Automotive Art: Hood Ornaments and Badging

You don’t have to be a motor head to appreciate automotive art. And beyond these items as art, many of us have recollections of cars we grew up with and admired; automotive iconography evokes strong memories for many of us who are of an age. Its themes have mirrored – and in part defined – popular culture art themes over many decades. One gets a meaningful glimpse at developed world culture through this chrome, glass and enamel (OK, and more recently, plastic).

Hood ornaments began in the 1910s as a decorative cover for what until then had been utilitarian radiator caps or caps plus thermometers. The earliest ones were hybrid radiator thermometers plus ornamentation. Exterior radiator caps went away in the 1920s, so the hood ornament became solely decorative. Imagination, materials (along with what the public would tolerate as far as some serious sensuality) became the limits. Art deco and sensuality morphed into streamlined rockets, planes, tubes, and other symbols of post-war progress, for hood ornaments and other badging. Car model naming, scripting, and brand iconography followed suit.

Today, classic original hood ornaments may sell for thousands of dollars. The few luxury brands that still offer them typically give buyers a choice if they want to risk it or not on today’s streets. We can still recognize our Toyotas and Fords from their logos, but it just isn’t the same.

Please enjoy these casual photos from a fun walk through just part of the inventory of January’s huge Barrett-Jackson Auto Auction in Scottsdale, which was getting underway just as Community Medical Centers’ Winter Symposium was wrapping up. See anything that evokes memories for you?

Physician Editor:
David L. Slater M.D., FCAP

Managing Editor:
Laurie Smith
Manager, Physician Education and Communication

Deadline to submit articles for the April 2016 issue of Physicians’ Edition is Friday, March 18.
BE ALERT to Email Attacks on CMC and YOU

Message from the desk of George Vasquez
Chief Technology Officer

During recent weeks you have received emails regarding the REAL security threats attacking hospitals via email. It's important that you continue to be vigilant and cautious about opening email attachments or clicking links that could have serious consequences for Community Medical Centers.

Equally important: Here’s what you need to do on your own home computers:

Beware “Ransomware”! There is a particularly nasty malware called Lokey that is buried in Word attachments being sent through emails. CMC received and blocked over 10,000 of those attacks last week alone. The email looks like there is an invoice attached that the reader is asked to review. In reality there was no invoice and if you open the Word document it is designed to encrypt the entire hard drive of your computer and demand a ransom in payment from the reader or from CMC to get the keys to unlock the computer. While no attack has been successful in our CMC computers, we have had a CMC employee’s personal home computer get damaged and encrypted by this Lokey malware.

RECOMMENDATION: Be sure that all of your home computers are up-to-date with anti-virus software. Never use a computer without anti-virus protection. And of course, do not open any emails with “invoice” attachments or “remittance” attachments unless you are 100% confident that the invoice is real.

Phishing – An increased number of emails continue to come into our network asking employees to click a link or open attachments. Again, please do not open or forward these emails to anyone. Delete them. Hackers use these types of emails to learn login credentials. As recommended previously, simply delete any email that is suspicious.

If you would like help in determining whether an email is a phishing attempt please call the Help Desk at x56560.

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

Charles Hoo M.D.
Department: Radiology
Specialty: Tele-radiology

Jarriet Anne Ting M.D.
Department: Medicine
Specialty: Internal Medicine

John Moritz Wiemann M.D.
Department: Pediatrics
Specialty: Pediatric Orthopedics

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

Daniel Brocksmith P.A.
Department: Surgery
Specialty: Neurosurgery

Annie Fagundes N.P.
Department: Surgery
Specialty: General Surgery

Ruby Ratcliff N.P.
Department: Medicine
Specialty: Critical Care

Jonathan Wylie N.P.
Department: Cardiology
Specialty: Cardiology
Thank You Physician Donors

By Katie Zenovich, Vice President
Corporate Development, Community Medical Foundation

Our physicians are some of the hardest working people. The work you do to take care of patients each and every day is so important. With Doctor’s Day around the corner, we at Community Medical Foundation want to make sure we pause to recognize our physician donors who believe in our vision and support efforts to make Community the one place everyone turns to when they need healthcare.

Over the last decade, physicians have contributed almost $5 million! That has definitely made an impact – from improvements in their own departments, to building new spaces and remodeling projects. Not to mention bringing the latest technologies to our facilities and even providing scholarships/educational opportunities to nursing students and Community employees.

“We give because as physicians, we feel we have to set the example of what many are asked to do. There is a need that has to be filled, and we are grateful to be a part of the solution.” – Dr. Grant Nakamura, Medical Director, Community Medical Providers.

Taking care of everyone who comes through our doors is a big challenge. But, our patients and families need and deserve the best. Therefore we appreciate your dedication and expertise, and are truly grateful for your generous donations to the Foundation that help make amazing things possible. Thank you!

You too can be a part of the solution and become a physician donor. Call Community Medical Foundation at 559-459-2670 or visit CommunityMedical.org/Foundation.

Dr. David Hodge Honored by Fresno Madera Medical Society

CMC Pediatric Surgeon Dr. David Hodge was recently honored for decades of service, though receipt of FMMS's 2015 Physician Community Service Lifetime Achievement Award. Along with co-awardee and distinguished colleague Dr. Fitzalbert Marius, Hodge was feted at the annual FMMS gala in November. Ever humble, Hodge noted, “I feel physicians need to be involved in community activities so they can better understand the community in which they live and practice.”

The full interviews with both Drs. Hodge and Marius are available in the winter edition of FMMS's beautiful new Central Valley Physicians newsletter, and are highly recommended to readers who wish to be inspired by the best of medical professionalism among us. (Print readers can find it at fmms.org).

Congratulations and thanks to Drs. Hodge and Marius for highly distinguished service to our profession of medicine.

Drs. A.M. Aminian, David Hodge, Krishnakumar Rajani and Robert Kezirian
Spring has sprung! How quickly 9 months has passed – and there’s no shortage of things to do!

The newly formed Joint Informatics Council is plowing through hundreds of requests for changes to the EMR, prioritizing them as they align with corporate and facility strategic plans, identifying the technical effort to accomplish them, and streamlining a review process so operational leaders have visibility into both what is being requested, and the effort required.

Our new Director of Analytics is here, and Sarang has hit the ground running as well…we’ve been working diligently with Dr. Utecht to refine the analytics strategy, identify the right tools to harness all the information we collect in multiple systems, and look at the plans around data governance. As mentioned in my last column, our need for at-the-fingertips information is growing exponentially, and we’ll continue to need a clear set of processes to gather, validate, and present it to support decision-making for multiple groups within the organization.

The Division of Informatics has continued to standardize and collaborate across our facilities; the latest focus is on creating clean programs for training new providers so everyone is doing things in a standard fashion – documenting in the same place for the same thing will help our information be clean from the start. We’re preparing for the large influx of new residents, fellows and medical students coming late Spring/early Summer – getting them off on the right foot with our clinical IT systems will be key to everyone’s success. Finally, we’re working with CIS (IT) to improve our communications to staff and medical staff around changes in the system; there have been a few unintended bumps of late, and for that I apologize. I’m working with IT leadership to see if we can reconfigure our scheduling of changes to provide more ‘stable-time’ for you.

To that end, I want to provide a heads up on some fairly significant changes that will be coming by summer (see the list printed on the left); we have a number of large projects that will directly impact everyone working with the EMR.

I know it seems as if things are always changing… they are! Value based purchasing is our new foundation of reimbursement and measurement of how we are doing to provide efficient, cost-effective quality care. On the horizon are more ‘bundled payments’ with DRG structures, which will continue to depend upon very specific and concise documentation of your history and physical, progress notes and procedure notes, as well as use of the problem list. More and more information about us, our quality and cost of care are being shared publicly, so while much of it is not recent data, we want to focus our efforts to ensure the results being reported are as positive as they can be in short order. My pledge when I started was to try to help make the tools as clean and effective as they could be to support you and the work we do…hopefully, I’m slowly delivering on that promise on a global level.

As always, please feel free to reach out…I look forward to hearing from you.

PS: On a personal note, racing season has begun…my husband is ecstatic, and I’m back into my pit crew role—if you’re interested in coming with us….
**IT Changes**

Continued from page 5

**Beacon:** this is an oncology module for ordering and administration of chemotherapy and non-chemo infusions. We’ve been working to build all the most common chemo protocols into the system; once the Ambulatory Infusion Center at Clovis is completed, licensed and then live on the EMR pharmacy module (Willow), we will be able to go live with Beacon to provide electronic ordering of chemo for patients. Depending upon the licensure timing, this could be live as early as May, but may be more likely this summer.

**Professional Fee Charge Capture:** we’ve launched a pilot with CCFMG to capture pro-fee charges within EPIC to eliminate pieces of paper, stickers, face sheet copies, etc. So far, the pilot has gone well. We’re looking into rolling it out to other areas – the precursor is using ‘problem based charting’ workflows.

**Communication method clean up:** we’re trying to ensure that for those of you who do not log into EPIC regularly, you receive your results, consult notices and letters via fax, rather than through EPIC inbasket. Some of you have received letters that we’ve changed your method based on a last log in date... we’ll continue to update information and clean up the records in months ahead and as providers re-credential.

---

**Introduction to the essay below:** As we move into 2016, it seems that the winds of change are blowing-value based purchasing, heightened focus on quality metrics, managing populations, taking on risk… and it’s not just here at Community. It’s everywhere. Providers everywhere are less than thrilled by the increasing requirements to be met, the changes happening in the EMR to meet those requirements, and then, there is the whole Meaningful Use ‘thing’. I found this article in a recent edition of HealthLeaders magazine, and it struck a chord with me... I hope you’ll find it thought-provoking, and maybe insightful about why we’re always trying to change things! – Judi Binderman, MD VP-CMIO CMC.

**Embrace Change or Be ‘Eaten Up’**

Tinker Ready, for HealthLeaders Media, February 25, 2016

In the quest for quality care, business as usual won’t do. Progress is what change is all about. And there’s an upside: When value-based payments really hit, evidence-based medicine may get some traction.

“**As we contemplate its contentious present and problematic future, we remain prisoners of its past.”** – Charles E. Rosenberg.

Change rarely comes easily. Hospitals are currently coping with major shifts in payment models, patient care, technology, and more. These changes are designed to improve the quality of care, but not all them are going well.

Lately, we’ve seen revolts against meaningful use and excessive quality measurement. In addition, data is piling up on the failure of doctors and hospitals to deliver evidence-based care.

So, here’s some blunt advice for the hospital industry: Change is constant. Deal with it.

Lee Penrose is the CEO of St. Jude Medical Center, a 351-bed Fullerton, California hospital which is part of the St. Joseph Hoag Health system. “In order to embrace a new future, we have to be more comfortable with change,” he says.

“We have to be ready to experience our work in a different way. In this consumer-driven industry, were either going to change or we are going to be eaten up.”

Still, Penrose, a 20-year industry veteran, says that hospitals are currently dealing with an unprecedented level of change. On his plate: a merger between St. Joseph Hoag Health and Providence Health & Services, a system with 34 hospitals in five states.

**Old Days, Old Ways**

One way to understand the need for change is to look at what some might call the good old days. In the pre-DRG era, doctors ordered whatever care they saw fit, no one questioned it and insurance covered it.

Patients paid little; they were either too poor or too insured. With no consumer pressure, costs ballooned. Patient experience? Patient stays were longer, the food was horrible, and there was no cable TV. All the doctors were men, all the nurses were women, and all the bosses were white.

“If we can’t help those around us understand why change is happening, and why perhaps it is good for all of us, all we are going to meet is resistance.”

See Embracing Change page 7
Embracing Change

Continued from page 5

Patient safety and infection control measures were not what they should be. And, orders were scrawled on note pads, recorded on paper, and transmitted via courier or fax. No one wants to go back there. But, with change, it is good to keep in mind that sometimes things get worse before they get better. Take the implementation of electronic medical records.

Anyone who has ever had to learn a new software program knows it takes time and practice. Until you get that muscle memory, you fumble around with tutorials, lose your work, and make many mistakes before you get it right.

In Epic or Cerner, of course, the stakes are higher than in, say, Photoshop. But you still have to account for the learning curve.

The HITECH Act's Messaging Failure

It usually takes a good decade for any industry to see returns from a large investment in information technology, says Julia Adler-Milstein, assistant professor of information, School of Information and assistant professor of health management and policy at the University of Michigan's School of Public Health. She is studying the implementation of HIT and says there is no reason to think it will happen more quickly in healthcare.

“That was really a failure of the message behind the HITECH (Act),” she told me. “It was sold as, ‘You put in these systems and care gets better tomorrow.’ There is no reason we should have thought that. This is always going to be a 10-year journey – maybe eight years, more like 12 years. The expectations were never set at that time scale. So, partly, that has led to this great backlash.”

Even well-executed changes can be hard to take, but in the case of HIT, users are coping with clunky systems that are not user-friendly, she says. And, it’s not always clear to users how all that input is improving care.

And then there is the question of interoperability. All of the players – vendors, policy makers, and providers – share the blame for the inability of many systems to exchange data, Adler-Milstein says. “I think they really underappreciated how hard interoperability would be to begin with, let alone, after you’ve allowed thousands of different system to be implemented in your country,” she said.

Physician Alignment

Another big change for hospitals is the growing ranks of doctors as employees. Healthcare systems are struggling to bring more physicians into their operations in a way that helps improve quality, safety and efficiency, says Peter Angood, MD, the CEO of American Association for Physician Leadership [formerly the American College of Physician Executives].

Both parties get too focused on the mechanics of the contract, he says.

“Those places that are failing on the engagement of doctors haven’t stopped to take that moment and clarify in a transparent way the purpose of the relationship and how to make it work on the short-, intermediate- and long-term,” he says.

Beyond financial arrangements, issues that need to be clarified include the scope of responsibility, the amount of clinical work, and administrative work and expectations regarding measurement and outcome results, Angood says.

One way to improve that transitions? Angood recommends that hospitals make sure they have doctors in top jobs. Evidence suggest that “physicians in leadership roles can make the place run better,” he said.

In general, good leadership can be key to successfully managing change at hospitals, Penrose says. “As leaders, were called on to help frame the change and put it in proper context and understand and articulate the ‘why’ behind change,” he says.

“If we can’t help those around us understand why change is happening, and why perhaps it is good for all of us, all we are going to meet is resistance. It is human nature to resist change and we see it every day.”

Finally, it is good to remember that even when a new initiative goes off the rails and creates chaos, it’s possible to steer things right. Last week, CMS and the insurance industry agreed to harmonize their quality measures. When value-based payments really hit, evidence-based medicine may get some traction.

HIT? Stop groaning. One thing the HITECH push did do right was drive the adoption of HIT.

“And we have to figure out how to use these systems well,” Adler-Milstein says. That means providers will need a better sense of the day-to-day value of the systems.

She also says there seems to be a consensus that interoperability needs to be fixed: “This high tech investment will be wasted if we don’t get interoperability right. There is a consolidation of focus on that issue that I’ve never seen before. It means that there is an opportunity to make some progress.”

And progress, it could be argued, is what change is all about.
Don’t Let Your Joint Replacement Cases Be Denied By Third Party Payers

Submitted by Brenda Chung RHIT  
Margie Hill RN, CCDS  
Sandra Sidel RHIA, CCS

Lack of detailed documentation of medical necessity for joint replacement leads to denials of inpatient hospital claims by third party payers. A prepayment review of CMC claims by Noridian Healthcare Solutions revealed the need for improved documentation of the inpatient medical record to support joint replacement.

The medical record must contain documentation to support ADLs are diminished due to pain and/or disability despite non-surgical medical management. This includes:

- Pain or functional disability at the hip or knee. For example, documented pain that interferes with ADLs (functional disability), or pain that is increased with initiation of activities or pain that increased with weight bearing.
- Unsuccessful conservative therapy (non-surgical medical management) if appropriate. For example, documented trial of NSAIDs or contraindication to such therapy and/or documented supervised physical therapy.

Documentation must contain one of the following to support the diagnosis of Osteoarthritis:

- Subchondral cysts,
- Subchondral sclerosis
- Periarticular osteophytes
- Joint subluxation
- Joint space narrowing
- Avascular necrosis or
- Bone on bone articulation

In addition, Operative Report documentation must include the type of joint prosthesis:

- Synthetic substitute: ceramic, ceramic on polyethylene, metal, metal on polyethylene
- Cemented or uncemented
- Nonautologous tissue substitute
- Autologous tissue substitute

If you would like more information, contact Brenda Chung, RAC Program Coordinator (559) 459-6539/Ext. 56539 or bchung@communitymedical.org, Margie Hill, Clinical Documentation Improvement Specialist (559) 459-6710/Ext. 56710 or mhill5@communitymedical.org or Sandra Sidel (559) 459-6003/Ext. 56003 or ssidel@communitymedical.org

CDC Updates Zika Virus Guidelines for U.S. Health Care Providers

In late February the Centers for Disease Control and Prevention (CDC) issued updated guidelines for testing pregnant women who live in or travel to areas with ongoing Zika virus transmission, and new guidelines for preventing sexual transmission of the virus. Thirty-five travel-associated cases of Zika virus have been detected in 11 states and the District of Columbia since 2015. Another 10 cases have been reported in Puerto Rico and the U.S. Virgin Islands, all but one of them locally acquired. Recent evidence suggests a possible association between maternal Zika virus infection and adverse fetal outcomes, such as microcephaly.

Until more is known, CDC strongly advises pregnant women to consider postponing travel to Zika-affected areas, or talk to their health care provider before they do and strictly follow steps to avoid mosquito bites during the trip. Only about one in five people infected with the mosquito-borne virus will get sick, and their illness is usually mild. There are currently no vaccines or medications to prevent or treat Zika infections. As a precaution, both the American Red Cross and AABB have recommended individuals refrain from donating blood for 28 days after traveling to Zika-affected areas. For more information, visit www.cdc.gov/zika and www.aha.org/zika.

The CDC site has information which is updated daily on case incidence, testing guidelines, and patient management. Note that there are also excellent resources for the general public. NPR has had some very interesting features regarding Zika in South America and Puerto Rico as well as CDC’s boots on the ground public health investigations to rapidly add to our understanding of the illness (print readers may search NPR Zika Virus). CMC’s Forum is also keeping readers up to date on Zika.

Don’t wait until conditions are perfect to begin.  
Beginning makes conditions perfect.”

– Alan Cohen, writer and motivational speaker
Case Presentation: A 38 year old man with hypertension (who did not take his antihypertensive medication for the week prior to presentation), diabetes mellitus, and history of hyperlipidemia presented the ED complaining of multiple episodes of chest pain and dyspnea. On examination he was afebrile, BP 179/103, HR 85, RR 24, SpO2 100% on room air. Two separate EKG’s were interpreted as normal; CXR was normal. Serial Troponin (TnI) levels are presented in Graph 1 below. For reference, the usual pattern of TnI rise and fall with acute myocardial injury is represented in Graph 2 below. Additional laboratory studies included normal WBC count, Hgb 14.7 gm/dl, D-dimer within reference range, glucose 294 mg/dl, and Cr 0.8 mg/dl.

The cardiologist sought assistance from the laboratory regarding interpretation of the unusually stable pattern of Troponin results over time. Laboratory investigation included review of TnI assay quality control and calibration, review of TnI results prior to and following this patient’s samples, repeat testing using the backup analyzer, paired testing of serum and heparinized plasma samples, and dilution studies. All studies indicated the TnI analyzer was performing as expected. Two of the previously tested patient samples were sent to another facility which uses a different vendor’s TnI assay. Results from both samples were within reference range. The laboratory investigation strongly suggested the presence of a substance in the patient’s serum that was interfering with our particular TnI assay. This conclusion contributed to the clinical decision to avoid cardiac catheterization. The patient did well and was discharged home after a period of observation. Serum samples were then sent to CMC’s TnI analyzer vendor (Beckman Coulter) for further investigation.

Discussion: Troponin I is, for clinical purposes, a cardiac-specific molecule that normally has very low plasma concentrations. Concentrations rise when myocardiocytes are injured and release TnI. Injury can be due to myocardial infarction, but other processes including pulmonary embolus, heart failure, sepsis, myocarditis, trauma, and strenuous exercise may also injure myocardiocytes and lead to elevated plasma TnI. TnI is cleared by the kidneys and impaired renal function may result in increased plasma concentration. The elevated TnI results in these clinical settings are analytic true positives – i.e., the assay correctly detects TnI molecules and accurately reports increased concentrations. The clinical significance of an elevated TnI for a given patient can only be determined in the context of other clinical and laboratory information. The absence of a rise and/or fall in TnI values over time (graph 2 illustrates a prototypical MI pattern) in our patient is good evidence against myocardial infarction, but the cardiologist’s...
evaluation found no other clinical conditions that are known to be associated with increased TnI. This lack of other clinical explanations for increased TnI prompted consultation of the laboratory.

Uncommonly, an elevated TnI test result will occur in the absence of increased plasma TnI levels; i.e., an analytic false positive result. Most often, this occurs when small fibrin thrombi in the sample non-specifically bind the reagent antibodies. CMC laboratories have procedures in place to proactively minimize the chances of this occurring including use of Rapid Serum Tubes which rapidly clot the sample, centrifugation of the sample to precipitate any remaining microthrombi, and either duplicate testing of all samples or repeat testing of certain samples with elevated results. Multiple lines of laboratory investigation in this case excluded microthrombi as the cause of our patient’s elevated TnI result. Heterophile antibodies are another source of analytic false-positives. These naturally occurring human antibodies can bind to other animal species’ antibodies (such as those used as reagents in immunoassays). All TnI immunoassays use antibodies as reagents, but each vendor has developed its own unique antibody, which bind to different areas of the TnI molecule. The various reagent antibodies have differing susceptibilities to heterophile antibody interference. Because of this, a patient sample containing a heterophile antibody may experience interference with one vendor’s assay, but not with another’s. This could explain why our patient’s result was normal when tested at another facility using a different TnI assay than CMC’s, but our laboratory’s investigation found no other evidence of a heterophile antibody in our patient. Less commonly, patients harbor an endogenous substance which interferes with the assay by nonspecifically binding the reagent antibodies. Like heterophile antibodies, different vendors’ assays have different susceptibilities to interfering substances. Analysis by CMC’s TnI vendor identified an endogenous interferent in our patient. The patient was notified of this finding and its implications should he require TnI testing in the future.

Elevated TnI concentrations are associated with an identifiable clinical condition in most cases. Myocardial infarction will have the characteristic rise and/or fall of TnI concentrations over time; other conditions are associated with relatively stable values. In those cases where there is discordance between clinical findings and TnI results, or the pattern of TnI concentrations over time is unusual, the possibility of an analytic false positive can be pursued. In rare instances this may uncover a significant finding with implications for the patient’s future health care encounters.

Advice: Clinical laboratories expend considerable resources to minimize the risk of releasing erroneous results, but achieving a zero error rate is unlikely. Most (46% - 68%) erroneous laboratory results are traceable to the pre-analytic phase of testing (Ref). Patient identification errors, specimen collection errors, and hemolysis of the sample are examples. Post-analytical errors are the second most common (19% - 47%) source – results posted to the wrong patient record and errors of data entry are examples. Analytic errors (e.g., QC failures, analyzer malfunction) are the least common source of error. Laboratory generated data are highly accurate, but not infallible. Results must be critically interpreted in the clinical context, and resolution of discrepancies sought. The clinical laboratory and pathologists are resources available to assist in that process. We commend the cardiologist in this case for his critical thinking and his request to the laboratory for assistance.

CMC’s Syphilis Screen Algorithm:
A Potentially Problematic End Point

Submitted by David Slater, MD, CRMC Lab Medical Director

It has been 5 months since the CRMC Lab went live with our “reverse” algorithm for Syphilis testing. Many larger labs nationwide have adopted the same approach, which can be easily automated (unlike the RPR), yields rapid turn around time for initial screening results, and meets needs of most patients – exceptions being neonates and infants, and patients being followed for known Syphilis. As previously communicated, and for review now, CMC’s algorithm – with testing end points and their interpretations (based on CDC guidance) – is represented on the following page.

One of the more problematic end points is the one with the red star. When you consider that this endpoint is reached via RPR being negative, you realize this is NEW information compared to an RPR-first approach to Syphilis screening. Two things are important to understand the implications of this end point:

1 Treponemal-specific tests (the one done at CRMC that starts the algorithm and the TPPA test at Quest) often remain positive for life once Syphilis is contracted – whether or not a patient has been treated, whether or not the disease is active or not. RPR is the test to monitor disease activity.

2 Treponemal assays turn positive up to a few weeks before RPR in recent infection – this is a strength of the reverse algorithm if you get one crack at a high risk patient.

Given #1 and #2, the range of possibilities is wide. Fortunately, clinical correlation and judicious use of retesting can sort this out at least to the point of reaching a management decision. This excerpt from CDC’s comprehensive 2015 Guidelines for STD Treatment is the basis for the Interpretation text in the CMC algorithm:

After a positive treponemal screen but a negative RPR: “…if a second treponemal test is positive, persons with a history of previous treatment will require no further management unless sexual history suggests likelihood of re-exposure. In this instance (i.e., there is a possibility of re-exposure), a repeat non-treponemal test in 2-4 weeks is recommended to evaluate for early infection. Those without a history of treatment for syphilis should be offered treatment. Unless history or results of a physical examination suggest a recent infection, previously untreated persons should be treated for late latent syphilis (emphasis added)…”

Next, a refresher on latent syphilis from the same CDC Guidelines:

“…Latent syphilis is defined as syphilis characterized by seroreactivity without other evidence of primary, secondary, or tertiary disease. Persons who have latent syphilis and who acquired syphilis during the preceding year are classified as having early latent syphilis, a subset of latent syphilis. Persons can receive a diagnosis of early latent syphilis if, during the year preceding the diagnosis, they had:

1) a documented seroconversion or a sustained (>2 week) fourfold or greater increase in nontreponemal test titers;
2) unequivocal symptoms of primary or secondary syphilis; or
3) a sex partner documented to have primary, secondary, or early latent syphilis. In addition, for persons with reactive nontreponemal and treponemal tests whose only possible exposure occurred during the previous 12 months, early latent syphilis can be assumed. In the absence of these conditions, an asymptomatic person should be considered to have (late) latent syphilis (clarification added). All persons with latent syphilis should have careful examination of all accessible mucosal surfaces (i.e., the oral cavity, perianal area, perineum and vagina in women, and underneath the foreskin in uncircumcised men) to evaluate for mucosal lesions.”

CDC’s 2015 STD Treatment Guidelines also recommends treatment appropriate for late latent Syphilis (remember that Penicillin allergy changes things considerably – see CDC Guidelines):

“Late Latent Syphilis or Latent Syphilis Unknown Duration:
Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals”

What about sex partners? Generally, latent Syphilis is NOT transmitted sexually, though there certainly still is risk of maternal-fetal transmission. Longer term sex partners have more risk, since infectious mucosal lesions may have been present at an earlier time. CDC advises that:

“Long-term sex partners of persons who have late latent syphilis should be evaluated clinically and serologically for syphilis and treated on the basis of the evaluation’s findings.”

Our decision to in-source Syphilis screening has been well received by our customers and local Public Health experts. It

See Syphilis Testing on page 12
was the right time for this, given a national upward trend in Syphilis, the importance of learning quickly about positive screening results, and our particularly alarming high regional incidence of maternal and neonatal Syphilis – called an “Outbreak” by public health experts. The testing algorithm above – like the traditional algorithm – has some gray zones. It also has a new endpoint that benefits from clinical judgment and occasional additional patient questions. Let’s continue to gain more experience with it. Please make use of CDC’s 2015 Sexually Transmitted Disease Treatment Guidelines and uptodate.com, in addition to our own Infectious Disease experts.
Editor’s Note: We asked HIV Specialist Simon Paul, MD to comment on this month’s HIV Care Choosing Wisely List. We are paraphrasing his comments a bit here. The lab has some comments as well. Specific comments follow:

For #2, complex lymphocyte panels. Dr. Paul expressed frustration ordering the recommend testing (CD4 Helper cell enumeration and percentage) from CMC's Epic menu. It is true that the current test “T-cell enumeration” is NOT this assay – it gives CD4, CD8, and the ratio between them. The laboratory is working on creating the directly orderable reference lab test which corresponds to the Choosing Wisely recommendation.

For #4, G6PD screening: “Not testing people based on race/ethnicity seems a bit unwise. Our population is too diverse and there are too many people of mixed ethnicity, and it is too easy to mix up this racial predisposition with the racial predisposition for hlab5701 testing, so overall, I’d still test everyone.”

For #5, CMV testing: “…I’ve debated for awhile. A colleague has found 1-2 people who are surprisingly cmv neg, so he still likes to test.”

Note from Dr. Slater: The discussion refers to “CMV negative blood products.” All our RBC and platelets are leukocyte reduced and should be considered to be CMV risk reduced. We do not advise ordering CMV antibody-negative blood products, given this. The Choosing Wisely list did not address blood irradiation for HIV/AIDS. It should be stated that HIV/AIDS is NOT an indication for irradiation of RBC or platelets.

Choosing Wisely
An initiative of the ABIM Foundation

Five Things Physicians and Patients Should Question

Avoid unnecessary CD4 tests.
A CD4 count is not required in conjunction with every viral load test. Viral load testing is a better indicator of a patient’s response to therapy. CD4 monitoring is not necessary for patients who have stable viral suppression. For the first two years after treatment initiation, the CD4 count should be monitored every three to six months. After two years, if the viral load is undetectable, the CD4 count should be measured yearly if it is 300–500 cells/mm³. If it is consistently above >500 cells/mm³ then further monitoring is optional.

Don’t order complex lymphocyte panels when ordering CD4 counts.
Order only CD4 counts and percentages rather than ordering other lymphocyte panels. For example, CD8 testing, including the CD4/CD8 ratio, adds cost without providing useful information. More complex lymphocyte panels are unnecessary and increase costs even more.

Avoid quarterly viral load testing of patients who have durable viral suppression, unless clinically indicated.
Viral load testing should be conducted before initiation of treatment, two to eight weeks after initiation or modification of therapy, and then every three to four months to confirm continuous viral suppression. In clinically stable patients who have durable virological suppression for more than two years, clinicians may extend the interval to six months.²

Don’t routinely order testing for glucose-6-phosphate dehydrogenase (G6PD) deficiency for patients who are not predisposed due to race/ethnicity.
G6PD deficiency testing is recommended upon entry into care or before starting therapy with an oxidant drug only in HIV-infected patients who are predisposed to this genetic disorder that can cause hemolytic anemia. G6PD most frequently occurs in populations of African, Asian and Mediterranean descent and is most likely to affect HIV-infected patients with one of these racial or ethnic backgrounds.

Don’t routinely test for CMV IgG in HIV-infected patients who have a high likelihood of being infected with CMV.
Cytomegalovirus (CMV) IgG testing is recommended only in patients who are at lower risk for CMV to detect latent CMV infection. CMV IgG testing is not necessary in patients at higher risk for CMV, including men who have sex with men and injection drug users, because they can be assumed to be CMV positive. Testing for CMV antibody in low-risk populations is recommended to foster patient counseling in avoidance of CMV infection through practicing safe sex and to avoid transfusion except with CMV-negative blood products. Patients at lower risk for CMV infection, e.g., patients who are heterosexual and have not injected drugs, should be tested for latent CMV infection with an anti-CMV IgG upon initiation of care.

¹ These recommendations do not supersede grant reporting requirements.
² Note: Some patients may still require a face to face visit every three to four months to make certain that other comorbid conditions are stable, and to assess if there are other social changes that might have surfaced which could impact HIV medication adherence. Multidisciplinary practices can consider interim visits with other non-prescribing practitioner team members to support treatment adherence.

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.

Released February 8, 2016
The current edition of “Your Community at Work,” the Community Medical Centers corporate social responsibility report, highlights how Community is working politically in Washington D.C. and through our 40-year partnership with UCSF Fresno to bring more doctors to the Valley. This edition outlines the Valley’s unique health challenges, the fact we have one of the lowest doctor-to-patients ratio in California and the huge investments Community has made in graduate medical education. Federal funding has been frozen at 1997 levels for graduate medical education while our patient population has continued to grow.

“Your Community at Work” runs monthly in The Fresno Bee. It’s also published in the Business Journal and the California Advocate, – and delivered to our patients in the hospital and mailed out to our donors. Its content also is available on www.CommunityMedical.org and through our social media.

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. Erin Kennedy in the Corporate Communications Department 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.

http://www.communitymedical.org/news-events/facts-reports-publications

Print readers: Go to Communitymedical.org > News & Events > Facts, Reports and Publications > scroll down to “Your Community at Work.”
Public Health Comments:  
The Wide Gaps in Our Physician Workforce  

By Ken Bird M.D., Fresno County’s Public Health Officer

Whenever I am asked what the unique factors are that contribute to the poor state of our individual health and well-being and the public health in our county and our valley, it’s easy to point to the obvious, our concentrated poverty and our poor air quality. But also holding us down in all statewide and national health rankings is the equally obvious paucity of medical care providers, especially primary care providers, in our valley.

The changes in health care and health care coverage brought about by the ACA have made even more evident the effect this insufficient number of medical providers has had on our collective health and well-being.

I have been a physician here in the valley for 35 plus years now. I know a little bit about medicine and health care, but I can tell you that at times I have had difficulty obtaining appropriate preventive and specialty care in a timely manner, and without unnecessary roadblocks.

But imagine for a moment that you are an individual born here in the valley to parents who, because of limited means, sought medical care for themselves and their family members at the local emergency department only when they were significantly ill or injured. The only preventive care you received growing up was in the form of the standard immunizations offered by the health department.

The concepts of preventive care and medical home were never introduced to you, and the rules of health insurance coverage may as well be a foreign language.

Now, as an adult with a family of your own, you find yourself with health care coverage that, whether of greater or lesser value, must provide free preventive evaluation and intervention.

Suppose that you are fortunate enough to have been made aware of this opportunity. Your first hurdle is find a provider whose practice isn’t already full, and that actually accepts the low reimbursement offered by your coverage plan.

Say you finally find a provider. Because of the huge patient load the appointment date is far down the road and offered only at times frustratingly incompatible with both school and work.

But you obligingly waited and made the necessary arrangements to keep the appointment. However, the hours you allotted from your work for this turns into two hours and more waiting in an overcrowded waiting room.

Your thinking this is because the provider is taking the time and care to learn, in detail, everyone’s health status and what has contributed to it; carefully explaining how best to manage those health determinants; and describing the consequences of not properly managing them. Sadly, you discover that because the provider is so pressed for time in an overworked practice you leave a 10 to 15 minute interaction with the provider with nothing more than a lab request slip (with printed directions on where to take it), a prescription for a medication you’re not sure how to take nor exactly why you’re taking, and vague advice about quitting smoking, losing weight, and exercising more.
You still don’t know what the 165/95 blood pressure means to you and your health, nor the 285 mg/dl random blood glucose. Certainly the unhappy picture does not play out everywhere here, and where it does, it may not be merely because the health care system is overwhelmed and understaffed with providers.

But according to the Public Health Institute, California will need an estimated 8,243 additional primary care physicians by 2030, and this is 32% of its current workforce.

The institute’s further assertions apply even more to Fresno County and our valley than they do to California as a whole.

“The primary care workforce shortage has reached a critical point and will continue to devolve if we don’t take immediate steps to address our unmet needs.”

“It has become clear... that we cannot deliver on the promise of health care access if we don’t have a robust workforce capable of providing timely, culturally competent, high quality care that patients deserve.”

But, “… primary care workforce shortages are a product of a complex array of barriers and … strengthening capacity on a scale large enough to address emerging needs requires multifaceted solutions and system change.”

As a community we owe it to ourselves to work together to recruit and retain a compassionate, energetic, bright, and diverse cadre of medical providers to our valley.

CURES Important Reminder

By July 1, 2016 all physicians who are authorized to prescribe, order, administer, furnish or dispense Schedules II, III, or IV controlled substances MUST BE registered with the CURES system (Controlled Substance Utilization Review and Evaluation System). The California Medical Association is hosting a webinar with the Department of Justice to provide an overview of the registration process and key features of the newly upgraded system. This webinar is free to all attendees. For more information on this webinar, please visit: www.cmanet.org/events/detail?event=cures-20-navigating-the-states-new. To register for CURES, please visit the Department of Justice’s registration page https://cures.doj.ca.gov/registration/confirmEmailPnDRegistration.xhtml.

Visit the Board's website at www.mbc.ca.gov.

Well Being

Continued from page 15

March Physician Photographer

David L. Slater M.D., F.C.A.P.

Key Recommendations

Consume a healthy eating pattern that accounts for all foods and beverages within an appropriate calorie level.

A healthy eating pattern includes:

- A variety of vegetables from all of the subgroups – dark green, red and orange, legumes (beans and peas), starchy, and other
- Fruits, especially whole fruits
- Grains, at least half of which are whole grains
- Fat-free or low-fat dairy, including milk, yogurt, cheese, and/or fortified soy beverages
- A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), and nuts, seeds, and soy products
- Oils

A healthy eating pattern limits:

- Saturated fats and trans fats, added sugars, and sodium

Key Recommendations that are quantitative are provided for several components of the diet that should be limited. These components are of particular public health concern in the United States, and the specified limits can help individuals achieve healthy eating patterns within calorie limits:

- Consume less than 10 percent of calories per day from added sugars
- Consume less than 10 percent of calories per day from saturated fats
- Consume less than 2,300 milligrams (mg) per day of sodium
- If alcohol is consumed, it should be consumed in moderation – up to one drink per day for women and up to two drinks per day for men — and only by adults of legal drinking age

Editor's Note: These very influential (and no doubt somewhat political) Guidelines warrant attention from all US physicians. The nutritional habits, diabetes risk, and body habitus of the average American continue to go in the wrong direction. But many Americans recognize the state of affairs we are in, and are increasingly attuned to the importance of what we eat and drink. The US's official dietary guidance – now in its 8th edition – is of great importance to patients' health maintenance, not to mention to our own families' nutritional status. It also drives much public policy and has large economic impact. Below are some introductory comments from the 2015-2020 Guidelines, including the significant shift of emphasis from “food groups” to “eating patterns”.

Every 5 years since 1980, a new edition of the Dietary Guidelines for Americans has been published. Its goal is to make recommendations about the components of a healthy and nutritionally adequate diet to help promote health and prevent chronic disease for current and future generations. Although many of its recommendations have remained relatively consistent over time, the Dietary Guidelines has evolved as scientific knowledge has grown. These advancements have provided a greater understanding of, and focus on, the importance of healthy eating patterns as a whole, and how foods and beverages act synergistically to affect health. Therefore, healthy eating patterns is a focus of the 2015-2020 Dietary Guidelines.

“The Dietary Guidelines is required under the 1990 National Nutrition Monitoring and Related

See Diet on page 18
Diet

Continued from page 17

Research Act, which states that every 5 years, the U.S. Departments of Health and Human Services (HHS) and of Agriculture (USDA) must jointly publish a report containing nutritional and dietary information and guidelines for the general public. The statute (Public Law 101-445, 7 U.S.C. 5341 et seq.) requires that the Dietary Guidelines be based on the preponderance of current scientific and medical knowledge. The 2015-2020 edition of the Dietary Guidelines builds from the 2010 edition with revisions based on the Scientific Report of the 2015 Dietary Guidelines Advisory Committee and consideration of Federal agency and public comments.

“The Dietary Guidelines is designed for professionals to help all individuals ages 2 years and older and their families consume a healthy, nutritionally adequate diet. The information in the Dietary Guidelines is used in developing Federal food, nutrition, and health policies and programs. It also is the basis for Federal nutrition education materials designed for the public and for the nutrition education components of HHS and USDA food programs. It is developed for use by policy makers and nutrition and health professionals. Additional audiences who may use Dietary Guidelines information to develop programs, policies, and communications for the general public include businesses, schools, community groups, media, the food industry, and State and local governments.

“Previous editions of the Dietary Guidelines focused primarily on individual dietary components such as food groups and nutrients. However, people do not eat food groups and nutrients in isolation but rather in combination, and the totality of the diet forms an overall eating pattern. The components of the eating pattern can have interactive and potentially cumulative effects on health. These patterns can be tailored to an individual’s personal preferences, enabling Americans to choose the diet that is right for them. A growing body of research has examined the relationship between overall eating patterns, health, and risk of chronic disease, and findings on these relationships are sufficiently well established to support dietary guidance. As a result, eating patterns and their food and nutrient characteristics are a focus of the recommendations in the 2015-2020 Dietary Guidelines.”
Palliative Care

Continued from page 18

suicidal I began to discuss with him other “options” aside from a pill that would end his life.

I first asked his caregiver to come in for a meeting. It was an interesting situation as the patient had no family he wanted me to contact. He was living with “a friend” and apparently the dying process was not completely understood by the caregiver and she felt too uncomfortable having the patient come back to her home. We worked it out that he was made comfort care at the hospital so no more invasive tests were done. After initially refusing to eat he agreed to eat while at the hospital while we were working out the details for a transfer to a “board and care” facility with hospice services.

It’s always important to get family or friends involved in cases such as this. Secondly, exploring the motive behind wanting the pill is the other. Many people that I encounter don’t fear death but they fear the possibility that they might suffer during the dying process. Hospice trained individuals are superb at alleviating or ameliorating both physical and existential pain. If the more conventional means of pain relief are not suitable or adequate, palliative sedation can be initiated. This again requires family and informed consent.

I told the audience at the panel discussion I felt that primary care physicians would be having this discussion, at least on the front end, more than folks in my field. This remains to be seen, but certainly all of us will need to be prepared to explore with our patients their wishes and preferences for end of life care, which now includes the End of Life Option Act.

Suggested Reading: “Death and Dignity” by Dr. Timothy E. Quill

Poison Prevention Week
March 20-26
Submitted by Rais Vohra MD
Department of Emergency Medicine
Associate Medical Director, California Poison Control System

Every spring, the American Association of Poison Control Centers and the California Poison Control System commemorate the importance of preventing exposures to hazardous substances. The California Poison Control System (CPCS) is the largest single provider of poison control services in the U.S. and California’s primary source for treatment advice and information in case of poison exposure for both residents and health professionals. The CPCS is part of the University of California San Francisco School of Pharmacy. The CPCS is one of California’s most efficient services—every $1 spent on poison control services saves an estimated $7 in medical spending. This 7:1 cost-benefit ratio is more than 3 times that of child safety seats, smoke detectors, or bicycle helmets.

The CPCS manages over 330,000 calls annually (~900 per day). Poison control saves California over $70 million in health care costs and averts an estimated 61,000 emergency department visits annually. Services are free, and interpreters are available at all times for over 100 languages. While children constitute the majority of preventable exposures that get reported to our nation’s poison centers, middle aged and older adults are also at risk from a variety of home, occupational, and outdoor toxins.

Poison control services are also essential to public health in California, providing real-time detection and surveillance for emergent health events such as pandemic flu, and during CBRNE (Chemical, Biological, Radiological, Nuclear and Explosives) threats. For vulnerable and non-English speaking communities, CPCS experts may provide the only access to a medical professional. Tailored poison prevention programs and materials distributing nearly 1 million educational materials to consumers in 10 languages throughout California’s 58 counties.

Despite all these great achievements, the poison centers still need your help, as many people do not know how to access the toll-free number or may be unaware that these services are even available. When you counsel patients about preventive care, make sure they have the number to poison control programmed into their phone ahead of time (800) 222-1222 and share the flyers – found in the attached flyer packet – with your patients and families to help spread the message about the Poison Control Helpline. And last, check out the website www.calpoison.org for updates, detailed poison prevention advice, and sign up there to get alerts and updates directly to your phone via SMS.
Some adverse effects of transfusion are due to infectious agents or chemical and immunologic causes. But – given that transfusion is intravascular infusion of substantial fluid – it is not surprising that Transfusion Associated Circulatory Overload (TACO) is also an important cause of morbidity and mortality.

TACO is indeed a leading cause of transfusion-related morbidity and mortality, accounting for 22% of the transfusion-related fatalities reported to the FDA from 2010-2014. Clinical evidence has demonstrated that up to 21% of TACO cases are life-threatening with associated increases in the duration of time in the ICU and hospital stay.

While TACO symptoms have long been recognized, until recently this type of transfusion reaction is not been well understood or thoroughly studied. It is certain that TACO is under recognized and under reported. We believe this is true in our hospitals, too. Respiratory distress is a common clinical complaint which has many etiologies; there may be multiple factors with failure to recognize its potential association with a current or recent transfusion.

Risk factors: The primary pathophysiologic process underlying TACO is believed to be fluid overload with resulting in hydrostatic (cardiogenic) pulmonary edema. Given that mechanism of injury, some familiar and intuitive risk factors for TACO emerge. You should think seriously about TACO risk as you contemplate a transfusion. If you proceed, preventive strategies (see below) and closer monitoring of the patient are advised:

TACO events typically have one or more of these risk factors:
- Elderly patient.
- Smaller body size.
- Pre-existing congestive heart failure or chronic renal failure.
- Higher total transfused volume/greater number of blood products administered.
- Positive fluid balance prior to transfusion
- Rapid rate of blood infusion.

Definition: It is useful for physicians who order transfusions and staff who monitor transfusions to be aware of the “formal” definitions of this entity (ISBT being International Society of Blood Transfusion and CDC being the US Hemovigilance program definition).

These definitions (printed on page 25) are helpful in recognizing TACO. Acute respiratory distress with increased blood pressure, elevated CVP, and new or further elevation of BNP, are all helpful. Other types of serious transfusion reactions share acute respiratory distress with TACO, including transfusion related acute lung injury (TRALI) and allergic reaction with a pulmonary component. These typically do not show the signs of positive fluid balance that TACO has, but instead are more likely to present with hypotension.

Prevention: The best prevention is often avoidance – in this case, avoidance of unneeded transfusion and minimization of transfusion volume when blood is needed. Avoidance of unnecessary transfusion also reduces risk for other reactions. There are many reasons to initiate transfusion orders conservatively (in many clinical contexts, at least). TACO is yet one more.

Diuretics may be helpful before transfusion or between units. High quality evidence is weak but it is intuitive. Risks of diuretics should also be assessed.

Decrease the infusion rate. CMC has “suggested” non-emergent infusion rates in its Blood Products Transfusion” procedure. But we hope you are aware you can specify a specific infusion rate. One common scenario for doing so is in response to a higher TACO risk.

Warfarin oral anticoagulant reversal. CMC has pharmacologic alternatives to plasma for emergent warfarin reversal (eg, FEIBA). This is important because patients on warfarin are often elderly with comorbidities, and require multiple units of plasma if that is used instead. Critical care physicians should be familiar with this preferred alternative to warfarin reversal. See “Hemostatic Medications for Trauma/anticoagulated Patients Presenting with Life-threatening Hemorrhage” order set.

Treatment: Once TACO is suspected or diagnosed, the transfusion should be immediately stopped and reported to the blood bank for investigation. The patient’s oxygenation status should be monitored with consideration for oxygen supplementation. Upright posture is helpful. Any additional infusions that exacerbate volume overload should be halted when appropriate. Loop diuretics such as furosemide are usually given but their risks should be evaluated. In more severe cases of TACO, non-invasive ventilation (CPAP or BiPAP), mechanical ventilator support, or intensive care may be needed. Remember that TACO is one of the leading causes of acute transfusion-related mortality. Some experts
When to Suspect Transfusion Associated Circulatory Overload:

<table>
<thead>
<tr>
<th></th>
<th>ISBT</th>
<th>CDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing of respiratory distress onset</td>
<td>Occurring within 6 hours of completion of transfusion</td>
<td>Within 6 hours of cessation of transfusion</td>
</tr>
<tr>
<td>Diagnostic criteria</td>
<td>PRIMARY FEATURES</td>
<td>• Acute respiratory distress</td>
</tr>
<tr>
<td></td>
<td>• Acute respiratory distress</td>
<td>• Evidence of positive fluid balance</td>
</tr>
<tr>
<td></td>
<td>• Evidence of positive fluid balance</td>
<td>• Acute or worsening pulmonary edema on frontal chest radiograph</td>
</tr>
<tr>
<td></td>
<td>• Acute or worsening pulmonary edema on frontal chest radiograph</td>
<td>• Radiographic evidence of pulmonary edema</td>
</tr>
<tr>
<td></td>
<td>• Tachycardia</td>
<td>• Evidence of left heart failure</td>
</tr>
<tr>
<td></td>
<td>• Increased blood pressure</td>
<td>• Elevated central venous pressure (CVP)</td>
</tr>
<tr>
<td></td>
<td>SUPPORTIVE FEATURES</td>
<td>• Elevated BNP</td>
</tr>
<tr>
<td></td>
<td>• Elevated BNP</td>
<td></td>
</tr>
<tr>
<td>Confirmed/definite case definition</td>
<td>Four or more primary features.</td>
<td>Three or more of the diagnostic criteria, with no other explanations for volume overload possible.</td>
</tr>
<tr>
<td>Possible/Probable case definition</td>
<td>Not applicable</td>
<td>Probable: Transfusion is a likely contributor to volume overload and either the patient received other fluids or the patient has a history of cardiac insufficiency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Possible: Patient history of cardiac insufficiency that most likely explains volume overload.</td>
</tr>
</tbody>
</table>

TACO

Continued from page 20

believe TACO may have an inflammatory component in which case steroids might be of benefit. However, this is hypothetical and not standard of care.

Note: An excellent resource is AABB Bulletin 15-2 on TACO. Readers can find it here. Print readers can contact me for a copy at dslatermd@communitymedical.org.
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 02/02/2016 to 02/16/2016. 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.

<table>
<thead>
<tr>
<th>Epic PRL#</th>
<th>Order Set Name</th>
<th>Description of Changes</th>
</tr>
</thead>
</table>
| 1480      | Adult Diabetic Ketoacidosis (DKA) | CCMC only Pilot:  
  • Routine blood glucose measurement  
  • Insulin drip titration instructions modified  
  • Electrolyte replacement orders modified  
  • Lab orders are CCMC specified |
| 1596      | Adult Organ Donor | Remove lactate level order and replace with lactic acid level every 6 hours for 5 days. |
| 1327      | Ambisome Liposomal Amphotericin (AMB) | Biennial Review:  
  • Pre-administration medication orders are combined with the infusion orders  
  • Outpatient access only |
| 1313      | Ambisome Liposomal Amphotericin LAmB | Biennial Review:  
  • Pre-administration medication orders are combined with the infusion orders |
| 1330      | Amphotericin B Deoxycholate Outpatient | Pre-administration medication orders are combined with the infusion orders  
  • Outpatient access only |
| 1312      | Amphotericin B Deoxycholate(Conventional) | Pre-administration medication orders are combined with the infusion orders |
| 1275      | Antepartum – Special Services | Biennial Review:  
  • Corrected verbiage on medication |
| 1247      | GEN IP THERAPEUTIC APHERESIS CMC | Updated hyperlink to Lucidoc policies |
| 1193      | Glycemic Control CBHC |  
  • Updated insulin order set  
  • Restricted only to CBHC  
  • Updated hypoglycemia management orders |
| 1418      | Management of Hemophilia Type A and B | Biennial Review:  
  • Factor VIII and Factor IX Assay are in one section for selection  
  • Updated verbiage for bolus dosing calculation |
| 606       | Nasogastric Tube Insertion | Biennial Review:  
  • Medications for nasogastric tube insertion are now pre-selected in Epic  
  •Updated SCIP antibiotic prophylactic agents, MRSA screen, and VTE prophylaxis  
  • Standardized with PRL1375 |
| 1363      | Pre Admission Cardiopulmonary Surgery | Updated hyperlink to Lucidoc policies |
| 1345      | Anti-Arrhythmic/Vasodilator Infusion-Adult | Removed specific fluid information on bolus dose for easier product selection in Pharmacy |
| 599       | ENT IP THYROID PRE-ADMIT (AMB) CMC | Updated hyperlink to Lucidoc policies |
| 1302      | NICU PICC Placement | Updated order set with more accurate and comprehensive fluid/medication  
  • Modified with correct Mechanical Ventilator and Oxygen orders. |
| 1087      | Pediatric PACU orders | Updated hyperlink to Lucidoc policies |
| 974       | SUR IP PRE-ADMIT BREAST SURGERY AMB CMC | Updated hyperlink to Lucidoc policies |
| 1241      | SUR IP PRE-ADMIT COLOSTOMY CLOSURE ORDERS AMB CMC | Updated hyperlink to Lucidoc policies |
| 25        | SUR IP PRE-OP ORDERS FOR PATIENT IN HOSPITAL (IP) CMC | Updated hyperlink to Lucidoc policies |
| 1589      | SUR IP PRE-OP STANDARDIZED NURSING PROCEDURE (AMB) CMC | Updated hyperlink to Lucidoc policies |
| 42        | SUR IP PRE-OP STANDARDIZED NURSING PROCEDURE CMC | Updated hyperlink to Lucidoc policies |
| 1247      | THERAPEUTIC APHERESIS | Updated hyperlink to Lucidoc policies |
| 227       | Universal CRRT: Citrate continuous Renal Replacement Therapy Citrate Orders | Updates made in Epic to prevent provider omissions of electrolyte replacement orders and facilitate pharmacy processing and dispensing of CRRT meds. |

The following order sets have been retired

<table>
<thead>
<tr>
<th>Order Set Name</th>
<th>Description</th>
</tr>
</thead>
</table>
| 405/626        | Adult Contrast Orders  
  Biennial Review: Zero usage in past year |
| 1597           | ICU IP COPD ICU Module Z  
  Used 1 time in past year |
| 634            | Pre-Op GU Retropubic Urethral Suspension Orders  
  Biennial Review: Zero usage in past year |
| 1392           | Recombinant Factor Vila  
  Zero usage in past year |
CRMC Presents:
UCSF Fresno Psychiatry Department

Title: “Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span”
Date: Thursday, March 10, 2016
Speakers: Drs. Sarah Sicher and Karen Kraus
Time: 4:00pm-5:00pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 116
CME: 1 CME

Title: “On Methmory”
Date: Thursday, March 24, 2016
Speakers: Avak Howsepian M.D., PhD
Time: 4:00pm-5:00pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 116
CME: 1 CME

UCSF Fresno Department of Surgery Grand Rounds

Title: “HIPEC-Hyperthermic Intraperitoneal Chemoperfusion”
Date: Friday, March 11, 2016
Speakers: Amir Fathi M.D.
Time: 7:30am-8:30am
Place: CRMC-Sequoia West Conference Room
Contact: Denise Goodman at 559-459-3770 or dgoodmanatcommunitymedical.org
CME: 1 CME

CRMC Perinatal M & M

Title: “Neonatal Surgery at CRMC- 1 year in Review”
Date: Wednesday, March 16, 2016
Speakers: Drs. Nathalie Nguyen, Holly Williams, Chris Downer and Krishna Rajani
Time: 12:30pm-1:30pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 136
Contact: Bernadette Neve at 559-459-7059
CME: 1 CME

UCSF Fresno Department of Surgery
Trauma Critical Care Conference

Title: “Abdominal Compartment Syndrome”
Date: Thursday, March 24, 2016
Speakers: Shana Ballow M.D.
Time: 12:00pm-1:00pm
Place: CRMC-Sequoia East Conference Room
Contact: Kelley Medico Montgomery at 459-3722 or kmedicoatfresno.ucsf.edu
CME: 1 CME

UCSF Fresno Department of Medicine

Title: “Medical Update in the Valley”
Date: Friday and Saturday, March 11 & 12, 2016
Speakers: Various
Time: Friday 4:00pm-8:00pm and Saturday 8:00am-5:15pm
Place: UCSF Fresno Center Auditorium
Contact: Monica Sozinho at 559-499-6421 or msozinhotatfresno.ucsf.edu
CME: 11.25 CME

CCMC Presents:

Title: “Breastfeeding with Maternal Infections”
Date: Tuesday, March 8, 2016
Speakers: Amy Evans M.D., FAAP, FABM
Time: 6:00pm-7:00pm
Place: CCMC H. Marcus Radin Conference Center, The Palm Room
Dinner will be provided
Contact: Jessica Lipsius at 559-324-4002 or jlipsiusatcommunitymedical.org
CME: 1 CME

Title: “Frontiers in Gastroenterology and Hepatology Symposium”
Date: Saturday, April 2, 2016
Speakers: Various
Time: 8:00am-12:00pm
Place: CCMC H. Marcus Radin Center Conference
Contact: Jessica Lipsius at 559-324-4002 or jlipsiusatcommunitymedical.org
CME: 4 CME

Please also see the enclosed individual flyers for more on these & other upcoming local CME activities to meet your CME needs.
See page 2 for details
How safe is your house?

4 million poisonings occur each year, over half to children

TOP 10 WAYS TO POISON-PROOF YOUR HOUSE

1. Keep 1-800-222-1222 on or near all phones, and in your cell phone. It’s the fast, free, private and 24/7 poison center helpline.

2. Keep cosmetics, personal care products, prescription and over-the-counter medicines, cleaning products, dietary supplements and vitamins, pesticides and lighter fluid, locked up or out of reach. Be sure household plants are also out of reach.

3. Always keep cleaning products, gasoline, lighter fluid, antifreeze, paint and paint thinners in the containers they came in.

4. Never put something that is not food in a food or beverage container, such as a soda bottle, cup or glass.

5. Do not store food and household cleaners in the same cabinet; they often look alike.

6. If you are a grandparent visiting or caring for little ones, put purses or bags that might contain your medication where a child can’t reach.

7. Put smoke alarms and carbon monoxide detectors in your home, make sure they work and change the batteries every 6 months.

8. Never call medicine candy.

9. Do not take medicine in front of children; they love to do what adults do.

10. Objects that use small batteries, like toys or remotes, should be kept out of reach of young children. Disc batteries are both poisonous and a choking hazard.

Order your free materials today at www.calpoison.org

Don’t Guess. Be Sure.

Play at: pillsvscenter.com or get the app

Text TIPS to 69866 for a weekly text on home & family safety

Facebook/CaliforniaPoisonControl

Twitter@poisoninfo

YouTube youtube.com/poisoninfo

UCSF California Poison Control System is managed by the University of California San Francisco School of Pharmacy.
¿Qué tan segura es su casa?

4 millones de intoxicaciones ocurren cada año, más de la mitad de los afectados son niños.

10 CONSEJOS PARA PREVENIR INTOXICACIÓN O ENVENENAMIENTO

1. Mantenga el número 1-800-222-1222 programado en su teléfono celular, en o cerca de todos los teléfonos de su casa. Es la línea de ayuda del centro para el control de intoxicaciones y envenenamientos que es rápida, gratuita, privada y disponible los 24/7.

2. Mantenga bajo llave o fuera del alcance los cosméticos, productos de cuidado personal, medicamentos recetados y de venta libre, productos de limpieza, suplementos dietéticos y vitaminas, pesticidas y líquido para encendedores. Asegure que las plantas del hogar también estén fuera del alcance.

3. Siempre mantenga los productos de limpieza, gasolina, líquido para encendedores, anticongelantes, disolventes y pinturas en los envases originales.

4. Nunca ponga algo que no es comida en un recipiente de comida o bebida, como una botella de refresco, copa o vaso.

5. No almacene alimentos y productos de limpieza en el mismo gabinete; se pueden parecer y ser confundidos.

6. Cuando visite hogares con niños pequeños ponga sus carretas o bolsas que pueden contener medicamento fuera del alcance de ellos.

7. Instale alarmas de humo y detectores de monóxido de carbono en su hogar, asegúrese de que funcionen y cambie las pilas cada 6 meses.

8. Nunca se refiera a la medicina como un dulce; se confunden los niños.

9. No tome medicamentos delante de los niños, les encanta hacer lo que hacen los adultos.

10. Los objetos que utilizan pilas pequeñas, como juguetes o controles remotos, deben mantenerse fuera del alcance de los niños pequeños. Pilas de discos son venenosas y pueden ser un peligro de asfixia.

DATE:  
Tuesday, March 8, 2016  
6:00 pm - 7:00 pm  
Dinner will be provided

LOCATION:  
H. Marcus Radin Conference Center  
The Palm Room

ATTENDEES WILL:  
- Improve patient outcomes by learning up-to-date information based on clinical scenarios that physicians often encounter during patient care focusing on maternal infections and how that relates to babies who are breastfeeding.  
- Gain an understanding of possible treatment options for maternal infections and the recipient infant including current medications and apply that knowledge in practice.  
- Review recommended maternal vaccinations and the safety of these to the nursing infants in order to improve patient safety.  
- Become familiar with where to go for advice and further help for maternal infections and the safety for their breastfeeding infant to achieve better outcomes and allow safe breastfeeding to continue.

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

CME: 1.0

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

www.ClovisCommunity.org

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

Disclosures: Speaker and Activities Director, Amy Evans, MD has no Commercial Disclosures to make. Planner, Jessica Lipsius has no Commercial Disclosures to make.
UCSF Fresno Department of Internal Medicine Presents:

2ND ANNUAL MEDICAL UPDATE IN THE VALLEY

MARCH 11-12, 2016

UCSF Fresno Center Auditorium
155 North Fresno St.
Fresno, CA 93701
(corner of Divisadero & Fresno)

SAVE THE DATE

AN EDUCATIONAL PROGRAM DESIGNED FOR INTERNSISTS, FAMILY PRACTITIONERS, PRIMARY CARE PHYSICIANS, AND NURSE PRACTITIONERS WHO WORK IN THE PRIMARY CARE FIELD.

Course Directors:
John Ambrose, MD, FACC
Vipul Jain, MD, MS

CME: 11.25 (applied for)
Early Registration Fee: $200
By February 12, 2016
After Feb. 12, Registration Fee: $249

FRIDAY, MARCH 11 | 4pm-8pm

<table>
<thead>
<tr>
<th>Topic</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>Naiel N. Nassar, MD, FACP</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>Ralph Wessel, MD</td>
</tr>
<tr>
<td>Women and Heart Disease</td>
<td>Teresa Daniele, MD</td>
</tr>
<tr>
<td>Hypertension Update</td>
<td>Sundararajan Srikanth, MD</td>
</tr>
</tbody>
</table>

SATURDAY, MARCH 12 | 8am-5:15pm

<table>
<thead>
<tr>
<th>Topic</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do I do With a Lung Nodule Found on a CT Scan?</td>
<td>Michael W. Peterson, MD</td>
</tr>
<tr>
<td>Clinical Strategies in PFT Interpretation: Lessons Learned But Not Taught</td>
<td>Vipul Jain, MD, MS</td>
</tr>
<tr>
<td>Allergen Immunotherapy / Therapeutic Vaccines for Allergic Diseases</td>
<td>A.M. Aminian, MD, FAAAAI</td>
</tr>
<tr>
<td>Fighting Against the Epidemic of Obesity: Current and Future Treatments</td>
<td>Anupama Poliyedath, MD</td>
</tr>
<tr>
<td>Stroke / TIA</td>
<td>Tanya Warwick, MD</td>
</tr>
<tr>
<td>Mild Traumatic Brain Injury / Concussion</td>
<td>Chris M. Bauer, PhD, Neuropsychologist</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Ernestina, Saxton, MD, PhD</td>
</tr>
<tr>
<td>The Difficult Patient: Personality Disorders in Primary Care</td>
<td>Shawn B. Hersevoort, MD, MPH</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>Narayana Ambati, MD</td>
</tr>
<tr>
<td>Dermatology Pearls</td>
<td>Leslie Storey, MD</td>
</tr>
<tr>
<td>Evaluation of Abdominal Pain</td>
<td>Vivek Mittal, MD</td>
</tr>
<tr>
<td>Controversies in the Management of Hypothyroidism</td>
<td>Soe Naing, MD, MRCP (UK), FACE</td>
</tr>
<tr>
<td>The A, B, Ca and D of Osteoporosis</td>
<td>Alan Kelton, MD</td>
</tr>
<tr>
<td>Sports Related Injuries in Primary Care</td>
<td>Siddharth Joglekar, MBBS</td>
</tr>
<tr>
<td>Update on Gout</td>
<td>Shefali Majmudar, DO</td>
</tr>
<tr>
<td>New Treatment Options for Rheumatoid Arthritis</td>
<td>Candice Yuvienco, MD, RhMSUS</td>
</tr>
</tbody>
</table>

Registration includes all educational programming and meals. Evening Welcome Reception (Friday, March 11 | 6-8pm)

Register at: www.fresno.ucsf.edu/conferences/update2016

For more information, contact Monica Sozinho at msozinho@fresno.ucsf.edu or 559-499-6421
Perinatal M & M Presents:

“Neonatal Surgery at CRMC - 1 year in Review”

Wednesday, March 16th, 2016 from 12:30pm – 1:30pm

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

Case Presentation
Obstetrics: Dr. Nathalie Nguyen
Neonatology: Dr. Holly Williams

Principal Discussants
Obstetrics: Dr. Chris Downer
Neonatology: Dr. Krishna Rajani
Pediatric surgery: Dr. Holly Williams

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 neonatal surgery.
2) Gain insight into neonatal surgery, 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

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
Resolving Diagnostic Dilemma in Lung Nodules

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

DATE/TIME: March 17, 2016
Thursday - 6:30 pm - 8:30 pm

ATTENDEES WILL:

1. Attendees will be able to learn and become familiar with current advances in diagnostic investigation including timing of intervention in lung nodules that can prevent delayed cancer diagnosis.

2. Attendees will be able to utilize current guidelines in the management of lung nodules in their clinical practice.

TARGET AUDIENCE:
Primary care physicians, Internal Medicine, Family Practice, Nurse Practitioners, Physician Assistants, RN’s, Geriatric M.D.’s and Oncologist, RN’s and all Allied Health Professionals who work in primary care field.

RSVP to: Ric Morales, Director Physician Relations at (559) 459-6211 or e-mail RMorales3@communitymedical.org or: cmersvp@communitymedical.org

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

CME 1.0
Dinner provided (vegetarian options available)

www.CommunityRegional.org

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

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

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

Disclosures: Speaker: Daya Upadhyay, M.D. and event planners Steve Esqueda and Ric Morales have no disclosures to make.
CME Dinner Lecture
Update In Neurosurgery: Brain Tumors, Neurocritical Care

SPEAKER: Yu-Hung Kuo, M.D.
Neurosurgeon
Arash Afshinnik, M.D.
NeuroIntensivist
University | Neurosciences Institute

DATE/TIME: March 29, 2016
Tuesday, 6:30 p.m. to 8:30 p.m.

ATTENDEES WILL:

1. Better understand the goal of surgical resection in brain and spinal metastases treatment in order to improve one’s practice.

2. Will know how to identify the indications for radiosurgery and will be able to add this competency to one’s practice.

3. Gain a better understanding the role of the Neurosurgeon as part of a multidisciplinary team.

4. Gain better understanding of the role of NeuroIntensivist in a comprehensive neuroscience institute.

5. Learn and become familiar with the role of a NeuroIntensivist, and the management of Acute Neurologic and Neurosurgical injury patients in an emergency room setting.

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

RSVP to: Ric Morales, Director Physician Relations at (559) 459-6211 or e-mail RMorales3@communitymedical.org

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

Disclosures: Speaker Yu Hung Kuo, M.D. and Arash Afshinnik, M.D. and event planner Ric Morales have no disclosures to make.

LOCATION: The Petroleum Club
5060 California Ave., Ste 1200
Bakersfield, CA 93309

CME 1.0
Dinner provided (vegetarian options available)

www.CommunityRegional.org
SPEAKER: Robert Ryan, M.D.
Minimally Invasive Endovascular Neurosurgery
Assistant Clinical Professor, UCSF

DATE/TIME: March 31, 2016
Thursday, 6:30 pm – 8:30 pm

ATTENDEES WILL:

1. Gain competency in clinical identification of cerebral aneurysms and their early management, including diagnostic tests and referrals.

2. Learn to identify patients that are good candidates for endovascular coiling of aneurysms and for surgical clipping of aneurysms. Learn to apply this to achieve better patient outcomes.

LOCATION: Galletto Ristorante
1101 “J” St., Modesto, CA 95354

CME 1.0
Dinner provided (Vegetarian options available)

TARGET AUDIENCE:
ER Physicians, Critical Care, Neurosciences, Primary Care Physicians, Internal Medicine, and Family Practice, N.P.’s, PA’s RN’s and All Allied Health Care Professionals.

RSVP required to Kimberly Goldring at (559) 260-4613 or e-mail at KGoldring@communitymedical.org

Limited seating available.

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 Kimberly Goldring have no disclosures to make.

www.CommunityRegional.org
FRONTIERS IN GASTROENTEROLOGY & HEPATOLOGY SYMPOSIUM

DATE:
Saturday, April 2, 2016
8:00 am—8:30 am Registration
8:30 am—2:45 pm Symposium
Breakfast & Lunch will be provided

LOCATION:
H. Marcus Radin Conference Center
on the Clovis Community campus

ACTIVITIES DIRECTORS:
AJIT ARORA, MD & SANDEEP SEKHON, MD

ATTENDEES WILL:

- Increase the ability to appropriately utilize new techniques in endoscopy when making assessments for patient care and apply these current guidelines for patient care.

- In order to improve patient safety, physicians will become more aware of the indications and contraindications in evaluation of commonly seen GI disease processes and will be more proficient with diagnoses.

- Increase physician recognition in the management of complex and endoscopic cases and use this knowledge in practice to develop better management plans for a diverse patient population and apply this to achieve better outcomes.

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

CME: 5.5

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

Symposium is offered free of charge.

Continued…
<table>
<thead>
<tr>
<th>SPEAKERS:</th>
<th>PHYSICIAN TITLES:</th>
<th>PRESENTATION TITLES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tyler Berzin, MD</td>
<td>Assistant Professor, Harvard Medical School; Associate Program Director Gastroenterology Fellowship Program and Advanced Therapeutic Endoscopy Fellowship, Beth Israel Deaconess Medical Center, Boston, MA</td>
<td>Managing GERD Symptoms: Myths and Truths</td>
</tr>
<tr>
<td>Robert Gish, MD</td>
<td>Professor Consultant Department of Medicine Division of Gastroenterology and Hepatology, Stanford University and Senior Medical Director and Staff Physician, St. Joseph’s Medical Center, Phoenix, AZ</td>
<td>Hot Topics in Liver Disease: Hepatitis B Virus, Hepatitis C Virus and New Important Primary Care Issues that can be Applied to Real Life Practice</td>
</tr>
<tr>
<td>Jennifer Lai, MD</td>
<td>Assistant Professor of Medicine General Hepatology and Liver Transplantation Department of Medicine, University of San Francisco, San Francisco, CA</td>
<td>Liver Disease in Pregnancy</td>
</tr>
<tr>
<td>Ali Lankarani, MD</td>
<td>Advanced Endoscopy Fellowship Director, Advanced Therapeutic Endoscopy Center, Borland Groover Clinic, Clinical Instructor, Family Medicine Residency Program at Vincent’s Hospital, Jacksonville, FL</td>
<td>The Tunnel at the End of the Light: Past, Present and Future of Endoscopy</td>
</tr>
<tr>
<td>Mimi Lin, MD</td>
<td>Director of Neurogastroenterology and Motility Education, Center for Neurogastroenterology and Motility, Sutter Pacific Medical Foundation, San Francisco, CA</td>
<td>Gastrointestinal, Motility and Beyond</td>
</tr>
<tr>
<td>Simon Lo, MD</td>
<td>Director of Endoscopy Service and Pancreatic and Biliary Disease Program, Cedars-Sinai Medical Center, Hollywood, CA</td>
<td>A Systematic Approach to Investigate the Cause of Acute Pancreatitis</td>
</tr>
<tr>
<td>Sandeep Sekhon, MD</td>
<td>Gastroenterology, Digestive Disease Consultants, Fresno, CA</td>
<td>Around the Gut in 20 Minutes</td>
</tr>
<tr>
<td>Shyam Thakkar, MD</td>
<td>Director of Development Endoscopy, West Penn Allegheny Health System, Temple University School of Medicine, Adjunct Professor, Biomedical Engineering, Carnegie Mellon University</td>
<td>Causes of Dysphagia and Endoscopic Solutions… No Pill too Difficult to Swallow</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 5.5 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

Disclosure: Chair and Activity Director Ajit Arora, MD would like to disclose that he has a financial interest/arrangement or affiliation with the following corporation or other organization that sell or develop products or drugs for medical use: AbbVie – Speaker’s Bureau and Takeda – Speaker’s Bureau. Speaker Tyler Berzin, MD would like to disclose that he has a financial interest/arrangement or affiliation with the following corporation or other organization that sell or develop products or drugs for medical use: Boston Scientific – Consultant and Medtronic – Consultant. Speaker Robert Gish, MD would like to disclose that he has a financial interest/arrangement or affiliation with the following corporation or other organization that sell or develop products or drugs for medical use: AbbVie – Consultant, Grants/Research Support, Speaker’s Bureau, Arrowhead – Consultant, Stock Options, Astra-Zeneca – Consultant, Bayer – Speaker’s Bureau, Bristol-Myers Squibb Company – Speaker’s Bureau, CoCrystal – Stockholder, Contravir – Consultant, Genentech – Consultant, Gilead Sciences Inc. – Speaker’s Bureau, Eiger – Consultant, Enyo – Consultant, HumAbs – Consultant, Intellia – Consultant, Interceptor – Consultant, Isis Pharmaceuticals – Consultant, Janssen – Consultant, Kirin – Stockholder, Medimmune – Consultant, MERCK – Consultant, Grants/Research Support, Nanogen – Consultant, Novira – Consultant, Presidio – Consultant, Synageva – Stockholder, RiboSciences – Stockholder, Valeant – Speaker’s Bureau.

Activity Director, Course Chair, and speaker Sandeep Sekhon, MD and speakers Jennifer Lai, MD, Ali Lankarani MD, Mimi Lin MD, and Shyam Thakkar, MD have no Commercial Disclosures to make. Planner Jessica Lipsius has no Commercial Disclosures to make.
**SAVE THE DATE**

**Department of Internal Medicine Presents:**

**Air Pollution & Climate Change Symposium**

<table>
<thead>
<tr>
<th>Symposium Topics</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Remarks</td>
<td>Michael W. Peterson, MD</td>
</tr>
<tr>
<td></td>
<td>Interim Associate Dean</td>
</tr>
<tr>
<td></td>
<td>Professor of Medicine</td>
</tr>
<tr>
<td></td>
<td>UCSF Fresno</td>
</tr>
<tr>
<td>Air Pollution and its Impact on Airway Disease</td>
<td>Jose Joseph Vempilly, MD</td>
</tr>
<tr>
<td></td>
<td>Associate Professor of Medicine</td>
</tr>
<tr>
<td></td>
<td>UCSF Fresno</td>
</tr>
<tr>
<td>Air Pollution and its Impact on Systematic Disease</td>
<td>Daya Upadhyay, MD</td>
</tr>
<tr>
<td></td>
<td>UCSF Fresno</td>
</tr>
<tr>
<td>Air Pollution in the US: The Best and Worst Over the</td>
<td>Bonnie Holmes-Gen, Senior Director,</td>
</tr>
<tr>
<td>Past 10 Years</td>
<td>Air Quality and Climate Change, American Lung Association in California</td>
</tr>
<tr>
<td>State of Air in the Central Valley Over the Past</td>
<td>Mr. Samir Sheikh, Deputy Pollution Control Officer, San Joaquin Valley</td>
</tr>
<tr>
<td>Decade</td>
<td>Air Pollution Control District</td>
</tr>
<tr>
<td></td>
<td>UCSD Fresno</td>
</tr>
<tr>
<td>Climate Change and Effects on Human Health</td>
<td>William Rom, MD, MPH</td>
</tr>
<tr>
<td></td>
<td>New York University</td>
</tr>
<tr>
<td>Climate Change: The Consequences for the Next Century</td>
<td>Helene G. Margolis, MA., PHD</td>
</tr>
<tr>
<td>for Business as Usual Strategy</td>
<td>University of California, Davis</td>
</tr>
<tr>
<td>Solutions for Reducing the Burden of Global Air</td>
<td>Joel D. Kaufman, MD</td>
</tr>
<tr>
<td>Pollution</td>
<td>University of Washington</td>
</tr>
</tbody>
</table>

**Course Director:** Jose Joseph Vempilly, MD  
**Co-Director:** Daya Upadhyay, MD  
**CME:** 5.5 (Applied For)  
**Early Registration Fee:** $25  
(By March 4, 2016)  
**After March 4th, Registration Fee:** $50

**Saturday, April 23, 2016 - 7:30am to 2:00pm**

**To Register Visit:** [www.fresno.ucsf.edu/conferences/air2016](http://www.fresno.ucsf.edu/conferences/air2016)

**For More Information Call:** 559-499-6421 or Email msozinho@fresno.ucsf.edu

**UCSF Fresno Center – Auditorium**  
**155 N. Fresno Street – Corner of Fresno and Divisadero**
May 18-20, 2016
The Pines Resort at Bass Lake, CA

Testimonials from past attendees:

“Great use of actual animal tissue for skills; good hands-on practice.”
“Hands on practical labs very useful. Love the techniques!”

For more information and to register online, go to:
http://www.ucsfcmec.com/2016/MMC16025/info.html
Department of Surgery
Trauma Critical Care Conference
Thursday 12p.m-1p.m

March 2016

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Location</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/03/16</td>
<td>TBD</td>
<td>Seq. East</td>
<td>Lawrence Sue, MD</td>
</tr>
<tr>
<td>03/10/16</td>
<td>Combined ED/Surgery Conference</td>
<td>Seq. East</td>
<td>Dr. Salsbery &amp; Rachel Caiafa, MD (video review)</td>
</tr>
<tr>
<td></td>
<td>Burn Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03/17/16</td>
<td>TBD</td>
<td>Seq. East</td>
<td>Kathryn Bilello, MD</td>
</tr>
<tr>
<td>03/24/16</td>
<td>Abdominal Compartment Syndrome</td>
<td>Seq. East</td>
<td>Shana Ballow, MD</td>
</tr>
<tr>
<td>03/31/16</td>
<td>Esophageal Injuries</td>
<td>Seq. East</td>
<td>Meg Wolfe, MD</td>
</tr>
</tbody>
</table>

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

Objectives:

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

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

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.
March 2016

March 3
No Grand Rounds – Resident Open Meeting

March 10
“Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span”
Sarah Sicher, MD, Presenter
Karen Kraus, MD, Discussant
UCSF Fresno Psychiatry Residency Program

March 17
Case Presentation
Saydra Wilson, MD, Presenter
Sherry Walling, MD, Advisor
UCSF Fresno Psychiatry Residency Program

March 24
“On Methmory”
Avak Howsepian, MD, PhD
Assistant Professor, Adjunct Series
UCSF Fresno Psychiatry Residency Program

March 31
“Four Patients, One Illness”
Michael DeLollis, M.D.
Associate Clinical Professor
Department of Psychiatry

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>Date</th>
<th>Time</th>
<th>Course Title</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday, March 1, 2016</td>
<td>12:30-1:30 p.m.</td>
<td>&quot;One Minute Preceptor&quot;&lt;br&gt;Paul Francis, M.D.</td>
<td></td>
</tr>
<tr>
<td>Tuesday, March 8, 2016</td>
<td>12:30-1:30 p.m.</td>
<td>&quot;GME 101&quot;&lt;br&gt;GME Team</td>
<td></td>
</tr>
<tr>
<td>Tuesday, March 15, 2016</td>
<td>12:30-1:30 p.m.</td>
<td>&quot;Physician Wellness&quot;&lt;br&gt;Aaron Snyder, M.D. FAAFP</td>
<td></td>
</tr>
<tr>
<td>Tuesday, March 22, 2016</td>
<td>12:30-1:30 p.m.</td>
<td>&quot;Working with Struggling Learners&quot;&lt;br&gt;Heather Peters, PhD</td>
<td></td>
</tr>
<tr>
<td>Tuesday, March 29, 2016</td>
<td>12:30-1:30 p.m.</td>
<td>&quot;EMRT Code Blue&quot;&lt;br&gt;(not video-conferenced)&lt;br&gt;Mary Jo Quintero, RN</td>
<td></td>
</tr>
<tr>
<td>Thursday, March 3, 2016</td>
<td>12:30-1:30 p.m.</td>
<td>&quot;Evidence-based Medicine vs Clinical Reasoning&quot;&lt;br&gt;James Pierce, M.D.</td>
<td></td>
</tr>
<tr>
<td>Thursday, March 10, 2016</td>
<td>12:30-1:30 p.m.</td>
<td>'I hate to tell you this but …’&lt;br&gt;“Giving Effective Feedback in the Clinical Setting”&lt;br&gt;Jolie Limon, M.D.</td>
<td></td>
</tr>
<tr>
<td>Thursday, March 17, 2016</td>
<td>12:30-1:30 p.m.</td>
<td>no lecture scheduled - (event moved to Friday, 3/8/16, for Ethics Conference)</td>
<td></td>
</tr>
<tr>
<td>Thursday, March 24, 2016</td>
<td>12:30-1:30 p.m.</td>
<td>no lecture scheduled</td>
<td></td>
</tr>
<tr>
<td>Thursday, March 31, 2016</td>
<td>12:30-1:30 p.m.</td>
<td>&quot;The Relationship Between the Primary Doctor and the Consultant&quot;&lt;br&gt;James Pierce, M.D.</td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
<td>Thursday</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>8:00am</td>
<td>12:30pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Emergency Medicine Committee</td>
<td>CCMC Medical Staff Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Outpatient Conference Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>12:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peds/Neo CFPRC</td>
<td>CRMC Facility Executive Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC 4 West NICU Conference Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>5:30pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Robotic Steering Committee</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TCCB 3 Surgery Conference Room</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>12:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CIDP</td>
<td>CRMC Pediatrics Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>12:30pm</td>
<td>4:45pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Emergency Medicine Committee</td>
<td>Quality Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia West Room</td>
<td>CRMC Sequoia East Room</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>6:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Surgery Committee</td>
<td>Medical Executive Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia West Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>6:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCIMC Surgery/Pathology/Anesthesia</td>
<td>CCMC Multispecialty Peer Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Outpatient Conference Room</td>
<td>CCMC Outpatient Conference Room</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>9:00am</td>
<td>2:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Medicine/Family Medicine/Psychiatry/Psychology/Physical Med and Rehab Committee</td>
<td>FHSU Facility Executive Advisory Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Outpatient Conference Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td>12:30pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Ob-Gyn Committee</td>
<td>CCMC Quality Patient Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia East Room</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>6:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Well Being Committee</td>
<td>CCMC Multispecialty Peer Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC 4 West NICU Conference Room</td>
<td>CCMC Outpatient Conference Room</td>
</tr>
<tr>
<td>11</td>
<td>12</td>
<td>12:30pm</td>
<td>2:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Cardiology Committee</td>
<td>Pharmacy &amp; Therapeutics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>2:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Utilization Review</td>
<td>CCMC Facility Executive Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia East Room</td>
</tr>
<tr>
<td>13</td>
<td>14</td>
<td>6:00pm</td>
<td>12:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC EKG Review</td>
<td>CRMC EKG Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia West Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>14</td>
<td>15</td>
<td>2:00pm</td>
<td>12:30pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Ethics Committee</td>
<td>CRMC Quality Patient Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia East Room</td>
</tr>
<tr>
<td>15</td>
<td>16</td>
<td>6:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FHSU Facility Executive Advisory Committee</td>
<td>CCMC Quality Patient Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia West Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>16</td>
<td>17</td>
<td>2:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ethics Committee</td>
<td>CRMC Multispecialty Peer Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>17</td>
<td>18</td>
<td>6:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacy &amp; Therapeutics</td>
<td>CRMC Multispecialty Peer Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia West Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>18</td>
<td>19</td>
<td>12:30pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Cardiology Committee</td>
<td>CRMC Quality Patient Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>19</td>
<td>20</td>
<td>6:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Utilization Review</td>
<td>CCMC Facility Executive Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia East Room</td>
</tr>
<tr>
<td>20</td>
<td>21</td>
<td>2:00pm</td>
<td>12:30pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Utilization Review</td>
<td>CRMC EKG Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>21</td>
<td>22</td>
<td>6:00pm</td>
<td>12:30pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC EKG Review</td>
<td>FHSU Quality Patient Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia West Room</td>
<td>FHSU Riverpark Conference B</td>
</tr>
<tr>
<td>22</td>
<td>23</td>
<td>12:30pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Ethics Committee</td>
<td>CRMC Multispecialty Peer Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>23</td>
<td>24</td>
<td>2:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Cardiology Committee</td>
<td>CRMC Quality Patient Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>24</td>
<td>25</td>
<td>6:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Utilization Review</td>
<td>CRMC Multispecialty Peer Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>25</td>
<td>26</td>
<td>2:00pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Utilization Review</td>
<td>CCMC Facility Executive Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia East Room</td>
</tr>
<tr>
<td>26</td>
<td>27</td>
<td>6:00pm</td>
<td>12:30pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC EKG Review</td>
<td>FHSU Quality Patient Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia West Room</td>
<td>FHSU Riverpark Conference B</td>
</tr>
<tr>
<td>27</td>
<td>28</td>
<td>12:30pm</td>
<td>6:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Utilization Review</td>
<td>CRMC Multispecialty Peer Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>CRMC Sequoia West Room</td>
</tr>
<tr>
<td>28</td>
<td>29</td>
<td>2:00pm</td>
<td>12:30pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Utilization Review</td>
<td>FHSU Quality Patient Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>FHSU Riverpark Conference B</td>
</tr>
<tr>
<td>29</td>
<td>30</td>
<td>6:00pm</td>
<td>12:30pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCMC Facility Executive Committee</td>
<td>FHSU Quality Patient Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia East Room</td>
<td>FHSU Riverpark Conference B</td>
</tr>
<tr>
<td>30</td>
<td>31</td>
<td>12:00pm</td>
<td>12:30pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC EKG Review</td>
<td>FHSU Quality Patient Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRMC Sequoia West Room</td>
<td>FHSU Riverpark Conference B</td>
</tr>
</tbody>
</table>

As of 2/17/16
<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:30 - 7:15 am</td>
<td>Ortho Surg.-Foot/Angle/Hand SPOC</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>Ortho Surg-Adult Recon GR-Ortho Surgery Conf. Rm</td>
<td>7:30-8:30 am Chest Conference UCSF # 116</td>
</tr>
<tr>
<td>8:00 - 9:00 am</td>
<td>Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>Neuroscience Pt. Case Present. East Med-Plaza-NORC Conf. Rm.</td>
<td>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</td>
<td>FP Faculty Development UCSF Fresno Rm. 329</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>Emergency Medicine UCSF Rm 136</td>
<td>8:00-9:00 am Hematology Conference UCSF Rm 118</td>
</tr>
<tr>
<td>7:30-8:30 am</td>
<td>Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>Critical Care/Trauma CRMC-Sequoia East Conf Rm</td>
<td>8:30-9:30 am Surgery Clinical Case Rev. CRMC-Sequoia West Conf. Rm</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture TBD</td>
<td>Brain Tumor/Cyberknife Conf-Lower Level-Rad-Onc</td>
<td>Children’s Peds Lecture TBD</td>
<td>8:30am OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>CRMC-Sequoia East Conf Rm</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>8:30am Critical Care/Trauma &amp; Emergency CRMC-Sequoia East Conf Rm</td>
<td>12:30pm OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>6:30 - 7:15 am</td>
<td>Ortho Surg.-Foot/Angle/Hand SPOC</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>Ortho Surg-Adult Recon GR-Ortho Surgery Conf. Rm</td>
<td>7:30-8:30 am Chest Conference UCSF # 116</td>
</tr>
<tr>
<td>8:00 - 9:00 am</td>
<td>Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>Neuroscience Pt. Case Present. East Med-Plaza-NORC Conf. Rm.</td>
<td>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</td>
<td>FP Faculty Development UCSF Fresno Rm. 329</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>Emergency Medicine UCSF Rm 136</td>
<td>8:00-9:00 am Hematology Conference UCSF Rm 118</td>
</tr>
<tr>
<td>7:30-8:30 am</td>
<td>Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>Critical Care/Trauma CRMC-Sequoia East Conf Rm</td>
<td>8:30-9:30 am Surgery Clinical Case Rev. CRMC-Sequoia West Conf. Rm</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture TBD</td>
<td>Brain Tumor/Cyberknife Conf-Lower Level-Rad-Onc</td>
<td>Children’s Peds Lecture TBD</td>
<td>8:30am OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>CRMC-Sequoia East Conf Rm</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>8:30am Critical Care/Trauma &amp; Emergency CRMC-Sequoia East Conf Rm</td>
<td>12:30pm OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>6:30 - 7:15 am</td>
<td>Ortho Surg.-Foot/Angle/Hand SPOC</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>Ortho Surg-Adult Recon GR-Ortho Surgery Conf. Rm</td>
<td>7:30-8:30 am Chest Conference UCSF # 116</td>
</tr>
<tr>
<td>8:00 - 9:00 am</td>
<td>Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>Neuroscience Pt. Case Present. East Med-Plaza-NORC Conf. Rm.</td>
<td>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</td>
<td>FP Faculty Development UCSF Fresno Rm. 329</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>Emergency Medicine UCSF Rm 136</td>
<td>8:00-9:00 am Hematology Conference UCSF Rm 118</td>
</tr>
<tr>
<td>7:30-8:30 am</td>
<td>Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>Critical Care/Trauma CRMC-Sequoia East Conf Rm</td>
<td>8:30-9:30 am Surgery Clinical Case Rev. CRMC-Sequoia West Conf. Rm</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture TBD</td>
<td>Brain Tumor/Cyberknife Conf-Lower Level-Rad-Onc</td>
<td>Children’s Peds Lecture TBD</td>
<td>8:30am OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>CRMC-Sequoia East Conf Rm</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>8:30am Critical Care/Trauma &amp; Emergency CRMC-Sequoia East Conf Rm</td>
<td>12:30pm OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>6:30 - 7:15 am</td>
<td>Ortho Surg.-Foot/Angle/Hand SPOC</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>Ortho Surg-Adult Recon GR-Ortho Surgery Conf. Rm</td>
<td>7:30-8:30 am Chest Conference UCSF # 116</td>
</tr>
<tr>
<td>8:00 - 9:00 am</td>
<td>Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>Neuroscience Pt. Case Present. East Med-Plaza-NORC Conf. Rm.</td>
<td>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</td>
<td>FP Faculty Development UCSF Fresno Rm. 329</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>Emergency Medicine UCSF Rm 136</td>
<td>8:00-9:00 am Hematology Conference UCSF Rm 118</td>
</tr>
<tr>
<td>7:30-8:30 am</td>
<td>Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>Critical Care/Trauma CRMC-Sequoia East Conf Rm</td>
<td>8:30-9:30 am Surgery Clinical Case Rev. CRMC-Sequoia West Conf. Rm</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture TBD</td>
<td>Brain Tumor/Cyberknife Conf-Lower Level-Rad-Onc</td>
<td>Children’s Peds Lecture TBD</td>
<td>8:30am OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>CRMC-Sequoia East Conf Rm</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>8:30am Critical Care/Trauma &amp; Emergency CRMC-Sequoia East Conf Rm</td>
<td>12:30pm OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>6:30 - 7:15 am</td>
<td>Ortho Surg.-Foot/Angle/Hand SPOC</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>Ortho Surg-Adult Recon GR-Ortho Surgery Conf. Rm</td>
<td>7:30-8:30 am Chest Conference UCSF # 116</td>
</tr>
<tr>
<td>8:00 - 9:00 am</td>
<td>Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>Neuroscience Pt. Case Present. East Med-Plaza-NORC Conf. Rm.</td>
<td>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</td>
<td>FP Faculty Development UCSF Fresno Rm. 329</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>Emergency Medicine UCSF Rm 136</td>
<td>8:00-9:00 am Hematology Conference UCSF Rm 118</td>
</tr>
<tr>
<td>7:30-8:30 am</td>
<td>Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>Critical Care/Trauma CRMC-Sequoia East Conf Rm</td>
<td>8:30-9:30 am Surgery Clinical Case Rev. CRMC-Sequoia West Conf. Rm</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture TBD</td>
<td>Brain Tumor/Cyberknife Conf-Lower Level-Rad-Onc</td>
<td>Children’s Peds Lecture TBD</td>
<td>8:30am OBGYN Residency GR UCSF Rm 116</td>
</tr>
<tr>
<td>MON</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>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>6:30 - 7:15 am</td>
<td>Ortho Surg.- Foot/Ankle/Hand SPOC</td>
<td>7:00-8:00am</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>7:15-8:15 am</td>
</tr>
<tr>
<td>8:00-9:00am</td>
<td>Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>7:30-8:30 am</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am</td>
</tr>
<tr>
<td>12:00-1:00 pm</td>
<td>Neuroscience GR CRMC-TCCB3 Conf Rm</td>
<td>7:30-8:30 am</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>12:00-1:00pm</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture TBD</td>
<td>12:00-1:00pm</td>
<td>Brain Tumor/Cyberknife Conf-Lower Level-Rad-Oncc</td>
<td>12:00-1:30 pm</td>
</tr>
<tr>
<td>28</td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>6:30 - 7:15 am</td>
<td>Ortho Surg.- Foot/Ankle/Hand SPOC</td>
<td>7:00-8:00am</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>7:15-8:15 am</td>
</tr>
<tr>
<td>8:00-9:00am</td>
<td>Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>7:30-8:30 am</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>7:30-8:30 am</td>
</tr>
<tr>
<td>12:00-1:00 pm</td>
<td>Neuroscience GR CRMC-TCCB3 Conf Rm</td>
<td>7:30-8:30 am</td>
<td>Cardiac Cath &amp; Intervention Cath Lab</td>
<td>12:00-1:00pm</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture TBD</td>
<td>12:00-1:00pm</td>
<td>Brain Tumor/Cyberknife Conf-Lower Level-Rad-Oncc</td>
<td>12:00-1:30 pm</td>
</tr>
<tr>
<td>12:30-1:30 pm</td>
<td>Children’s Peds Lecture TBD</td>
<td>12:00-1:30 pm</td>
<td>Perinatal M&amp;M-Conf. UCSF-Rm. 136</td>
<td></td>
</tr>
<tr>
<td>4:00-5:00 pm</td>
<td>Psychiatry GR UCSF Rm 116</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>