In This Issue:

3 .......... CEO Corner
4 .......... Initial Appointments for December
5 .......... International Appointment for Bariatric Surgeon
7 .......... You Bring Joy to Our Patients
8 .......... Quality Corner: Updated Order Sets
12 ....... Your Community at Work
13 ...... Physician Well-Being
14 ...... CMS Posts Quality Performance Data on Doctors
15 ...... From the Desk of Judi Binderman M.D.
15 ...... New Service at CRMS
17 ...... Sirescripts
19 ...... ICD-10 Corner
19 ...... Medical Board of California Annual Report Available
20 ...... Hillblom Center on Aging Launches at UCSF Fresno
21 ...... New Commonwealth Fund Scorecard Ranks California
25 ...... Catheter Associated Urinary Tract Infections
26 ...... Important New Options at Community for Rapid Nucleic Acid Testing of Respiratory Pathogens
27 ...... Palliative Care Corner
28 ...... Laboratory Update
30 ...... Choosing Wisely: American College of Medical Genetics and Genomics
31 ...... CME Highlights
32 ...... Physician Photographer of the Month

**JANUARY PHYSICIAN PHOTOGRAPHER SUE SPANO M.D.**

Dr. Sue Spano is an Emergency Medicine attending at Community Regional Medical Center and the current Director of Continuing Medical Education. Summertime on the west coast of Greenland, a modern Icelandic Viking sculpture, and overnight accommodations from the original Icehotel are featured this edition. The UNESCO World Heritage Ilulissat Icefjord in Greenland is a miles-long river of icebergs held up at the channel mouth by a shallow ocean floor. Despite this obstruction, it is the fastest calving glacier in the world, birthing 35 cubic kilometers of ice into the ocean annually, including the famous iceberg that sank the Titanic. The Swedish Icehotel is also north of the Arctic Circle and is rebuilt from snow and ice every winter, with international artists competing to design its unique Art Suites. Iceland is a perfect milder-climate stop between these arctic destinations.

Physician Editor:  
David L. Slater M.D., FCAP  
Managing Editor:  
Laurie Smith  
Manager, Physician Education and Communication

Deadline to submit articles for the February 2016 issue of Physicians’ Edition is Friday, January 21.
I’m pleased to share with you a new joint venture that will benefit thousands of our patients long term across four counties in our region.

Adventist Health and Community Medical Centers are forming a state-licensed healthcare plan. The purpose of this joint venture is to deliver increased access to managed Medi-Cal members in Fresno, Kings, Madera and Tulare counties. Our goal is to deliver more comprehensive, efficient, lower-cost and high-quality healthcare to this underserved population.

Adventist Health and Community make good partners for multiple reasons. We have similar healthcare goals for the Central Valley, and our strengths complement each other to better manage the health of entire families. Adventist’s Central Valley Network has an extensive system of clinics, specialty outpatient facilities and rural-delivery expertise second-to-none, while we offer the region’s highest level of acute, inpatient services, including the only burn and Level 1 trauma centers from the Bay Area to LA. Together, we’re committed to developing a network of healthcare resources to ensure access and coordinated care for the Medi-Cal patients we currently serve as well as the thousands of additional members expected during the next couple of years.

Subject to approval by the California Department of Managed Health Care, we will build upon the managed Medi-Cal Adventist Health Plan that begins in Kings County on January 1. Adventist and Community will remain independent organizations, but the health plan will be jointly owned and operated. We estimate that within two years of its launch, the new plan could deliver coordinated, clinically integrated care to as many as 200,000 people.

As you know, this type of collaboration is common in today’s healthcare industry and consistent with the goals of the federal Affordable Care Act. By more effectively managing the care for health populations – improving access to services and helping patients be healthier – our aim is to lower overall healthcare costs.

Among the next steps are to determine a name and staffing model for the joint-venture health plan. Subject to regulatory approval, the new network should be ready for the market by fall 2016.

I’m proud of the lead role we are taking to respond to the needs of the still-expanding Medi-Cal patient population in this region. And, I’m extremely grateful to our physicians who support Community’s mission. This new venture further demonstrates our courage, innovation and careful stewardship of our resources to form one of California’s premier healthcare networks.

Initial Appointment to the Medical Staff effective December 10, 2015

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

Nathan Deis M.D.
Department: Surgery
Specialty: Neurosurgery

Adanna Ikedilo M.D.
Department: OB/GYN
Specialty: OB/GYN

Richa Kaushal M.D.
Department: Pediatrics
Specialty: Pediatrics

Anand Narayan M.D.
Department: Emergency Medicine
Specialty: Emergency Medicine

Padmapriya Senthilvelan M.D.
Department: OB/GYN
Specialty: OB/GYN

Kaushik Tiwary M.D.
Department: Medicine
Specialty: Internal Medicine

Jeff Van Gundy M.D.
Department: Pediatrics
Specialty: Pediatric Cardiology

Initial Appointment to the Medical Staff effective December 10, 2015

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

Naira Asatrian P.A.
Department: Surgery
Specialty: Neurosurgery

Patricia Barreto P.A.
Department: Emergency Medicine
Specialty: Emergency Medicine

Melissa Edginton N.P.
Department: Surgery
Specialty: Neurosurgery

Dana Forred N.P.
Department: Medicine
Specialty: Gastroenterology

Kathryn Hanks P.A.
Department: Surgery
Specialty: Neurosurgery

Genevieve Smith N.P.
Department: Surgery
Specialty: Neurosurgery

See page 2 for details
Dr. Kelvin Higa, medical director of Fresno Heart & Surgical Hospital’s Bariatric & Metabolic Surgery Program, was recently elected President of the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO).

Dr. Higa and partner Dr. Keith Boone pioneered the current laparoscopic gastric bypass technique used by many surgeons worldwide. He is a past president for the American Society of Metabolic and Bariatric Surgery (ASMBS) as well as its Foundation and was awarded the prestigious ASMBS Lifetime Achievement Award. He continues to chair many international conferences devoted to bariatric and metabolic surgery and organized the first International Consensus Conference on Metabolic/Bariatric Interventions that recently took place in Clovis, CA. Dr. Higa travels more than three months out of the year, lecturing and performing live surgical demonstrations worldwide.

Dr. Higa will be presiding over the IFSO World Congress in 2017 in London and will be spending next year preparing for that. We sat down with Dr. to Higa to talk about his new IFSO position and current trends and research in metabolic surgery.

Q: What do you hope to accomplish as president of this worldwide organization?

Dr. Higa: IFSO is a unique organization as it is the only society that brings every continent, every country together to share ideas and represent our specialty and the patients we serve. It is important that state-of-the-art care is available and accessible to all patients based on need, not social or financial status. I am hoping to continue to fight for individual’s right to health care through dissemination of knowledge and experience. I am also hoping to continue the proud tradition of IFSO of collaboration; working together for a common cause.

Q: Are there new surgeries or metabolic treatments being explored that show hope for those patients with diabetes?

Dr. Higa: Yes, there are many new treatments for diabetes and this is exciting. The success of procedures such as the gastric bypass, which has been around for more than 40 years has given researchers the push into looking into why surgery has been shown to be scientifically superior to traditional medical management. This has led to the discovery of incretins and hormones responsible for hunger and appetite as well as glucose control. Rather than just giving more insulin to treat diabetes, newer medications have been developed to work on the insulin resistance part of the equation.

Furthermore, through randomized, prospective studies, surgery has emerged as the gold standard for treatment of type 2 diabetes, when also associated with a body mass index (BMI) over 35. In some countries, such as China, surgery is being recommended in patients with a BMI as low as 28 – 30, since they are getting diabetes at lower BMIs. Also surgery has been shown to decrease the micro- and macrovascular damage brought on by diabetes, whereas traditional lifestyle and diets have not.

New interventions that do not require surgery are being tested as we speak. Some of these interventions use endoscopic methods to deploy barriers or to destroy the lining of the first part of the intestine. Others try to recreate the anatomy of existing operations such as the sleeve gastrectomy via the endoscope so there is no incision.

Q: Do you think the American Medical Association’s classification of obesity as a disease will change how bariatric and metabolic surgery is viewed?

See Dr. Higa on page 6
Dr. Higa

Continued from page 5

Dr. Higa: We still don’t have the groundswell of public support for treating obesity like a disease. Many still see obesity as a result of lifestyle choices. And yet, when I looked at the literature 25 years ago it was clear that obesity was not a conscious choice, but a disease governed by many factors outside our control, such as genetics.

I’ve been trying to figure out the psychology of primary care physicians who don’t address weight first rather than treating the symptoms of obesity – sleep apnea, diabetes, and hypertension. And why don’t primary care physicians refer patients earlier for surgery when they do have obesity and these symptoms? A focus group study showed they thought bariatric surgery was too risky, too dangerous and too complex. Insurance companies have a similar mindset.

Both bariatric surgery and aggressive medical treatment for obesity are not accessible to the vast majority of people. Most insurances won’t pay for the aggressive nutritional counselling and exercise and the preventative efforts it would take, and they require extensive weight loss attempts before approving bariatric surgery, but they will pay for the third coronary bypass surgery or expensive hypertension medications.

Q: Besides working to change attitudes toward obesity and aggressive treatments, what else would help?

Dr. Higa: Guidelines for deciding who is an appropriate candidate for bariatric surgery need to be updated. Approvals by insurance companies for surgery has been based not on medical need, but on BMI (Body Mass Index), and they’re using guidelines developed in 1991.

New research shows, especially in the Asian population, that diabetes comes on with a much smaller BMI. In China the average Type 2 diabetic has a BMI 27, but the National Institutes of Health guidelines say only those with a 35 or greater BMI should be candidates for bariatric surgery. It’s a policy that’s prejudiced racially against Asians and Hispanics. Hispanics also get diabetes at lower BMIs and have more severe diabetes symptoms, especially when they have native-American genetics as well.

My personal belief is that access to health care and disease prevention is a right, not a privilege. Reviewing the medical literature over 25 years ago was enough to convince me that the treatment of obesity and diabetes needs to be based on science, not ancient misconceptions and prejudice. If you think that racism is a problem today, compare this to society’s disregard for the millions of individuals denied treatment based on their weight. It is time to rise above the rhetoric and act accordingly.
As the holidays draw near and we embark on a new year, I ask you to join me this giving season by donating to Community Medical Centers to continue the great work that takes place each and every day. Let me tell you why I became a donor and what Community means to me and my family.

I was born in Burnett Sanitarium – the original site of Community Regional Medical Center and practiced there for nearly 60 years. I've watched Community become the region's top healthcare provider and been a part of many medical advancements – from antibiotics and polio vaccines, to house calls and open heart surgeries.

Community Regional has grown from the tiny Burnett Sanitarium in 1897, into the world-class trauma and critical care service provider we know today. From the expansion of Clovis Community Medical Center to the addition of Fresno Heart & Surgical Hospital, Community has helped so many in our region thanks in part to generous donor-investors.

But our success can't stop here – the changing healthcare environment makes it more important than ever for me to invite you to continue your generous support. More than ever, our participation is vital to the advancements and expansion of leading-edge healthcare for our Valley. As we approach the giving season, I hope you will remember Community Medical Centers.

Best wishes for good health to you and your family during the holiday season and thank you so much for your generosity.

Respectfully,

Joseph C. Woo, Jr., MD, FACP, FACC, FCCP
Physician Leader and Board Emeriti
ANNOUNCING UPDATED ORDER SETS BEING RELEASED

Submitted by Quality/Performance Improvement

Please see below for a list of Order Sets that were released into production between 10/27/2015 to 12/22/2015. If you identify a problem with one of the retired order sets 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.

The following order sets were released between 10/27/2015 to 12/22/2015

<table>
<thead>
<tr>
<th>Epic PRL #</th>
<th>Order Set Name</th>
<th>Description of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>571</td>
<td>Acute Coronary Syndrome</td>
<td>Removed “Nursing Consult to Dietician” order replaced with “IP Consult to Dietary” order with evaluation preselected</td>
</tr>
<tr>
<td>5</td>
<td>Acute Coronary Syndrome Module Z</td>
<td>Epic changes only – Adding the option to order Imaging orders Portably</td>
</tr>
<tr>
<td>1367</td>
<td>Acute Ischemic Stoke TIA</td>
<td>Head of bed order corrected to pre-select 30 degrees</td>
</tr>
<tr>
<td>629</td>
<td>Adult Burn Service</td>
<td>Removed “Nursing Consult to Dietician” order replaced with “IP Consult to Dietary” order with evaluation preselected</td>
</tr>
<tr>
<td>530</td>
<td>Adult Pentobarbital Coma Induction and Maintenance</td>
<td>Modified to separate adult and pediatric combined order set</td>
</tr>
<tr>
<td>1322</td>
<td>Adult Trauma Surgical ICU Admit</td>
<td>Removed “Nursing Consult to Dietician” order replaced with “IP Consult to Dietary” order with evaluation preselected</td>
</tr>
<tr>
<td>1452</td>
<td>Amnio Infusion Supplemental</td>
<td>LR and NS orders built in EPIC as irrigation instead of infusion so that they can be documented by nursing in the MAR and not flow to the I&amp;O.</td>
</tr>
<tr>
<td>1226</td>
<td>Bariatric Surgery</td>
<td>Epic changes only – Adding the option to order Imaging orders Portably</td>
</tr>
<tr>
<td>1558 &amp; 1559</td>
<td>Blood and Body Fluid Exposure or Needle Stick</td>
<td>Removed order set from Epic only. It is still available in Lucidoc.</td>
</tr>
<tr>
<td>700</td>
<td>CAP Pneumonia</td>
<td>Removed “Nursing Consult to Dietician” order replaced with “IP Consult to Dietary” order with evaluation preselected</td>
</tr>
<tr>
<td>588</td>
<td>Complicated UTI/Urosepsis</td>
<td>Removed “Nursing Consult to Dietician” order replaced with “IP Consult to Dietary” order with education preselected</td>
</tr>
<tr>
<td>570</td>
<td>COPD Exacerbation Asthma</td>
<td>Removed “Nursing Consult to Dietician” order replaced with “IP Consult to Dietary” order with education preselected</td>
</tr>
<tr>
<td>1242</td>
<td>Dronedarone Orders</td>
<td>Biennial review: Black box warning for permanent atrial fibrillation updated to comply with medication safety standards and Labs added</td>
</tr>
<tr>
<td>1456</td>
<td>External Cephalic Version</td>
<td>Biennial review: Terbutaline dosing statement updated</td>
</tr>
<tr>
<td>1309</td>
<td>Extracorporeal Membrane Oxygenation/ Extracorporeal Life Support</td>
<td>Removed “Nursing Consult to Dietician” order replaced with “IP Consult to Dietary” order with evaluation preselected</td>
</tr>
<tr>
<td>1193</td>
<td>Glycemic Control</td>
<td>Removed “Nursing Consult to Dietician” order replaced with “IP Consult to Dietary” order with education preselected</td>
</tr>
</tbody>
</table>
| 1404       | Intracranial Mass Effect without ICP Monitor | Biennial review:  
  - Capnography order added  
  - Seizure prophylaxis modified  
  - Titration dosing added to Nicardipine  
  - Vasopressor dosing modified to link to appropriate order set  
  - Removed nutrition support  
  Diabetes Insipidus screening modified |
| 1274       | Intrapartum C Section Special Services | Biennial review:  
  - Updated Indwelling Urinary Catheter  
  - Clinical Labs modified  
  - Antiretroviral orders for labor clarified  
  - Kaletra dosage modified  
  - Sulfamethoxazole dosing and generic name added |
| 1273       | Intrapartum Special Services Labor/ Rupture of Membranes | Biennial Review- clinical labs updated, medications modified, removal of group B strep status |
| 1454       | Labor Epidural Analgesia               | Dosing updated for following medications-Fentanyl, Lidocaine and Nalbuphine            |
| 18         | Labor Orders                           | Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy |

Order Sets continued on page 9
<table>
<thead>
<tr>
<th>Code</th>
<th>Order Set</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1614</td>
<td>Laser Lead Extraction Pre Op</td>
<td>Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy</td>
</tr>
<tr>
<td>321</td>
<td>Neuro Protection Magnesium Sulfate</td>
<td>Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy</td>
</tr>
<tr>
<td>1449</td>
<td>Newborn Care Orders</td>
<td>Epic change only: Bili test added when babies going home within a 24 hour period</td>
</tr>
<tr>
<td>1328</td>
<td>Newborn Care, Assessment and Orders by Standardized Procedure</td>
<td>Epic change only: Bili test added when babies going home within a 24 hour period</td>
</tr>
<tr>
<td>1280</td>
<td>Oral Penicillin Desensitization</td>
<td>Update order set to reflect the antimicrobial desensitization policy and procedure.</td>
</tr>
<tr>
<td>305</td>
<td>Patient Controlled Analgesia</td>
<td>CCMC Pilot: Added capnography order as an option for monitoring</td>
</tr>
<tr>
<td>1232</td>
<td>Pediatric Critical Care Analgesia/ Sedation for Mechanical Ventilation</td>
<td>· Ketamine Infusion added Titration instructions modified to improve RN workflow</td>
</tr>
<tr>
<td>1209</td>
<td>Pediatric Critical Care Blood Glucose Management</td>
<td>Name of order set changed from “ Pediatric Critical Care Blood Glucose Management Orders” to “ Pediatric Critical Care Insulin Infusion Orders (Non-DKA)”</td>
</tr>
</tbody>
</table>
| 1087   | Pediatric PACU Orders                          | · Corrected mechanical ventilation  
· Added spinal precautions and mobility clearance  
· Updated lab section to be current  
· Updated respiratory section  
Corrected medication section/IV fluids per pharmacy                                                                                                     |
| 1408   | Pediatric Pentobarbital Coma Induction and Maintenance | Adding Bispectral Index (BIS) monitoring for compliance with patient safety standards.                                                                                                                     |
| 191    | Pediatric Post Op Short Stay                    | Added maintenance IV fluids and updated medication dosing to be weight based to comply with policy                                                                                                        |
| 1379   | Pediatric Surgery Pre Admit Orders             | New order set created for pre-admitting pediatric patients                                                                                                                                               |
| 1086   | Post Cardiac Cath                              | Removed “Nutrition Education per Dietitian” Replace with “IP Consult to Dietary”                                                                                                                        |
| 601    | Post Interventional Endovascular               | Removed “Nursing Consult to Dietician” order Replaced with “IP Consult to Dietary” order with education preselected                                                                                       |
| 1461   | Post Op Admit TURP                              | Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy                                                                                                         |
| 20     | Post Op C Section                              | Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy                                                                                                         |
| 569    | Post Op Carotid Endarterectomy                 | Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy                                                                                                         |
| 1566   | Post Op Instructions Shoulder Arthroscopy      | Discharge instructions modified to read: If patient has a predisposition to urinary retention, do not discharge until patient urinates                                                                     |
| 1546   | Post Op Knee Arthroplasty                      | Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy                                                                                                         |
| 1287   | Post Op Pediatric Surgery Admission Orders     | New order set to direct the care of pediatric patients following surgery                                                                                                                                  |
| 1401   | Post Op Spine Orders                           | Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy                                                                                                         |
| 19     | Post Vaginal Delivery                          | Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy                                                                                                         |
| 1363   | Pre Admission Cardiothoracic Surgery           | Standardized “Pulmonary Function Complete”                                                                                                                                                               |
| 1340   | Pre Admit Pacemaker                            | Epic changes only – Adding the option to order Imaging orders Portably                                                                                                                                    |
| 974    | Pre Op Brest Surgery AMB                       | Header and Footer updated                                                                                                                                                                               |
| 21     | Pre Op C Section                               | Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy                                                                                                         |
| 1375   | Pre Op Cardiothoracic Surgery                  | Standardized “Pulmonary Function Complete”                                                                                                                                                               |
| 1445   | Pre Op Hysterectomy                            | Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy                                                                                                         |
| 1399   | Pre Op Pacemaker                               | Epic changes only – Adding the option to order Imaging orders Portably                                                                                                                                    |
| 306    | Pre Term Labor Magnesium Sulfate Orders        | Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy                                                                                                         |
| 1189   | Routine Admitting Adult Psychiatry             | Biennial Review – clinical labs updated                                                                                                                                                                 |
| 1577   | Sepsis 6 Hour Bundle                           | Epic changes only – Adding the option to order Imaging orders Portably                                                                                                                                    |
ANNOUNCING UPDATED ORDER SETS BEING RELEASED – continued from page 9

Submitted by Quality/Performance Improvement

Please see below for a list of Order Sets that were released into production between 10/27/2015 to 12/22/2015. If you identify a problem with one of the retired order sets 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.

**The following order sets were released between 10/27/2015 to 12/22/2015**

<table>
<thead>
<tr>
<th>Epic PRL #</th>
<th>Order Set Name</th>
<th>Description of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1569</td>
<td>SSS Post Op Instructions Knee Arthroscopy</td>
<td>Discharge instructions modified to read: If patient has a predisposition to urinary retention, do not discharge until patient urinates</td>
</tr>
<tr>
<td>1570</td>
<td>SSS Post Op Instructions Knee Arthroscopy Complex</td>
<td>Discharge instructions modified to read: If patient has a predisposition to urinary retention, do not discharge until patient urinates</td>
</tr>
<tr>
<td>1568</td>
<td>SSS Post Op Instructions Shoulder Labral Repair</td>
<td>Discharge instructions modified to read: If patient has a predisposition to urinary retention, do not discharge until patient urinates</td>
</tr>
<tr>
<td>1567</td>
<td>SSS Post Op Instructions Shoulder RC Repair</td>
<td>Discharge instructions modified to read: If patient has a predisposition to urinary retention, do not discharge until patient urinates</td>
</tr>
<tr>
<td>1471</td>
<td>Sur IP Gyn Post Op Major Surgery Orders</td>
<td>Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy</td>
</tr>
<tr>
<td>1528</td>
<td>Surgical Urinary Catheter Management</td>
<td>Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy</td>
</tr>
<tr>
<td>1460</td>
<td>Termination of Pregnancy</td>
<td>Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy</td>
</tr>
<tr>
<td>1247</td>
<td>Therapeutic Apheresis</td>
<td>Following synonyms to Lucidoc and Epic: plasmapheresis, leukapheresis, erythrocytapheresis</td>
</tr>
<tr>
<td>1400</td>
<td>Universal Acute Stroke t-PA</td>
<td>Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy</td>
</tr>
<tr>
<td>1207</td>
<td>Universal Admitting</td>
<td>Removed “Nursing Consult to Dietician” order Replaced with “IP Consult to Dietary” order with evaluation preselected</td>
</tr>
<tr>
<td>1302</td>
<td>Universal NICU PICC</td>
<td>Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy</td>
</tr>
<tr>
<td>1269</td>
<td>Universal Post Partum Special Services</td>
<td>Biennial Review- updated dosing and added generic name for Septra</td>
</tr>
<tr>
<td>1499</td>
<td>Universal Surgical Admit Z</td>
<td>Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy</td>
</tr>
<tr>
<td>1410</td>
<td>Universal Therapeutic Hypothermia</td>
<td>Indwelling urinary catheter orders updated to comply with CAUTI Adult Prevention Program policy</td>
</tr>
<tr>
<td>1482</td>
<td>Universal Therapeutic Phlebotomy</td>
<td>Biennial Review- Procaine and duplicate lactated ringers infusion orders removed</td>
</tr>
<tr>
<td>1344</td>
<td>Wound Management supplement Order</td>
<td>• New antimicrobial and wound treatment regimens added • Correction of duplicated items on current order set • Added new wound management (new antimicrobial for highly colonized wounds) • Added missing elements to negative pressure wound therapy</td>
</tr>
</tbody>
</table>

**THE FOLLOWING ORDER SETS HAVE BEEN RETIRED**

<table>
<thead>
<tr>
<th>Epic PRL #</th>
<th>Order Set Name</th>
<th>Description of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1325</td>
<td>Med IP Echo Request</td>
<td>Biennial Review: Zero usage in 1 year</td>
</tr>
<tr>
<td>952</td>
<td>Post Op AV Access Thrombectomy/Revision</td>
<td>Biennial Review: Zero usage in 1 year</td>
</tr>
<tr>
<td>1541</td>
<td>Post Op Retropubic Urethral Suspension</td>
<td>Biennial Review: Zero usage in 1 year</td>
</tr>
<tr>
<td>1606</td>
<td>Pre Op Anesthesia Orders</td>
<td>Biennial Review: Zero Usage in 1 year</td>
</tr>
<tr>
<td>1442</td>
<td>Pre Op Av Access Thrombectomy</td>
<td>Biennial Review: Zero usage in 1 year</td>
</tr>
<tr>
<td>1353</td>
<td>Universal Resuscitation/Life Sustaining Treatment</td>
<td>Biennial Review: Zero usage in 1 year</td>
</tr>
</tbody>
</table>
ANNOUNCING IMPORTANT IMPROVEMENTS TO SQ INSULIN ORDER SET #572 Going Live  
at CRMC on January 11, 2016 –

Order Set Goal #1  
Improve Patient Glycemic Control
• by NOT using “sliding scale insulin” as the main therapy for diabetes

Order Set Goal #2  
Decrease Insulin Events at CRMC
Avoid severe hyperglycemia events:
• By building basal (long-acting) insulin prescribing into order set based on patient’s nutritional status. Basal insulin should NOT be held if the bedtime or pre-dose blood glucose level is within normal or desired range.
• By building prandial/bolus (rapid-acting) insulin prescribing into order set around meal times

Avoid hypoglycemia events:
• By building standardized hypoglycemia management into SQ Insulin OS #572

Order Set Goal #3  
Assist Physicians With Ordering Scheduled Insulin
REVISED ORDER SET IS BASED ON PATIENT’S NUTRITIONAL STATUS  
(Patients who are: eating, NPO, peri-operative who are NPO, continuous tube feeding or TPN)
• Choose type of diet
• Choose frequency of blood glucose testing
• Choose basal insulin
• Choose prandial/meal insulin
• Choose correction insulin
• Remember to discontinue any other insulin orders the patient may have

Roller Coaster Effect of Insulin Sliding Scale

Basal-Bolus vs. Sliding Scale Insulin Regimens

What’s wrong with Sliding Scale by Itself?
• Reactive Approach – waiting until BG elevates
• Causes Roller Coaster effect for patient
• Basal/Bolus Approach is proactive; more like normal insulin delivery
• Basal/Bolus with correction should be used, not correction by itself in most cases.
The current edition of “Your Community at Work,” the Community Medical Centers corporate social responsibility report, highlights Community Regional Medical Center’s role as a safety net hospital and celebrates the fact that the emergency department treated its one millionth patient in December. When the Table Mountain Rancheria Trauma Center opened in 2007, the football-field sized ER was the largest in California. It quickly became one of the busiest serving an average of 355 patients a day.

“Your Community at Work” began publication in May 2014. It runs monthly in The Fresno Bee. It’s also published in the Business Journal and the California Advocate, and its contents are available through Community’s website, public affairs newsletter and elsewhere.

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

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

For the second year in a row, worldwide online publication “PR Daily” has named “Your Community at Work” as one of four finalists for “Best Publication” in its corporate social responsibility contest. Other finalists have included Fortune 500 companies such as Coca-Cola, MasterCard and JetBlue and this year include the World Cocoa Foundation and FMC Corporation.

Here’s a link to the Web page that contains the current report as well as previous editions. Please scroll down to the “Your Community at Work” archive.

Print readers: Go to Communitymedical.org > News & Events > Facts, Reports and Publications > scroll down to “Your Community at Work.”
Burnout among U.S. physicians is getting worse. An update from a three-year study evaluating burnout and work-life balance shows that American physicians are worse off today (2014 data) than they were three years earlier. These dimensions remained largely unchanged among U.S. workers in general, resulting in a widening gap between physicians and workers in other fields. The study conducted by Mayo Clinic researchers in partnership with the American Medical Association compared data from 2014 to metrics they collected in 2011 and found that now more than half of U.S. physicians are experiencing professional burnout.

“Burnout manifests as emotional exhaustion, loss of meaning in work, and feelings of ineffectiveness,” says Tait Shanafelt, M.D. “What we found is that more physicians in almost every specialty are feeling this way and that’s not good for them, their families, the medical profession, or patients.”

The researchers say evidence indicates that burnout leads to poor care, physician turnover and a decline in the overall quality of the health care system. In the 2011 survey 45 percent of physicians met the burnout criteria, with highest rates occurring in the “front lines” – general internal medicine, family medicine and emergency medicine. In 2014, 54 percent of responding physicians had at least one symptom of burnout. Satisfaction with work-life balance also declined. The survey results were based on 6,880 physicians across the United States, a 19 percent response rate, as well as a population based sample of 5313 working U.S. adults in other fields.

**In a snapshot:**
- Physician burnout is up 10 percent over the last three years
- Burnout rates are up across almost all specialties
- No overall increase in physician work hours was reported
- No increase in rates of depression was observed among physicians

See *Burnout* on page 14
Researchers say the problem of physician burnout is largely a system issue and that health care organizations have a shared responsibility in addressing the problem. They say more needs to be done by healthcare organizations to help physicians by improving the efficiency of the practice environment, reducing clerical burden, and providing physicians greater flexibility and control over work.

**What must be done:**
- Urgent need for research to provide “evidence-based interventions” addressing burnout, including improving efficiency
- Factors in the practice or work environment have to change
- Offering self-help solutions is no longer enough

References:

**CMS Posts Quality Performance Data On Individual Doctors**

In early December Centers for Medicare and Medicaid announced that for the first time it has posted quality performance data on individual physicians to its Physician Compare website. The data include 2014 clinical quality performance measures for about 40,000 individual physicians who reported such information through Medicare’s Physician Quality Reporting System. In a statement, American Medical Association President Steven Stack said his organization was “dismayed” by CMS' decision to publish individual physician data.

Readers are invited to explore the website, which includes substantial provider demographic data, Medicare participation data, PQRS data, and patient satisfaction data (Consumer Assessment of Healthcare Providers and Systems) for both group practices and now individual physicians. Print readers can easily find this by searching “Physician Compare and CMS”.

**A THOUGHT FOR WELL BEING**

“Who is the happier man, he who has braved the storm of life and lived or he who has stayed securely on shore and merely existed?”

– Hunter S. Thompson, journalist and writer

Editor’s Note: Those who know a bit about the author of this quote will remember that some storms end in tragedy, and a well-being case can be made for avoiding them.
Happy New Year! Welcome to 2016, the year of new adventures!
Lots of change happening in this new year… IT/Informatics governance processes, clinical content tools development, Pediatrics service line expansion, partnering with Adventist, new Director of Analytics and growth of that division, introduction of clinical and identification photos… the list goes on, and probably includes things we haven’t even dared get excited about!

With respect to governance – the ultimate goal is for IT, Informatics and Analytics to become a vital supporting service to clinical and business operations. As service lines identify new (more efficient or effective) processes by which to deliver care, or identify new clinical best practices, the Clinical Content Tools team will work to provide a tool-kit to support the changes. Joint Informatics Council (JIC) will be the body to receive all requests and ‘prioritize’ them to allocate resources to get the work done. The prioritization is really to ensure two things:
1) the request supports either corporate strategy, facility strategy, regulatory requirements, or best practices, and
2) to get our arms around the total volume of work being requested by any/all avenues, so I can work to develop a realistic estimate of the resource growth needed to support the volume of work already in the pipeline, and new requests.

As I have learned more details about what it currently takes to keep EPIC and other technical systems running (continuous maintenance), plus accommodate change requests, upgrades, fixes and implementation of new modules, beds/towers and staffing, I find there is room for significant growth within IT, analytics and informatics to keep it all afloat. I’m not sure anyone realized how much energy and effort is being expended just on routine maintenance, least of all me! So, as we continue to add modules, users and patients, while also extending our relationship with external partners, we need to grow the fleet of mechanics, service technicians and translators to facilitate being able to respond in a timely manner.

The organization is slowly becoming data-aware and data-curious. In order to have near real-time access to dashboards to monitor performance, identify trends, make process changes that improve metrics, and point out internal best practices we will need to move forward with a data warehouse… initially within EPIC, and very quickly at the enterprise level. This will allow us to ask questions about any number of things – does it make sense to expand into this market area; are we being good stewards around the cost of care for our patients; are we meeting our quality of care targets (or even better, blowing them away)? Be prepared to hear a lot more chatter about data and analytics, measurement and performance – all educational in nature.

I am excited by all these new adventures, and hope you’ll feel similarly energized. Our goal in Informatics is to support you, so please continue to let us know how we can do a better job, provide comprehensive communications, and be available.

To quote a sage master: Do or Do Not — there is no try! – Yoda

New Service at CRMC: Pharmacists and Pharmacy Technicians Providing Prior-to-Admission Medication List Review in the ED

Submitted by Hagop Afarian MD, Associate CMIO

Background: The prescribing of new medications and the adjustment of existing prior-to-admission (PTA) medication regimens are critical services for many patients admitted through the emergency department (ED). In many instances, it is necessary to consult outside resources (skilled nursing facilities, outpatient pharmacies, etc.) to attain an accurate and comprehensive PTA medication list.

Traditionally, nurses and physicians have assembled the information on PTA medication regimens. However, their ability to collect an accurate and comprehensive list is limited by the inefficiencies of this process in the face of heavy workloads and increasing patient-care responsibilities.

See New Service on page 16
Settling for inaccurate or incomplete PTA medication list places patients at high risk for unintentional medication errors and subsequent adverse drug events (ADE’s), adverse drug reactions (ADR’s), or drug related problems (DRP’s). Since these inaccuracies have been associated with ADE’s, ADR’s, and DRP’s, the Joint Commission has designated inpatient medication reconciliation as a National Patient Safety Goal since 2005.

Pharmacy Technicians Performing PTA Medication List Review: Recent literature demonstrates clear advantages to utilizing skilled pharmacy technicians to complete medication histories in conjunction with pharmacist oversight and review. In a busy environment the pharmacy technician has the advantage of being able to specifically focus time and attention on assembling accurate and comprehensive information. In addition, well-trained pharmacy technicians are proficient in communicating medication information and understand medication use.

CRMC Inpatient Pharmacy PTA Medication Review Service: Beginning on December 1, 2015, Pharmacy technicians – working with a pharmacist – began performing PTA medication list review for patients being admitted through the CRMC ED. The goal is to provide an accurate PTA medication list at the time of patient admission, in order to optimize pharmacotherapy, decrease medication errors, and increase patient safety. This service will initially be active in the ED at CRMC only and will focus primarily on admitted patients in the ED. This is just the first step to more comprehensive services that CRMC Pharmacy, and ultimately all of CMC, will be providing in the future.

What to Look For in EPIC: You will be able to tell if the pharmacy technician is in the process of obtaining an accurate PTA medication list by viewing the Med List Status. The Med List Status will be marked as “Pharm Tech: In Progress” (at CRMC Only) if the pharmacy technician is in the process of reviewing the PTA medication list; and “Pharm Tech: Complete” (at CRMC Only) if they have completed the list and are awaiting pharmacist review. After the pharmacist has reviewed the pharmacy technician’s work on the PTA medication list, the pharmacist will mark “Ready for Provider” in the Med List Status. Below is a screen shot in EPIC that displays the Med List Status options discussed in this section.

When a medication list has been marked “Ready for Provider,” that indicates the medication list has been reviewed and verified, and is now ready for the provider to complete medication reconciliation as part of their admission process. This status can be added as a column on your patient list by following the instructions below.

You can add the status of Prior to Admission Med Review to your My Patient List. From Patient lists Highlight your list select properties and add the PAF columns to your list.
New Service

Continued from page 15

My Patient List with the PTA Med Review Columns:

The pharmacists will still be available as usual in the CRMC ED in addition to now being involved in this service. If there are any questions, please feel free to reach out to Tim Lopez (Pharmacy Manager) tlopez2@communitymedical.org or Bruce Lepley (Director of Pharmacy) blepley@communitymedical.org.

References

Surescripts

When an E-prescription is written in Epic, it is communicated to outside pharmacies through an interface known as Surescripts. Although new prescriptions and refills are effectively communicated electronically, until recently, Surescripts has not had the functionality to transmit discontinuation or cancellation requests to those pharmacies. Currently the majority of pharmacies are not set up to receive discontinue orders, and therefore, cancellation of e-prescribed medications in Epic will NOT forward any notification to the Pharmacy where that E-prescribed medication order was sent.

Until pharmacies are set up to receive discontinue notifications we must continue to be diligent in ensuring our patients do not receive inappropriate medications. If it is necessary to discontinue an outpatient medication order that was e-prescribed, the prescriber MUST also contact the pharmacy where the order was sent to prevent the patient from receiving the cancelled medication. It is also recommended that an attempt be made to contact the patient or responsible party with the information that he/she should NOT receive and/or stop taking that particular medication.

Since the cancellation functionality is dependent on each pharmacy’s ability to interface with Surescripts to receive this particular order, it is unclear how quickly this will be universal. In the meantime, we are working on developing a process in Epic to remind providers to contact the appropriate pharmacy when they discontinue or cancel a prescription through Epic.

On the following page you will find an Epic Tip Sheet to assist you with the process required to cancel any outpatient e-script.

See Surescripts on page 18
Cancellation of E-prescribed medication order

Cancelling an E-prescribed medication order does NOT automatically notify the pharmacy!

Cancellation of an outpatient medication order in Epic does NOT automatically send a cancellation notification to the receiving pharmacy. While it is possible to cancel an outpatient medication order within Epic, it is necessary to notify the pharmacy to prevent the ordered medication prescription from being filled.

Try It Out

After cancelling the outpatient medication order:

1. Identify the pharmacy that the e-prescription was sent to
2. Call the pharmacy on the telephone and inform them of the patient name and the medication that was cancelled within Epic.
3. Here’s how to find the patient’s pharmacy contact information:
   - From the Admission, or Discharge Navigator, select Order Reconciliation, and locate the Pharmacy button and listing, just above the Prior to Admission medication listing.
4. Click on the pharmacy button, to display the pharmacy contact information:

   ![Image of pharmacy contact information]

When a pharmacy is displayed, click on the Pharmacy button to display the detail, including the telephone number.

You Can Also...

- If the medication was not E-prescribed (no pharmacy listed in Epic), remember to notify the patient that you are cancelling the prescription.
**Depth of Debridement Documentation**

Submitted by Sandra Sidel, RHIA, CCS

**A**VOID Queries for clarification by documenting the depth of debridement: Enhanced documentation for debridement = assigning codes that accurately reflect the patient's severity of illness, risk of mortality and intensity of service.

Debridement requires specificity of the depth of tissue involved:
- Skin
- Subcutaneous tissue
- Fascia
- Tendon
- Muscle
- Bone

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

**Tips to a Successful ICD-10 Transition**

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

**Prior ICD-9 Documentation**

45 year old male with diabetic ulcer of lower leg, debrided.

**Improved ICD-10 Documentation**

45 year old male with diabetic ulcer. Non-excisional debridement through fascia of right lower leg.

The following documentation improvements are needed for ICD-10: Depth of Tissue Involved, Type, Laterality

“The There is nothing noble in being superior to your fellow man; true nobility is being superior to your former self.”

– Ernest Hemingway, writer

---

**Medical Board of California Annual Report Now Available**

MBC licensees will likely have been recently notified about the availability of this report. While perhaps not the most scintillating read one could find, the Report does contain items of professional interest to those regulated by it, and whose fees fund it. Particularly for younger physicians, it is good to know the scope of MBC activities and some of the nomenclature surrounding its actions.

A couple items that represent good news:

1. The number of physician California license applications was up by 542 in fiscal year 14-15 compared to prior year.

2. The number of complaints against licensed physicians and the number of cases opened for investigation were both down.

3. The number of medical malpractice reports received from all sources was down substantially, from 721 the prior year to 603 in FY14-15.

Download the report for that next long FAT airport wait or case-delay wait. Print readers can find it at mbc.ca.gov under News.
As the Baby Boomer generation ages into retirement, this country and our state and region are going to experience an immense shift in the demographic of our population. Despite the fact that California is one of the youngest states in the country, the proportion of people over the age of 65 will increase from the current 11% or 4.5 million people to 20% or roughly 8 million in a short 15 years. It will further increase to 22% or 9 million people by 2050.

As physicians understand, the level of disability and chronic disease that expresses itself in this age population increase significantly. This translates into significant increases in the cost of their care, hospitalizations and the potential need for chronic care facilities. In addition, we are increasingly recognizing the unique medical characteristics of the elderly population:

- They do not do as well with medications and tend to have more side effects and severe side effects with their medications
- They do not benefit in the same way from preventive services that we advocate for younger patients
- They experience a significant increase in the incidence of memory and other cognitive decline
- They experience increased risk of falls with their attendant complications from hospitalizations and surgeries

For all of these reasons, we need to focus on the special needs of this population, and we need to better understand how to best meet their healthcare needs.

To accomplish this goal, we are very fortunate that the Larry L. Hillblom Foundation has provided us with a nearly $1,000,000 gift to establish the Larry L. Hillblom Center on Aging at UCSF Fresno. With this gift, we will bring together a number of unique resources that are available through UCSF, UCSF Fresno, and the Fresno medical community to benefit our population. This extraordinary gift from the Hillblom Foundation will provide us the resources to build the umbrella organization that will better coordinate the UCSF Fresno programs and the UCSF research enterprise for our patients in the Central Valley. We will use these funds to establish a clinical center where patients can be seen in a multidisciplinary fashion to coordinate their care across many disciplines. Additionally, we will recruit a physician leader as the director, we will recruit a nurse navigator to help patients and their families coordinate care, and we have recruited a research coordinator who will facilitate providing access to the leading edge research at UCSF for our patients. This umbrella organization will allow us to coordinate care among the UCSF Fresno Alzheimer’s Center, the UCSF Fresno Neurosciences Center, the UCSF Fresno Palliative Care program, the UCSF Pharmacy School, various UCSF Fresno faculty specialists, and CRMC clinical resources such as physical therapy. In addition, the center will provide us the opportunity to work with Fresno State and their programs in gerontology, physical therapy and the nurse practitioner program.

Forty years ago UCSF Fresno was created to help address the healthcare needs of the Central Valley and our unique populations. This generous gift from the Hillblom Foundation will allow us to continue to expand the services and training that we can provide for our fellow citizens in the Central Valley.
Every state, including California, made more improvements in 2015 among 42 health care measures than declines, compared with 2014, according to a just-released report by the Commonwealth Fund. (Note: print readers can find it at www.commonwealthfund.org). This is the fourth annual such scorecard report by this highly regarded organization (which is also the source of highly respected international health system performance comparisons). As in previous years, this report continued to find extensive variation among states in people’s ability to access care when they needed, the quality of care they received, and their likelihood of living a long and healthy life.

Details of Report

The report ranked all 50 states and Washington, D.C., based on their performance on 42 measures related to health care that fell under the dimensions of:

- Access and Affordability;
- Prevention and Treatment;
- Avoidable Hospital Use and Cost;
- Healthy Lives;
- Equity

Minnesota ranked first overall, while Mississippi ranked last. States in the upper Midwest and northeastern parts of the country ranked higher than other regions. States in such areas tended to expand coverage and to have lower insurance rates.

California Findings

Overall, California ranked 23rd for health care access, costs, outcomes and quality.

In terms of access to health care, California ranked 30th. The report showed in 2015:
- 17% of adults ages 19 to 64 were uninsured;
- 14% of adults skipped care in the last year because of costs; and
- 6% of children up to age 18 were uninsured.

California ranked 37th among prevention and treatment measures. The report found:
- 78% of children ages 19 to 35 months had receive all recommended doses of seven key vaccines;
- 74% of adults had a usual source of care;
- 65% of children had a medical and dental preventive care visit in the last year; and
- 32% of adults ages 50 and older had received recommended screening and preventive care.

The report projected that if California improved its performance equal to that of the top performing state in each measure about:
- 2.9 million additional adults would be insured;
- 2.1 million fewer adults would forego care because of costs; and
- 388,387 fewer children up to age 18 would be uninsured.

Further, the report found that California ranked:
- 22nd for equity measures, or performance by income and race;
- 14th among avoidable hospital use and cost measures; and
- Seventh among healthy lives measures.

In the following pages we feature the expanded 2015 Commonwealth Fund scorecard for the Avoidable Hospital Use and Costs of Care dimension. Similar expanded scorecards can be found in the report for the other dimensions. There is also a Health System Data Center Tool to drill down to individual regions, including Fresno. (Some of that regional data does not appear to be up to date, though.) Print readers can find that at commonwealthfund.org.
Avoidable Hospital Use and Costs of Care

Inefficient or wasteful health care, along with high costs, are among the chief problems burdening our health care system. To measure inefficiency, this scorecard dimension focuses on rates of potentially avoidable and expensive hospital care. It also looks at two cost measures: the average cost of an individual employer-based health insurance premium and average annual spending per Medicare beneficiary. Many studies have found that higher spending is not systemically associated with better outcomes. The Affordable Care Act encourages changes to the way we deliver and pay for care and encourages new models, like accountable care organizations and bundled payment arrangements.

Key Findings

Hospitalizations for ambulatory-care sensitive conditions

Among Medicare beneficiaries ages 65 to 74, hospital admissions for ambulatory care-sensitive conditions—that is, conditions that can be managed outside the hospital, like hypertension—fell 2 percent from 2007 to 2008 and then an average 6 percent annually between 2008 and 2013.

The worst-performing states improved the most for this indicator in 2013. The rate fell 16 percent in Oklahoma and 14 percent in West Virginia; rates varied about threefold across states.

30-day hospital readmissions

The hospital readmission rate for Medicare beneficiaries fell by 10.5 percent in 2012 and 10.8 percent in 2013, after declining an average 3.8 percent annually between 2007 and 2011. In October 2012, the Medicare program began financially penalizing hospitals with high rates of readmissions, motivating hospitals to reduce readmissions to avoid these penalties.6

Data: Ambulatory-care sensitive hospitalizations & 30-day readmissions: Medicare claims via Feb. 2015 CMS Geographic Variation Public Use File.
There was considerable variation among states in hospital admission and readmission rates among nursing home residents and home health patients.

Long-term care for elderly Americans is often funded by state Medicaid programs, while their hospital stays and postacute care are paid for by Medicare. Postacute care in either patients’ homes or institutions, like skilled nursing facilities, is the greatest source of Medicare spending variation. Hospital admissions or readmissions from these settings can often be avoided with good transitional care and proactive patient monitoring and intervention.

Wide state variation on indicators of potentially avoidable hospital use suggests opportunities for improvement

<table>
<thead>
<tr>
<th>Top state</th>
<th>Bottom state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-stay nursing home residents with a hospital admission (2012)</td>
<td>31%</td>
</tr>
<tr>
<td>Short-stay nursing home residents with a 30-day readmission to the hospital (2012)</td>
<td>26%</td>
</tr>
<tr>
<td>Home health patients with a hospital admission (10/2013–9/2014)</td>
<td>17%</td>
</tr>
</tbody>
</table>

Data: Nursing home admissions/readmissions: V. Mor, Brown University, analysis of 2012 Medicare enrollment data, Medicare Provider and Analysis Review (MedPAR), and Minimum Data Set (MDS) data; Home health admissions: authors’ analysis of CMS Medicare claims data from CMS Home Health Compare.

States with the highest hospital readmission rates in 2012 tended to have the largest reductions in 2013

Notes: States are arranged in order (lowest to highest) of their readmission rate in 2012.
*Denotes states with at least -0.5 standard deviation change (5 readmissions per 1,000) between 2012 and 2013.
Data: Medicare claims via Feb. 2015 CMS Geographic Variation Public Use File.
**Change in State Health System Performance by Indicator**

<table>
<thead>
<tr>
<th>Number of states that:</th>
<th>Improved</th>
<th>Little or no change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-stay nursing home residents with a 30-day readmission to the hospital</td>
<td>23</td>
<td>28</td>
</tr>
<tr>
<td>Medicare 30-day hospital readmissions, per 1,000 beneficiaries</td>
<td>17</td>
<td>34</td>
</tr>
<tr>
<td>Home health patients with a hospital admission</td>
<td>10</td>
<td>35</td>
</tr>
<tr>
<td>Medicare admissions for ACS conditions, age 75 and older</td>
<td>8</td>
<td>43</td>
</tr>
<tr>
<td>Potentially avoidable emergency department visits among Medicare beneficiaries</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Medicare admissions for ACS conditions, ages 65–74</td>
<td>6</td>
<td>45</td>
</tr>
<tr>
<td>Long-stay nursing home residents with a hospital admission</td>
<td>6</td>
<td>45</td>
</tr>
<tr>
<td>Hospital admissions for pediatric asthma, per 100,000 children</td>
<td>3</td>
<td>45</td>
</tr>
<tr>
<td>Health insurance premium for employer-sponsored single-person plans</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Total Medicare (Parts A &amp; B) reimbursements per enrollee</td>
<td>2</td>
<td>31</td>
</tr>
</tbody>
</table>

Notes: This exhibit measures indicator change over the two most recent years of data available. See Appendix A1 for baseline and current data years for each indicator. Trend data are not available for all indicators. Improvement or worsening refers to a change between the baseline and current time periods of at least 0.5 standard deviations. The “little or no change” category includes the number of states with changes of less than 0.5 standard deviations, as well as states with no change or without sufficient data to assess change over time. ACS = ambulatory care–sensitive.

**Cost of Care**

- National per-beneficiary Medicare spending grew by 7.8 percent between 2008 and 2013, representing average annual growth of 1.9 percent.

- Per-person Medicare spending growth between 2008 and 2013 was 8 percent or less in 31 states and higher than 15 percent in only North Dakota and South Dakota.

- Average health insurance premiums for employer-sponsored individual plans increased in every state between 2008 and 2013, with growth ranging from 16 percent in Arkansas to 39 percent in South Dakota, North Dakota, Ohio, and Alaska.

**Future Implications**

If all states performed as well as the top-performing state:

- Medicare beneficiaries would have over 1.4 million fewer emergency room visits for care that could be provided outside the emergency room.

- Children between 2 and 17 would endure about 85,000 fewer asthma-related hospital admissions.
The risk of developing a catheter associated urinary tract infection (CAUTI) increases the longer an indwelling urinary catheter remains in place. For this reason, it is critical to avoid insertion when feasible and have ongoing assessment of the continued need for catheterization. To prevent infectious and non-infectious complications the following best practice is recommended:

Reduce the insertion of urinary catheters
• Use alternatives, such as condom catheters and intermittent catheterization when possible
• When inserted, utilize sterile technique

Practice proper catheter maintenance techniques
• Follow the CAUTI Adult Prevention Program maintenance bundle to include pericare, maintaining the seal, using a securement device, keeping the bag below the bladder and off of the floor.
• Assess and document the indication for the catheter on a DAILY basis

Remove urinary catheters as quickly as possible
• Early bladder training.
• In ambulatory patients use collection hats, bedpans, and bedside commodes to monitor intake and output.

Consequences of CAUTI

According to the Centers for Disease Control and Prevention (CDC), CAUTIs are the most common type of hospital acquired infections costing up to half a billion dollars in health care losses annually. CAUTIs can lead to an increase in morbidity, mortality, and unfunded hospital days and readmissions.

The reporting of hospital acquired CAUTI is required by all facilities receiving funds from the Centers for Medicare and Medicaid Services and is inclusive of critical care units and medical surgical units at this time. Hospitals that fail to meet benchmarks both for internal improvement goals and national standards are subject to a reduction in funds from the Annual Payment Update.

Anatomy of the CAUTI Definition

The CDC has created a set of surveillance definitions that all acute care hospitals are held to for reporting purposes. The complete definitions can be found at www.cdc.gov/nhsn/acute-care-hospital/cauti/index.html under Protocols.

Per the CDC, a patient is defined as having a CAUTI when the following 3 criteria are met within a 7 day window:
1. Indwelling urinary catheter in for greater than 2 days [day of insertion is day one]
2. Fever > 38°C or costovertebral angle pain or suprapubic tenderness
3. Urine culture growing a bacteria in quantities of >100,000 CFU/ml

A CAUTI has very few exclusions. The culture has to grow a bacteria of sufficient colony counts (yeasts and other fungi are excluded). A CAUTI cannot be deemed secondary to another site of infection nor can the fever be attributed to another cause. The white blood cell count is not part of the definition nor can urinalysis results be used to prove an infection was present on admission.

Surveillance Definitions Versus Clinical Infection

Surveillance definitions do not always directly correlate to the clinical state of the patient and the CDC CAUTI definitions are a case in point. Surveillance definitions developed by the CDC have been distilled into an algorithm that is very good at doing what it was designed to do - identify infections using objective data. Clinical definitions of infection by contrast are designed with individual patient care in mind, practitioner judgement, and consist of guidelines rather than fixed rules. Unfortunately the lines between these two entities get cross linked when incorporated into Pay for Performance initiatives and reimbursement. It is important to understand best practices for patients and how timeliness can play a part in prevention. Remember, place only if no other alternative, maintain and assess the need daily, and remove as soon as possible to prevent both surveillance and clinical CAUTIs.
Important New Options at Community for Rapid Nucleic Acid Testing of Respiratory Pathogens

Submitted by Marilyn Mitchell M.T. (ASCP) M.S., CRMC Microbiology Supervisor; and David Slater M.D., CRMC Lab Medical Director

Well timed for winter’s chill, peak respiratory illness season, and enhanced pediatric care, the Microbiology Lab at Community Regional is pleased to announce expanded testing for viral respiratory pathogens and several Bordetella species. Testing (by Verigene’s RP Flex method) is available from all CMC facilities and can also be done on specimens from offices and clinics.

This highly sensitive and specific RT-PCR testing – which uses a platform we have already been using for Influenza and Respiratory Syncytial Virus (RSV) testing – will be offered as a range of pathogen panels and as select individual pathogen tests. Our menu was developed with input from Community’s Infectious Diseases experts.

By providing menu of test choices rather than one all-inclusive panel, we hope testing resources will be used optimally for patient needs. Results are generated for all the pathogens when a sample is tested, but both we in the lab, and you as end user, will see results only for ordered tests. (This means if you later need information about a pathogen not initially ordered, you can place an add-on order and we then have access to that result without having to recollect a new specimen).

Other notes:
1. The only acceptable specimen is a nasopharyngeal swab (that familiar collection system used for prior years’ influenza testing). Material should be obtained from well back in the nasopharynx. Two swabs are provided – one for each nostril, submitted together in a single tube of Viral Transport Media.
2. This testing is performed and resulted throughout the day and evening shifts. Currently, testing is performed during night shift hours M-F with results reported on the early AM shift after review by the CLS.
3. For orders from outside the hospitals, samples should be refrigerated in the Viral Transport Media until delivered for testing. Such samples are stable for 48 hours.
4. PCR testing is highly sensitive and specific, though DNA similarity between rhinovirus and some enterovirus can result in cross reactivity. False negatives can occur in very early disease with low pathogen load, or if sample is too scant. Recent vaccination with nasal Influenza vaccine can produce false positives for influenza A and/or B.

<table>
<thead>
<tr>
<th>Order code</th>
<th>Description in EPIC</th>
<th>Pathogen Target(s) Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLUPC</td>
<td>Influenza A and B by PCR</td>
<td>Influenza A, Influenza A H1, Influenza A H3, Influenza B</td>
</tr>
<tr>
<td>RSVPC</td>
<td>RSV by PCR</td>
<td>RSV A, RSV B</td>
</tr>
<tr>
<td>ADNVP</td>
<td>Adenovirus by PCR</td>
<td>Adenovirus</td>
</tr>
<tr>
<td>BPTUP</td>
<td>Bordetella pertussis Group by PCR</td>
<td>B. pertussis, B. holmesii, B. parapertussis/B. bronchiseptica</td>
</tr>
<tr>
<td>VRPPC</td>
<td>Viral Respiratory PANEL, PCR.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RSVPC: RSV by PCR</td>
<td>RSV A, RSV B</td>
</tr>
<tr>
<td></td>
<td>ADNVP: Adenovirus by PCR</td>
<td>Adenovirus</td>
</tr>
<tr>
<td></td>
<td>PARIP: Parainfluenza by PCR</td>
<td>Parainfluenza 1, 2, 3, 4</td>
</tr>
<tr>
<td></td>
<td>HMPVP: Human Metapneumovirus by</td>
<td>Human Metapneumovirus</td>
</tr>
<tr>
<td></td>
<td>PCR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RHINP: Rhinovirus by PCR</td>
<td>Rhinovirus</td>
</tr>
</tbody>
</table>

Epic Test Names and Their Shorthand Codes:

Verigene testing in CRMC Micro Lab – it is still people who make it happen.
End of life care in America has made great strides over the past few decades. Throughout history, medical care was predominantly supportive, as there were few afflictions that could actually be cured. However, there has been tremendous growth in medical innovation since the arrival of the antibiotic age. Somewhere during that time, we physicians began to see death as a failure as opposed to the inevitable closing chapter of all of our lives. Nonetheless, it has become apparent that these treatments did not uniformly benefit all and could be associated with significant burden. It has been recognized that Palliative Care is vitally important to help ensure that treatment is congruent with the patient’s values and overall condition.

The California Healthcare Foundation in collaboration with the Coalition for Compassionate Care of California recently assessed end-of-life care in our state as it compares to the report of the Institute of Medicine. “Dying in California: A Status Report on End-of-Life Care” reports just 903 certified Palliative Care physicians for our entire state as of 2015. This is sobering. It does not seem realistic to expect that number to rise rapidly enough to meet Californians’ increasing needs, particularly given the aging population. Indeed, the number of both physicians and nurses in California’s Palliative Care workforce actually decreased between 2012 and 2015. Therefore, it is imperative to provide primary level training in Palliative Care to all. Medicare will now be providing payment for Advance Care planning which will hopefully spur interest in improved communication skills on the topic. Print readers can access this report by searching its title.

It is with pleasure that I would like to announce the quarterly Palliative Care Corner, which will have submissions from CRMC’s Dr. Patrick McMillan and myself on Palliative Care issues. We believe this will help us all work together to provide the best possible care to our patients.

Happy New Year to all!

The Institute of Medicine in 2014 issued a seminal report, “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life”

The key elements examined were:
1) delivery of care
2) clinician-patient communication and advance care planning
3) professional education and development
4) policies and payment systems
5) public education and engagement. Print readers can access this report by searching its title.
Usefulness of Standard Plasma Coagulation Tests in the Management of Perioperative Coagulopathic Bleeding: Is There Any Evidence?

Submitted by David Slater M.D., CRMC Lab Medical Director

This study in the British Journal of Anaesthesia (vol 114 (2): 217–24 [2015]) closely examined the utility of standard coagulation assays (PT and PTT) to predict abnormal bleeding. These are among the most commonly ordered tests in acute care hospitals, and this is an every-day question faced by clinicians in those hospitals – so this is important information.

You may remember that traditional coagulation tests (notably, PT/INR) were not designed to predict coagulopathic bleeding risk from surgery or a procedure. A long INR often responds poorly to plasma transfusion in part because the INR of thawed plasma may be up to 1.4. Only a substantially prolonged INR (generally, at least 2.0) signifies risk for factor depletion (<30%) significant enough to cause coagulopathy. The relationship between % factor activity and INR is not linear. Transfusion of coagulation factors will shorten a markedly prolonged INR e.g., an INR of 5) much more than a mildly prolonged INR e.g., an INR of 1.7).

The Article includes this Summary:

“Standard laboratory coagulation tests (SLTs) such as prothrombin time/INR or partial thromboplastin time are frequently used to assess coagulopathy and to guide haemostatic interventions. However, this has been challenged by numerous reports, including the current European guidelines for perioperative bleeding management, which question the utility and reliability of SLTs in this setting. Furthermore, the arbitrary definition of coagulopathy (i.e. SLTs are prolonged by more than 1.5-fold) has been questioned.

The present study aims to review the evidence for the usefulness of SLTs to assess coagulopathy and to guide bleeding management in the perioperative and massive bleeding setting. Medline was searched for investigations using results of SLTs as a means to determine coagulopathy or to guide bleeding management, and the outcomes (i.e. blood loss, transfusion requirements, mortality) were reported. A total of 11 guidelines for management of massive bleeding or perioperative bleeding and 64 studies investigating the usefulness of SLTs in this setting were identified and were included for final data synthesis.

Referenced evidence for the usefulness of SLTs was found in only three prospective trials, investigating a total of 108 patients (wherein microvascular bleeding was a rare finding). Furthermore, no data from randomized controlled trials support the use of SLTs. In contrast, numerous investigations have challenged the reliability of SLTs to assess coagulopathy or guide bleeding management. There is actually no sound evidence from well-designed studies that confirm the usefulness of SLTs for diagnosis of coagulopathy or to guide haemostatic therapy.”

Of interest to those who order transfusions at CRMC is that the authors advocate ROTEM (or the similar TEG instrument) in preference to SLTs to achieve a stronger predictive value for procedural bleeding propensity and to guide plasma and cryoprecipitate transfusion decisions. CRMC’s trauma and cardiac services do make extensive use of this technology, and are encouraged to continue to use it to guide coagulation factor (plasma, core precipitate) and platelet transfusion decisions.

For all our readers, the message is to not regard with too much reverence, the relationship between INR and bleeding propensity, nor to over-aggressively transfuse plasma or defer needed care on the basis of a modestly long INR. Yes you can find older guidelines based on “we got a bunch of white haired guys in a room (no, not our esteemed Dr. Dominic – some other guys) and this is what they say” approaches – but the evidence just isn’t there.

Practically speaking, all US hospitals still refer to standard coagulation tests in their transfusion guidelines – no one has jettisoned these tests completely for the purposes of ordering plasma – though European guidelines are getting there. But in recent years, widespread recognition of their limitations – along with increasing recognition of the risks of transfused plasma (immune modulation, infectious and respiratory consequences, fluid overload, allergic reactions) – has lead most hospitals and expert guidance to “dial up” the INR levels at which plasma transfusions should be considered in various scenarios. Community has done the same, though not as aggressively as some other facilities. Readers are advised to be familiar with our guidelines (which are embedded in the transfusion set as plasma is ordered for anything other than a massive transfusion).

The authoritative American Association of Blood Banks (AABB) reached this conclusion in 2012 after rigorous review of the evidence:

See Coagulation on page 29
Coagulation
Continued from page 28

“…80 randomized controlled trials have investigated frozen plasma with no consistent evidence of significant benefit for prophylactic and therapeutic use across a range of indications evaluated…”

And “…While many physicians transfuse plasma based on coagulation testing (e.g., prothrombin time and international normalized ratio), data from the available clinical studies did not allow outcomes of plasma transfusion to be correlated with differences in the degree of coagulopathy (based on this testing)…”


Total Unit Opportunity by Blood Product Group: Blood Product Opportunity Through Achieving Benchmark Rates of Utilization (Inpatient Only) The calculated number of units that could be saved if the facility transfuses at the targeted rates during the indicated period. The total potential for savings is illustrated below using both types of benchmark targets: BloodStat® Mean and BloodStat® 80th Percentile. (Numbers shown in parenthesis indicate the percentage opportunity based upon current use.)

strategicbloodportal.com

Here’s a high level snapshot of how CMC facilities use plasma compared to other US hospitals. Our use is compared to identically MSDK-coded care at dozens of other hospitals (there are over 5 million transfusions in the benchmark data base, from within past 2 years). The charts display units transfused over and above the mean of the benchmark data set, for same mix of care (as closely as that can be compared among different facilities at an MSDKG level) – designated “opportunity” units. Note: While the focus of this article is on plasma, other components are well represented in our opportunity pies.

If you’d like copies of the two referenced articles, let me know: Dslatermd@communitymedical.org.
Editor’s Note: Choosing Wisely continues to grow and is now a substantive resource for physicians and patients. A major new section is that of the Physician Communication Modules. The American Board of Internal Medicine Foundation funded the Drexel University College of Medicine to develop a set of interactive instructional modules to enhance physician and patient communication around the specialty society recommendations from the Choosing Wisely campaign. Developed in collaboration with nine medical specialty societies, these modules are designed to help physicians, patients and other health care stakeholders think and talk about overuse of health care resources by providing strategies for physicians to build trust and address patient attitudes and beliefs that more care is not always better care.

We will feature links to a number of these in future issues. This month, check out the module developed by the American College of Physicians. It includes sections on key communication skills, has video examples of communication skills, and features expanded discussions of that Society’s 5 Choosing Wisely Recommendations (Pre-OP chest x-ray, routine ECG, to name two). Print readers can find it by going to www.ChoosingWisely.org < Resources < Physician Communication Modules.

The 23rd in Our Series of Specialty Recommendations for “Choosing Wisely”

Don’t order a duplicate genetic test for an inherited condition unless there is uncertainty about the validity of the existing test result.

Prior to ordering a genetic test for an inherited condition, the health care provider should ask a patient about prior genetic testing and review the medical record for previously performed genetic tests. Repeating a genetic test should be considered if the existing result is inconsistent with the individual’s clinical presentation or if the test methodology has changed and may yield a different result from the original report that could impact patient management.

Don’t order APOE genetic testing as a predictive test for Alzheimer disease.

APOE is a susceptibility gene for later-onset Alzheimer disease (AD), the most common cause of dementia. The presence of an ε4 allele is neither necessary nor sufficient to cause AD. The relative risk conferred by the ε4 allele is confounded by the presence of other risk alleles, gender, environment and possibly ethnicity. APOE genotyping for AD risk prediction has limited clinical utility and poor predictive value.

Don’t order MTHFR genetic testing for the risk assessment of hereditary thrombophilia.

The common MTHFR gene variants, 677C>T and 1298A>G, are prevalent in the general population. Recent meta-analyses have disproven an association between the presence of these variants and venous thromboembolism.

Don’t order HFE genetic testing for a patient without iron overload or a family history of HFE-associated hereditary hemochromatosis.

The majority of hereditary hemochromatosis is due to inheritance of HFE gene mutations. HFE gene mutations are common among individuals of European ancestry; however, only a small proportion of individuals with these mutations develop clinical disease. Other genetic and non-genetic factors contribute to disease expression. HFE genotyping should only be performed among individuals with iron overload (e.g., elevated fasting transferrin saturation >45%) or a known family history of HFE-associated hereditary hemochromatosis.

Don’t order exome or genome sequencing before obtaining informed consent that includes the possibility of secondary findings.

The informed consent discussion for exome and genome sequencing should include the possibility of secondary findings unrelated to the indication for testing. In addition, before ordering an exome or genome sequencing test, review with the patient the potential benefits (e.g., confirming a suspected genetic diagnosis), potential harms (e.g., psychosocial concerns), limitations of testing (e.g., a mutation may be missed), implications of the test results for family members, and alternatives to exome or genome sequencing.

The items on the ACMG list are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. In determining the propriety of any specific procedure or test, patients should consult with their individual providers and providers should apply their own professional judgment to the specific clinical circumstances presented by each individual patient.
**Clovis Perinatal M & M**

Title: “Emergent Cardiac Disease of the Neonate: A Case Study”
Date: Tuesday, January 19, 2016
Speakers: Principal Discussants: Phillip Cheng M.D.; Ana Coll M.D.
Time: 12:30pm-1:30 pm (lunch provided)
Place: Clovis Community Medical Center – Outpatient Care Center
Conference Room
Contact: No RSVP required
CME: 1 CME

**CRMC Perinatal M & M**

Title: “Perinatal Hospice”
Date: Wednesday, January 20, 2016
Case Presentation: Genetic Counselor: Cory Airheart M.S., LCGC; NICU: Diana M. Cormier D.N.P., M.P.H., RNC-NIC; L&D: Mary Burke RNC-OB, Clinical Nurse Educator Obstetrics: Teresa Leung, DO;
Speakers: Principal Discussants: Genetic Counselor: Cory Airheart M.S., LCGC; NICU: Diana M. Cormier D.N.P., M.P.H., RNC-NIC; Director of Center for Grief & Healing and Angel Babies at Heinds Hospice Kathy Cromwell M.S.W., LCSW, CT; L&D: Mary Burke RNC-OB, Clinical Nurse Educator
Place: UCSF-Fresno, Room 136
155 N. Fresno St., Fresno, CA 93701
Contact: No RSVP required
CME: 1 CME

**“Chronic Cough”**

Date: Tuesday, January 26, 2016
Speaker: John Moua M.D. – Pediatric Pulmonologist; Paul Do M.D. – Pediatric Pulmonologist, UCSF Pediatric Specialist
Time: 6:30pm-8:30pm (dinner provided – vegetarian options available)
Place: Vintage Press, 216 N. Willis St., Visalia, CA
Contact: cmersvp@communitymedical.org
or contact Ric Morales at rmorales3@communitymedical.org, 559-459-6211
CME: 1 CME

**“Update on Interventions for Acute Ischemic Stroke”**

Date: Thursday, January 28, 2016
Speaker: Amir Khan M.D.
Time: 6:30pm-8:30pm
Place: Galletto Ristorante
1101 “J” Street, Modesto, CA 95354
Contact: Kimberly Goldring, cell: 559-260-4613 or Kgolding@communitymedical.org
CME: 1 CME

Please also see the enclosed individual flyers for more on these & other upcoming local CME activities to meet your CME needs.
SPEAKERS:
Robert Ryan, M.D.
Amir Khan, M.D.
Armen Choulakian, M.D.

ATTENDEES WILL:

1. Will improve patient treatment and outcomes by identifying the best treatment options available for each individual.

2. Will better facilitate communication between disciplines to improve patient care.

3. Will become familiar with different treatment modalities and options available to improve outcomes for patients with Ischemic and Hemorrhagic stroke.

4. Will improve follow-up compliance by discussion and agreement on a comprehensive treatment plan by the multidisciplinary group.

DATE/TIME:
January 6th from 12:00pm. to 1:00pm.

LOCATION:
Community Regional Medical Center
Sequoia East Conference Room

1 Hour CME and Lunch provided
***Must RSVP to:

Tyler Bandy
(559) 459-2097
tbandy@communitymedical.org

TARGET AUDIENCE:
Neurosurgeons, Neurologists, Vascular Surgeons, Radiologists, Rehabilitation Medicine Primary care physicians, Internal Medicine, ER Medicine, OT, PT, SLP, Residents, Mid-Level providers, and all Allied Health Professionals who work in primary care field.

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 Robert Ryan, M.D. and event planner Heather Stokes, Tyler Bandy and Kevin Ng have no disclosures to make.

www.CommunityRegional.org
ESSENTIALS OF PRIMARY CARE PSYCHIATRY
CME CONFERENCE

Friday, January 15 to Saturday, January 16, 2016
Hilton Sacramento Arden West in Sacramento, CA
Jointly Sponsored by the California Psychiatric Association and the University of California,
Davis, Department of Psychiatry and Behavioral Sciences

Approved for 11 AMA PRA Category 1 Credits™

• Registrants receive Lippincott’s Primary Care Psychiatry Textbook included with registration!
• Practical “primary care psychiatry” clinical pointers for primary care providers and mental health providers
• Important DSM-5 diagnostic updates
• Topics include: Mood/anxiety disorders, substance misuse, personality disorders, collaborative care, pain psychiatric management and how to do a primary care psychiatric interview
• Hear from speakers who are national experts in the practice of psychiatry in the non-psychiatric setting
• Small group discussion and personalized learning with faculty who practice in both primary care and psychiatric settings
• CPA / UC Davis Certificate of Completion for each attendee

For program/registration and hotel information please log onto: http://www.calpsych.org/#!education/c16zi
If you have question please contact Lila Schmall at 800-772-4271 or email at Lila-schmall@calpsych.org
Clovis Perinatal M & M
Presents:
“Emergent Cardiac Disease of the Neonate: A Case Study”

Tuesday January 19, 2016
12:30-1:30 p.m

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

Principal Discussant
Phillip Cheng M.D
Ana Coll 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 Cardiac Disease.
2) Gain insight into the potential problems related to Coarctation of the Aorta thereby improving patient safety & outcomes.
3) Learn, better understand and incorporate into patient care the knowledge of Coarctation of the Aorta, improving diagnostic methods and patient outcomes.

1 CME will be offered
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.
Perinatal M & M Presents:

“Perinatal Hospice”

Wednesday, January 20, 2016 from 12:30pm – 1:30pm

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

Case Presentation
Genetic Counselor: Cory Airheart, MS, LCGC
NICU: Diana M. Cormier, DNP, MPH, RNC-NIC
L&D: Mary Burke RNC-OB, Clinical Nurse Educator
Obstetrics: Teresa Leung, DO

Principal Discussants
Genetic Counselor: Cory Airheart, MS, LCGC
NICU: Diana M. Cormier, DNP, MPH, RNC-NIC
Director of Center for Grief & Healing and Angel Babies at Hinds Hospice: Kathy Cromwell MSW, LCSW, CT
L&D: Mary Burke RNC-OB, Clinical Nurse Educator

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 Perinatal Hospice.
2) Gain insight into Perinatal Hospice, 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

C. Airheart; D. Cormier; K. Cromwell; M. Burke and Program Director Dr. K. Rajani; and Program Planner Bernadette Neve have no relevant commercial relationships to disclose.

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

Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (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.
CME Dinner Lecture

Chronic Cough

SPEAKER: John Moua, M.D.
Pediatric Pulmonologist
Paul Do, M.D.
Pediatric Pulmonologist
UCSF │ Pediatric Specialist

DATE/TIME: Tuesday, Jan. 26, 2016
6:30 p.m. - 8:30 p.m.

ATTENDEES WILL:

1. Gain better understanding of cough mechanism/Reflex.
2. Better understand and put into practice the common etiologies of chronic cough in Pediatric population.
3. Develop a systematic approach to chronic cough in order to improve patient outcomes.

LOCATION: Vintage Press
216 N. Willis St., Visalia, CA

CME 1.0
Dinner provided (Vegetarian options available)

TARGET AUDIENCE:
Pediatricians, Physicians in Primary care, Family Practice, Physician Assistants and Nurse Practitioners.

RSVP e-mail to: cmersvp@communitymedical.org
Or contact Ric Morales at Rmorales3@communitymedical.org.
Ph. (559) 459-6211

Community Regional Medical Center

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: John Moua, M.D and Paul Do, M.D. and event planner Ric Morales have no disclosures to make.
CME Dinner Lecture
Update On Interventions For Acute Ischemic Stroke

SPEAKER: Amir Khan, M.D.
UCSF Neurosciences Institute

DATE/TIME: January 28, 2016
Thursday - 6:30 p.m. - 8:30 p.m.

ATTENDEES WILL:

1. Will know how to identify patients eligible for treatment with IV & PA endovascular stroke interventions, or Neuro-ICU management.

2. Gain competency to discuss acute stroke intervention treatment options with patients and patient families and/or caregivers.

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

RSVP to: Kimberly Goldring:
Kgoldring@communitymedical.org
Cell: 559-260-4613

CME 1.0
Dinner provided (Vegetarian options available)

LOCATION: Galletto Ristorante
1101 "J" Street, Modesto, CA 95354

www.CommunityRegional.org

Disclosures: Speaker: Amir Khan, M.D. and event planner Kimberly Goldring, Ric Morales and Louis Triana have no disclosures to make.
TARGET AUDIENCE: All Physicians and Allied Health Professionals

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

CME: 4 Applied for

Invitation to follow
January 2016

January 7
No Grand Rounds

January 14
No Grand Rounds – Resident Open Meeting

January 21
“Obscured PTSD, Idiopathic Parkinson’s and an Unrecognized Deliriogenic State.”
Binoj Matthew MD, Presenter
Christine Obata, MD, Advisor
UCSF Fresno Psychiatry Residency Program

January 28
TBD
Dwayne DePry, DO
Assistant Clinical Professor, Health Science Series
UCSF Fresno Medical Education Program

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.
<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00-8:00 am Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>7:00-8:00 am Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm.</td>
<td>7:30-8:30 am Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm.</td>
<td>7:00-8:00 am Chest Conference UCSF # 116</td>
<td>7:00-8:00 am Orthopedic GR UCSF Rm. 136</td>
</tr>
<tr>
<td>8:00 - 9:00 am Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>7:30-8:30 am Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am HPB Planning Conf. CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am Surgical Grand Rounds CRMC- Sequoia West Conf. Rm</td>
</tr>
<tr>
<td>7:30-8:30 am FP Faculty Development UCSF Fresno Rm. 329</td>
<td>7:30-8:30 am Cardiac Cath &amp; Intervention Cath Lab</td>
<td>8:00 am Emergency Medicine UCSF Rm 136</td>
<td>8:30-9:30 am Surgery Clinical Case Rev. CRMC Sequoia West Conf. Rm</td>
<td>8:30am 12:30pm OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>12:00-1:00 pm Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>12:00-1:00 pm Brain Tumor/Cyberknife Conf-Lower Level-Rad-Onc</td>
<td>12:00-1:00 pm Critical Care/ Trauma CRMC 1st Floor Surgery Conf</td>
<td>4-5 pm Psychiatry GR UCSF Rm 116</td>
<td></td>
</tr>
<tr>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
</tr>
<tr>
<td>7:00-8:00 am Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>7:00-8:00 am Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm.</td>
<td>7:30-8:30 am Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm.</td>
<td>7:00-8:00 am Chest Conference UCSF # 116</td>
<td>7:00-8:00 am Orthopedic GR UCSF Rm. 136</td>
</tr>
<tr>
<td>8:00 - 9:00 am Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>7:30-8:30 am Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am HPB Planning Conf. CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am Surgical Grand Rounds CRMC- Sequoia West Conf. Rm</td>
</tr>
<tr>
<td>7:30-8:30 am FP Faculty Development UCSF Fresno Rm. 329</td>
<td>7:30-8:30 am Cardiac Cath &amp; Intervention Cath Lab</td>
<td>8:00 am Emergency Medicine UCSF Rm 136</td>
<td>8:30-9:30 am Surgery Clinical Case Rev. CRMC Sequoia West Conf. Rm</td>
<td>8:30am 12:30pm OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>12:00-1:00 pm Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>12:00-1:00 pm Brain Tumor/Cyberknife Conf-Lower Level-Rad-Onc</td>
<td>12:00-1:00 pm Critical Care/ Trauma CRMC 1st Floor Surgery Conf</td>
<td>4-5 pm Psychiatry GR UCSF Rm 116</td>
<td></td>
</tr>
<tr>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
</tr>
<tr>
<td>7:00-8:00 am Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>7:00-8:00 am Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm.</td>
<td>7:30-8:30 am Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm.</td>
<td>7:00-8:00 am Chest Conference UCSF # 116</td>
<td>7:00-8:00 am Orthopedic GR UCSF Rm. 136</td>
</tr>
<tr>
<td>8:00 - 9:00 am Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>7:30-8:30 am Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am HPB Planning Conf. CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am Surgical Grand Rounds CRMC- Sequoia West Conf. Rm</td>
</tr>
<tr>
<td>7:30-8:30 am FP Faculty Development UCSF Fresno Rm. 329</td>
<td>7:30-8:30 am Cardiac Cath &amp; Intervention Cath Lab</td>
<td>8:00 am Emergency Medicine UCSF Rm 136</td>
<td>8:30-9:30 am Surgery Clinical Case Rev. CRMC Sequoia West Conf. Rm</td>
<td>8:30am 12:30pm OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>12:00-1:00 pm Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>12:00-1:00 pm Brain Tumor/Cyberknife Conf-Lower Level-Rad-Onc</td>
<td>12:00-1:00 pm Critical Care/ Trauma CRMC 1st Floor Surgery Conf</td>
<td>4-5 pm Psychiatry GR, UCSF Rm 116</td>
<td></td>
</tr>
<tr>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>12:30-1:30 pm Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
</tr>
</tbody>
</table>

Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. Community Medical Centers takes responsibility for the content, quality and scientific integrity of this CME activity. Community Medical Centers designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education. Email: lsmith@communitymedical.org
<table>
<thead>
<tr>
<th>MON</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>6:30 - 7:15 am</td>
<td>Ortho Surg. - Foot/Ankle/Hand SPOC</td>
<td>7:00-8:00 am</td>
<td>Orthopedic GR UCSF Rm. 136</td>
</tr>
<tr>
<td>26</td>
<td>7:00-8:00 am</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>7:15-8:15 am</td>
<td>Chest Conference UCSF # 116</td>
</tr>
<tr>
<td>27</td>
<td>7:15-8:15 am</td>
<td>Neuroscience Pt. Case Present. NORC Conf. Rm</td>
<td>7:30-8:30 am</td>
<td>7:00-8:00 am</td>
</tr>
<tr>
<td>28</td>
<td>7:30-8:30 am</td>
<td>Chest Conference UCSF # 116</td>
<td>USCFS # 116</td>
<td>7:30-8:30 am</td>
</tr>
<tr>
<td>29</td>
<td>7:30-8:30 am</td>
<td>HPB Planning Conf. CRMC-Seqouia West Conf. Rm</td>
<td>Surgical Grand Rounds CRMC-Seqouia West Conf. Rm</td>
<td>Surgical Grand Rounds CRMC-Seqouia West Conf. Rm</td>
</tr>
<tr>
<td>8:00-9:00 am</td>
<td>Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>7:30-8:30 am</td>
<td>Cancer Conference CRMC-Seqouia West Conf. Rm</td>
<td>8:30-9:30 am</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td>7:30-8:30 am</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>8:30-9:30 am</td>
</tr>
<tr>
<td>4-5 pm</td>
<td>Psychiatry GR UCSF Rm 116</td>
<td>12:00-1:00 pm</td>
<td>Critical Care/Trauma CRMC 1st Floor Surgery Conf</td>
<td>OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:00-1:00 pm</td>
<td>CCMC QPSC MRCC Palm Room</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture CRMC 10 West Conf. Rm.</td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
<td>Thursday</td>
<td>Friday</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>New Year’s Day Holiday</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12:30pm</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8:00am</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Emergency Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Outpatient Conference Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:00pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peds/Neon CFPRC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC 4 West NICU</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conference Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5:30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Robotic Steering Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TCCB Surgery Conference Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:30pm</td>
<td>4:45pm</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Medicine/Family Medicine/Psychiatry/Psychology/Physical Med and Rehab Committee</td>
<td>Quality Council</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Outpatient Conference Room</td>
<td>CRMC Sequoia East Room</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Cardiology Advisory</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Cardiology Advisory</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Cardiology Advisory</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6:00pm</td>
<td>6:00pm</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC/CRMC Radiology Advisory</td>
<td>CCMC Multispecialty Peer Review</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Sequoia East Room</td>
<td>CRMC Sequoia East Room</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6:00pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC/CRMC Radiology Advisory</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Sequoia East Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6:00pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9:00am</td>
<td>12:30pm</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Emergency Medicine Advisory</td>
<td>CRMC Multispecialty Peer Review</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>UCSF Fresno 116</td>
<td>CRMC Sequoia East Room</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ethics Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12:30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ethics Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6:00pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Facility Executive Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>MRCC Palm Room</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As of 12/29/15