventional Radiology”  
**Speaker:** Trevor Davis M.D.  
**Time:** 12:30-1:30pm  
**Place:** CRMC – 10 West Conference Room  
**CME:** 1 CME

**Perinatal M & M**

**Title:** “Preterm Premature Rupture of Membranes”  
**Date:** Wednesday, September 16, 2015  
**Speakers:** Corrina Liu M.D., Philip Cheng M.D., Subhasini Ladella M.D.  
**Time:** 12:30-1:30pm  
**Place:** UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 136  
**Contact:** Bernadette Neve, 459-7059  
**CME:** 1 CME

**Title:** “CMQCC/CPQCC Data Review for Mothers and Neonates 2012-2014”  
**Date:** Wednesday, October 21, 2015  
**Speakers:** TBD  
**Time:** 12:30-1:30pm  
**Place:** UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 136  
**Contact:** Bernadette Neve, 459-7059  
**CME:** 1 CME

**Title:** “Ethics and Guidelines for the Management of Extremely Premature Babies”  
**Date:** Wednesday, November 18, 2015  
**Speakers:** TBD  
**Time:** 12:30-1:30pm  
**Place:** UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 136  
**Contact:** Bernadette Neve, 459-7059  
**CME:** 1 CME

**Save the Date**

**Title:** “Central Valley Concussion Symposium”  
**Date:** Saturday, October 17, 2015  
**Speakers:** Rick Lembo, Jennifer Crocker, Paul Ullucci, David Harrington, Najdat Atallah, Terry Hutchison and Fran Pomaville  
**Time:** 7:30am-4:00pm  
**Place:** UCSF Fresno Auditorium  
**Contact:** Melissa Smith, 459-2728 or E-mail: msmith7@communitymedical.org  
**CME:** 5.5 hrs

**CCMC Presents:**  
**SAVE THE DATE**

**Title:** “Atrial Fibrillation Today: An Update in atrial Fibrillation Treatment and Medications”  
**Date:** Thursday, October 8, 2015  
**Speakers:** Michael Gen M.D.  
**Time:** 12:30-1:30pm  
**Place:** H. Marcus Radin Conference Center – The Palm Room  
**Contact:** Jessica Lipsius 559-324-4002 or E-mail: jlipsius@communitymedical.org  
**CME:** 1.0 applied for

**Clovis Perinatal M&M**

**Title:** “Congenital Diaphragmatic Hernia: Prognosis, Treatment and Repair”  
**Date:** Tuesday, October 20, 2015  
**Speakers:** Anand Rajani M.D. and David Hodge M.D.  
**Time:** 12-1pm  
**Place:** CCMC Outpatient Care Center Conference Room  
**Contact:** Becky Avila, RN 559-324-4937 or E-mail: ravila2@communitymedical.org  
**CME:** 1 CME

**Title:** “Reducing Preterm Births: Applying Current Interventions and Learning How Labor is Initiated”  
**Date:** Thursday, November 12, 2015  
**Speakers:** Joe Leigh Simpson M.D.  
**Time:** 6-7:30pm  
**Place:** H. Marcus Radin Conference Center – The Palm Room  
**Contact:** Jessica Lipsius 559-324-4002 or E-mail: jlipsius@communitymedical.org  
**CME:** 1.5 applied for

Please also see the enclosed individual flyers for more on these & other upcoming local CME activities to meet your CME needs.
Perinatal M & M Presents:

“Preterm Premature Rupture of Membranes”

Wednesday, September 16th, 2015 from 12:30pm – 1:30pm

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

Case Presentation
Obstetrics: Dr Corrina Liu
Neonatologist: Dr. Philip Cheng
Perinatologist: Dr. Subhasini Ladella

Principal Discussants
Neonatologist: Dr. Philip Cheng
Perinatologist: Dr. Subhasini Ladella

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 Preterm Premature Rupture of Membranes.
2) Gain insight into the potential problems related to Preterm Premature Rupture of Membranes, 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 will be offered
RSVP is not required
Lunch will be provided

Drs. Liu; Cheng; Ladella and Program Director Dr. K. Rajani; and Program Planner Bernadette Neve, RNC-NIC, MSN 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 (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.
JOIN US FOR 6 SESSIONS
September 17 - October 22, 2015
5:30 - 7:30pm

1. Life Begins
   Thursday, September 17, 2015
   - Critical Care of Newborn Babies: The State of the Art
     Stephen Elliott, MD, FAAP
     Associate Clinical Professor of Pediatrics, UCSF
     Neonatologist, Community Regional Medical Centers
   - Vaccines: Myths and Truths
     Mansi Desai, MD
     Clinical Instructor, UCSF
     Chief Resident, UCSF Fresno Department of Pediatrics

2. The Trials of Adolescence
   Thursday, September 24, 2015
   - Mental Health in the Teens and 20s
     Shawn B. Hersevoort, MD, MPH
     Health Sciences Assistant Clinical Professor, UCSF
     Director of Integrated Mental Health
     Psychiatry & Sleep Medicine, UCSF Fresno
   - Dermatology for Young Adults
     Greg Simpson, MD
     Assistant Clinical Professor, UCSF
     Medical Director, UCSF Fresno Dermatology

3. Focus on Women’s Health
   Thursday, October 1, 2015
   - Women and Heart Disease
     Teresa Daniele, MD
     Assistant Clinical Professor, UCSF
   - The Breast is Yet to Come...
     Ibiroko Adelaja, MD
     Assistant Clinical Professor of Surgery, UCSF
     General & Breast Surgery, UCSF Fresno

4. Health Issues in Young Adults
   Thursday, October 8, 2015
   - Aeromedicine: Life and Death in the Sky
     Janak Acharya, MD, FACEP
     Assistant Clinical Professor, UCSF
     Medical Director Skylife Air Ambulance and American Ambulance
   - Burn Injury in Young Adults: Mechanisms, Treatments, and Outcomes
     William Dominiti, MD
     Clinical Professor, UCSF

5. Life Renewed: Palliative Care & Organ Transplantation
   Thursday, October 15, 2015
   - Palliative Medicine: A Different Kind of Hope
     Patrick Macmillan, MD
     Associate Clinical Professor, UCSF
   - Hope for the Hopeless: Organ Transplantation and Tissue Donation
     Donor Network West

6. Training Tomorrow’s Doctors Today
   Thursday, October 22, 2015
   - The Use of Simulation in Medical Education
     Stacy Sawtelle Vohra, MD
     Assistant Clinical Professor, UCSF
     Stuart Maxwell, MD
     Assistant Clinical Professor, UCSF

Caring at Every Step: UCSF Fresno Provides Excellence in Health Care for All Ages of Patients in the Central Valley

The Academic Senate at UCSF Fresno hosts this lecture series for adults and students to learn about important trends in medicine and health. UCSF Fresno faculty will provide in-depth lectures on important issues and advances in medicine and research, linking biomedical science to patients and health care.

Course Director: Rais Vohra, MD

Registration: There is a $20 fee to reserve your seat for the series. Preregistration is required. Registration is on a first-come, first-served basis. Early registration is recommended, as seating is limited to 200 guests. Registration is open to the public. No previous medical training is required. This series of lectures includes mature topics and a minimum age of 17 is recommended for enrollment.

Location & Parking: All events will be held in the auditorium at the UCSF Fresno Center for Medical Education and Research, 155 N. Fresno Street, Fresno, CA 93701. Free parking will be available in the UCSF parking lot, at Illinois and Fresno Streets.

Register today! Seating is limited. Register online at: www.fresno.ucsf.edu/minimed

For more information, call 559-459-6299
E-mail: vconingsby@fresno.ucsf.edu
There and Back Again: Ebola Relief in West Africa

Dr Matthew Waxman (UCLA)

September 24 at Noon

UCSF BUILDING, Room 136

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/UCSFResnoglobalhealth/info?tab=page_info

Website: http://www.fresno.ucsf.edu/global_health/
“Staying Sane, Satisfied and Effective in Medicine & Life”

All Physicians Invited
Thursday September 24, 2015
Fort Washington Country Club
10272 N Millbrook, Fresno
Required R.S.V.P. by Sept. 21
(559) 224-4224 ext. 118 or csrau@fmms.org

Keynote Speaker
Linda Hawes Clever, M.D., MACP, is founder and president of the not-for-profit RENEW (www.renewnow.org), Clinical Professor of Medicine at UCSF, and member of the National Academy of Medicine. She is considered an expert on the well-being and professional renewal of physicians and other health care providers. She is author of “The Fatigue Prescription: Four Steps to Renewing Your Energy, Health and Life”.

“In order to do well, you have to be well.”

4-6 p.m. Leadership Workshop
“Life Preservers for Leaders”
(for Medical Staff Executive Committee members, Department Chairs, Well Being Committee members, Hospital Administrators)
Dr. Clever will provide clarity and sound advice to those in leadership positions in order to be at the top of their abilities.
- Establish effective and healthy clinical and administrative settings
- Evaluate situations in order to assure access to relevant information
- Explore the best approaches to dealing with competing demands

5-7 p.m. Exhibitor Reception & Networking

7 p.m. Physician Dinner Meeting & Keynote Presentation
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So much to do, so little time. Rarely enough time to relax and just be. Or maybe even sleep. Always the possibility of making a mistake. Relentless pressure and change. What kind of life is this? Is there anything to do about it? Yes indeed.

Fresno-Madera Medical Society

Co-Sponsored by
CME Dinner Lecture

Lung Cancer Screening Guidelines for Clinical Practice

SPEAKER: Daya Upadhyay, MD
Associate Professor of Medicine, UCSF
Medical Director, Lung Nodule Program
Director, Translational Research in Medicine
Pulmonary, Critical Care and Sleep Medicine
University of California San Francisco, Fresno

DATE/TIME: September 24, 2015
Thursday - 6:30 pm - 8:30 pm

ATTENDEES WILL:

1. Attendees will be able to learn and become familiar with current advances and future management strategies including timing of intervention that can prevent delayed cancer diagnosis and progression of lung cancer.
2. Attendees will be educated on early diagnosis of lung cancer that can improve patient survival in lung cancer.
3. Attendees will be educated on smoking Cessation Program and Pulmonary Rehab that can be utilized to improve in day to day patient care in their practice.
4. Guidelines indicate using lung cancer screening, however, understanding and limiting multi-billion dollar cost of healthcare burden is critical by using precise knowledge on how to select target patients.

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

CME 1.0

Dinner provided (Vegetarian options available)

TARGET AUDIENCE:
Primary Care Physicians, Internal Medicine, Family Practice, Geriatrics, General Physicians, Nurse Practitioners, Physician Assistants, RN’s and all allied Health Professionals who work in primary care field.

RSVP to Business Development Outreach
cmersvp@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: Daya Upadhyay, M.D. and event planners, Kimberly Goldring, Ric Morales and Louis Triana have no disclosures to make.

www.CommunityRegional.org
Fresno County has the 2nd highest chlamydia rate among young women in CA. Learn how effective clinical care can make a difference.

Tuesday, September 29th
12:30-4:00
UCSF Fresno Center, Fresno, CA

Conference Agenda:
12:30 - 1:00  •  Chlamydia Epidemic in Fresno
1:00 - 2:30  •  Chlamydia: Clinical Care Best Practices
•  Adolescent Sexual Risk Assessment: What to Ask and How
2:30 - 4:00  •  Quality Improvement: Methods & Strategies

Target Audience: Clinical providers and staff who serve adolescents and young adults

Registration Required:
http://tinyurl.com/FresnoCT for 12:30-2:30 sessions
http://tinyurl.com/FresnoQI for 2:30-4:00 sessions

Presented by:

This activity has been planned and implemented in accordance with the Institute for Medical Quality and the California Medical Association’s CME Accreditation Standards (IMQ/CMA) through the Joint Sponsorship of Cardea Services, Inc., and the California STD/HIV Prevention Training Center.

Cardea Services is accredited by IMQ/CMA for issuing AMA PRA Category 1 Credit(s)™ for physicians. Cardea Services designates this live activity for a maximum of 3.5 AMA PRA Category 1 Credit(s)™. Physicians should claim credit commensurate with the extent of their participation in this activity.

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

The California STD/HIV Prevention Training Center is approved by the California Board of Registered Nursing, Provider Number CEP 14547 for 3.5 contact hours for this activity.
Atrial Fibrillation Today:
An Update in Atrial Fibrillation Treatment and Medications

Speaker:
Michael Gen, MD, FACC, FSCAI – Cardiologist at Cardiovascular Consultants Heart Center

Save the Date

Date:
Thursday, October 8, 2015
12:30 pm – 1:30 pm Lunch will be provided

Location:
H. Marcus Radin Conference Center
The Palm Room

Target Audience:
All physicians, nurses and allied health professionals.

CME: 1.0 – applied for

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

UCSF Fresno

Women’s Heart Health Fair!
Wednesday, October 14 • 2:00–6:30 pm • UCSF Fresno

Participate in free screenings and learn what to watch out for and what your health risks might be. What is your body telling you?

Come hear from and talk with experts including:

“Women and Heart Disease”
Teresa Daniele, MD
Cardiology
Assistant Professor of Medicine, UCSF
Director, Center for Women’s Cardiovascular Disease

“Autoimmune Conditions: A Risk for Heart Disease”
Candice Yuvienco, MD
Rheumatology
Assistant Clinical Professor of Medicine, UCSF
Division Director of Rheumatology

“Mental Health, Hormones, and the Heart”
Shawn Hersevoort, MD, MPH
Psychiatry
Assistant Clinical Professor, UCSF School of Medicine

30-minute screenings will include:

- Blood Pressure, Height, Weight and Body Mass Index
- Cholesterol and Glucose
- Depression
- Nutrition
- Exercise

Enjoy an overview welcoming presentation on each specialty area then have the opportunity to talk with the experts about any questions you may have during the screenings.

Informational vendors and exhibitors will be on site
Light, healthy refreshments will be served
Space is limited!
Exciting raffle prizes will be drawn in closing session (must be present to win).

Please Register Online by October 9, 2015 at
http://www.fresno.ucsf.edu/womensfair

For more information, please call (559) 499-6426

This Heart Health Fair is a joint collaboration between:
SAVE THE DATE

Tuesday October 20, 2015
12:00 p.m - 1:00 p.m

Clovis Community Hospital-Outpatient Care Center
Conference Room
2755 Herndon Ave.
Clovis, Ca. 93611

Principal Discussant
Anand Rajani M.D
David Hodge M.D

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 Congenital Diaphragmatic Hernia.
2) Gain insight into the potential problems related to Congenital Diaphragmatic Hernia thereby improving patient safety & outcomes.
3) Learn, better understand and incorporate into patient care the knowledge of Congenital Diaphragmatic Hernia, improving diagnostic methods and patient outcomes.

1 CME will be offered (pending)
RSVP is not required
Lunch will be provided

Program Director Dr. K. Rajani; and Program Planner Rebecca Avila 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 (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.
Save the Date
Perinatal M & M Presents:

“CMQCC/CPQCC Data Review for Mothers and Neonates 2012-2014”
Wednesday, October 21, 2015 from 12:30pm – 1:30pm
UCSF – Fresno, Room: 136

“Ethics and Guidelines for the Management of Extremely Premature Babies”
Wednesday, November 18, 2015 from 12:30pm – 1:30pm
UCSF – Fresno, Room: 136

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.

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YOUR ONLINE TRAINING...  
Must be done by September 21

Complete your online training now!

> CMC is pleased to offer online training to unlock the mysteries of ICD 10 coding and documentation. Each physician has been assigned a curriculum of content most applicable to his/her specialty, plus modules on the tools available in EPIC, and a new electronic query process.

> Complete your training within HealthStream (HLC). Access HLC through the Forum, our intranet, whether you are in the hospital or not.

> Complete the curriculum before September 21 to be prepared and avoid EPIC restriction. The series takes just over an hour, and the information should be helpful for you both in the hospital and in your office. Avoid an avalanche of Clinical Documentation Improvement (CDI) queries by getting it right the first time!

> Reach out to your informatics team or the educators for assistance in getting into HLC.

> Work with the CDI specialists to improve your documentation.

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

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Questions?
Contact Dr. Judi Binderman – CMIO 
jobinderman@communitymedical.org 
559-324-6894 (office) or 559-259-8256 (cell)
September 2015

September 3
Resident Open Meeting – No Grand Rounds

September 10
“PsychoPharmacoGenomics & Precision Pharmacy:
Examining the variables that influence psychiatrist adoption of technology”
Adam Quest, MD, Presenter
UCSF Fresno Psychiatry Residency Program

September 17
“Quality Psychiatrists: Training Future Leaders in Mental Health Care”
Weston Fisher, MD
Assistant Clinical Professor, Department of Psychiatry
University of California, San Francisco

September 24
Faculty Development: Supervision in Psychiatric Training
Craig Campbell, MD
Health Sciences Clinical Professor, Psychiatry
Program Director, UCSF Fresno Psychiatry Residency Program

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## Critical Care Trauma Conference

### September

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Location</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/03/15</td>
<td>Spine Trauma</td>
<td>DOS</td>
<td>Emaad Farooqui, MD</td>
</tr>
<tr>
<td>9/10/15</td>
<td>Alcohol &amp; Trauma Patient ED/Surgery Combined Conference</td>
<td>Seq. West</td>
<td>Dr. Crebassa - Shaina Schaetzel, MD (video review)</td>
</tr>
<tr>
<td>9/17/15</td>
<td>TBD</td>
<td>DOS</td>
<td>TBD</td>
</tr>
<tr>
<td>9/24/15</td>
<td>SIM Trauma Activation</td>
<td>Seq. West</td>
<td>Amy Kwok, MD</td>
</tr>
</tbody>
</table>

**DOS' Dept. of Surgery Conference Room**

**Target Audience:** CMC Faculty, community physicians, house officers, physician assistants, nurse practitioners, nurses and others potentially involved with patient care.

**Objectives:**
- Increased knowledge and improved proficiency in the management of critically ill patients.
- Increased knowledge and awareness of the utility of comprehensive trauma and critical care management.
- Improved awareness and management of the physiologic alterations associated with trauma.

BCPS and Program Director Nancy Parks, MD and Program Planner Kelley Medico Montgomery have no relevant commercial relationships to disclose.

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Tuesday, September 1, 2015  
12:30-1:30 p.m  G150B.  
“Abdominal Trauma”  
James Pierce, M.D.

Thursday, September 3, 2015  
12:30-1:30 p.m.  
No Lecture scheduled

Tuesday, September 8, 2015  
12:30-3:30 p.m.  
No Lecture scheduled

Tuesday, September 15, 2015  
12:30-1:30 p.m.  G150B  
“Interventional Radiology”  
Trevor Davis, M.D.

Thursday, September 17, 2015  
12:30-1:30 p.m.  
“Patient Safety Alert Process”  
Karen Dahl, M.D.

Tuesday, September 22, 2015  
12:30-1:30 p.m.  G150B  
“TBA”  
Serena Yang, M.D.

Thursday, September 24, 2015  
12:30-1:30 p.m.  
“Schwartz Rounds”  
Linda Keele, M.D.

Tuesday, September 29, 2015  
12:30-1:30 p.m.  G150B  
(video-conferenced from UCSF Fresno)  
“The Chlamydia Epidemic”  
Presented by California Department of Public Health  
Fresno County Department of Public Health  
Center for Public Health Quality

CME CREDIT
As an organization accredited for continuing medical education (CME), Valley Children’s Hospital fully complies with the legal requirements of the Americans with Disabilities Act and regulations. Should a participant be in need of accommodations, a written request should be submitted at least one month in advance.

Valley Children’s Hospital earned accreditation with commendation as a provider of continuing medical education (CME) from the Institute for Medical Quality (IMQ). Only an estimated 5 percent of CME providers accredited by the IMQ in the state of California achieve this high level of recognition.

Accreditation Statement:
Valley Children’s Hospital is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. Valley Children’s takes responsibility for the content, quality and scientific integrity of this CME activity. Valley Children’s designates this live activity for a maximum of 4 AMA PRA Category 1 Credits™. 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.

Financial Disclosure Statement
As a CME Provider accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA), Valley Children’s Hospital works to ensure independence from commercial influence in its educational activities. Our aim is to present objective, balanced, and scientifically rigorous information that is based on appropriate clinical evidence representing best medical practices. All planning committee members, staff, and faculty participating in Valley Children’s Hospital’s medical education programs are required to disclose commitments to, and/or relationships with, pharmaceutical companies, biomedical device manufacturers or distributors, or others whose products may be considered to be related to the subject matter of this educational activity. Faculty must also disclose any off-label and/or investigational use of pharmaceuticals or instruments discussed in the course of their presentation. Financial relationship disclosures are made known to the audience prior to the presentation.
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This credit may be applied to the CMA Certification in Continuing Medical Education. Email: lsmith@communitymedical.org P: 559-459-1777 F: 59-459-1999
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**Patient Safety: Use of Filter Needles/Straws with Glass Ampules**

The purpose of this flyer is to warn you of the potential hazards of administering medications from a glass ampule without using a filter needle or filter straw.

**Why is this an issue? I have never used a filter needle when drawing up medication from a glass ampule.**

Glass fragments can enter the ampule when it is opened. If drawn up without a filter needle/straw, small glass particles can pass through into the syringe. These glass particles can cause damage to the liver, kidney, lungs and spleen. Glass fragments have caused adult respiratory distress syndrome, pulmonary artery granuloma in infants, impairment of microcirculation and phlebitis.

**How do I properly open the ampule and use a filter needle/straw?**

1. After proper hand hygiene and donning gloves, wipe the neck of the ampule with an alcohol swab. Allow the alcohol to dry (about 1 minute), use a gauze pad and grab the neck of the ampule, break the ampule (use quick and firm pressure). Proper aseptic technique is required to prevent microorganisms from entering the ampule.
2. Place the opened ampule on a flat surface.
3. Remove the cover from the filter needle, attach to a syringe and insert the needle/straw into the fluid. Pull back on the plunger and withdraw the medication. (NOTE: keep the tip of the needle/straw below the surface of the medication.)
4. Remove the filter needle/straw and administer the medication.

**My area does not stock filter needles. How do I get them stocked?**

The needles can be ordered through Materials Management using the following ordering codes:

- For filter needle (19 gauge) FN 5119
- For filter straw (4 inches long, used for larger ampules) FS 5000
Review of Safe Injection Practices
Jennifer Tryptten, PharmD, BCPS, CICP
Interim Director Quality Performance Improvement / IRB / Research

Assuring compliance with recommendations for safe injection practices continues to be a high priority at CMC. We’ve demonstrated our commitment by our active participation in the CDC “One and Only” Campaign, compliance with the Joint Commission Sentinel Event Alert related to injection safety, ongoing education, and practice validation efforts. The recently completed update to the CMC “Medication – Single and Multi-Dose Vials” policy summarizes key principles for clinicians to abide by:

• Alcohol swabs should be used to scrub the septum of every vial and outer surfaces of ampules. Vial caps do not confer a sterile septum and alcohol swabs should always be used even for newly opened vials.
• Filter needles should be used for drawing up ampule contents.
• NEVER leave needles or other items in the septum of the vial between uses.
• **Single dose vials (SDV):**
  o Contain no preservative
  o Should be discarded after a single use.
  o Should never be pooled or stored for future use for another patient.
  o If a SDV must be entered more than once during a single procedure, must only be used for a single patient. A NEW NEEDLE and NEW SYRINGE is used for each entry in the vial.
• **Multi-dose vials (MDV):**
  o Contain a preservative and are labeled for multiple dose use.
  o Expire 28 days from the date punctured. User should write this expiration date on the appropriate sticker on vial.
  o MDVs should be stored away from immediate patient care areas (e.g. ER treatment bays, operating rooms, at bedside) after they are opened.
  o If an MDV is to be used for more than a single patient, it must be accessed in a medication clean area (away from patient care). Any MDV accessed in a patient care area (e.g. ER treatment bays, operating rooms, at bedside) should either be discarded after use or designated for use for only that patient.
  o A NEW NEEDLE and NEW SYRINGE must be used for each entry into an MDV.