On October 22, 2015, I began to fulfill a major ‘bucket list’ item. I flew to Katmandu, Nepal, for a 15-day trek to Mt. Everest base camp. I was accompanied by my hiking partner, Mr. John Kass. The transit time was 36 hours, followed by 3 days acclimating to the time change and learning the history, culture and religious diversity of Nepal. We were joined by 3 other trekkers, and flew to Lukla, Nepal at 9,000 ft. This is one of the 10 most dangerous airports in the world as you land onto a cliff and taxi uphill. Within 2 hours of landing, we began a 15-day trek into the Solu Khumbu region of the Himalayas. We carried day packs, and our porters and yaks carried most of our gear. We were honored to have excellent Sherpa guides and an amazing Hindu chef among our support crew.

Over the next 10 days, we ascended to Mt. Everest base camp at 17,600 ft with an elevation gain/loss of over 15,000 ft. Overall elevation gain averaged 1,000 ft/day to reduce the chance of acute mountain sickness. A slow steady pace with two nights spent at 12,000 and 14,000 ft allowed for acclimatization. On these days we had day hikes to higher elevations, then descended to sleep. A few nights were spent in tents, most nights in lodges/tea houses (the tents were warmer!). We had snow for 2 days, but mostly enjoyed the cool, clear days to the Himalayas.

I have never seen clearer, bluer skies than in the Himalayas. Our journey took us through rhododendron forests, Buddhist temples and monasteries, and small villages. We had impressive panoramic views of multiple 7,000+ meter mountain peaks that are higher than the clouds. The last two days of ascending were along alpine boulders and talus left by the Khumbu glacier. Along this path are prayer flags and memorials dedicated to those climbers who have perished in pursuit of their dreams. Base camp exists for only 2 months of the year for those brave souls daring to climb Mt. Everest. During the rest of the year it is marked with Tibetan prayer flags to honor the mountain and those who visit it. The recent loss of life there from the earthquake last year is not forgotten either. It is awe inspiring to be there.

We descended in 5 days, including a visit to the volunteer run, Himalayan Rescue Association clinic in Pheriche (14,000 ft). This is staffed by volunteer physicians and is an important medical facility for trekkers, climbers, and local people. Throughout the trek, we saw or heard helicopters daily, transporting people with altitude sickness down to lower elevations. We ended our 15-day trek at a comfortable lodge in Lukla, had our first shower in 2 weeks, and a party with our trekking team. As we flew back to Katmandu to spend another 3 days to enjoy Nepal and supporting the local economy, most of our crew walked another 2-3 days back to their villages and families.

This was a trip I will never forget, in an unbelievable place. The Sherpa have a culture without cars and western luxuries. Many of the joys of trekking are intangible. The silence and scenery of the mountain peaks allows your mind to settle and enjoy the simple pleasures of life. It is hard to think of a better way to spend three weeks of your life. All photos were taken with my iPhone 6s.

Mark Cunningham, M.D., F.A.C.S.
Chair, CCMC Department of Surgery
Chair, CCMC Multispecialty Peer Review Committee

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

Deadline to submit articles for the May 2016 issue of Physicians’ Edition is Friday, April 22.
Peer Review: Your Ongoing Professional Practice Evaluation Report is Coming Soon

Our Peer Review Department has been working hard to produce the inaugural OPPE (Ongoing Professional Practice Evaluation) Information Reports for our medical staff members. OPPE is a process by which the medical staff can track the quality of care each of us provides. Department chairs work with the Peer Review Department to establish indicators on which individual providers are assessed. Historically, the Peer Review process was engaged retrospectively, in response to adverse or questionable outcome. By contrast, OPPE is the mechanism by which all members of the medical staff delivering patient care are evaluated objectively on an annual ("ongoing") basis.

OPPE differs from FPPE (Focused Professional Practice Evaluation) in that FPPE is designed to bring attention to those found to be outliers on the basis of data collection, or who have had adverse outcomes. FPPE can be initiated by a department chair or the MEC with notification going to the provider involved. FPPE is not considered punitive or disciplinary, but it does initiate a closer, real-time look at the medical staff member's hospital care.

Members of the medical staff (includes active, associate, ambulatory and AHP) should receive their OPPE report in the weeks to come. This report will detail one's performance for the predetermined indicators. We believe medical staff members should have access to data, which the medical staff has deemed to be important quality measures of your professional practice. Your OPPE report will provide that opportunity. Should you have any questions regarding your individual report, please feel free to contact your department chair or the Peer Review Department directly.

I would also like to take this opportunity to remind you about Community Regional’s Medical Staff Spring Fling event coming up May 3 at Five restaurant. This Year's theme is “Changes in Latitude” so put on your best tropical attire and enjoy a casual relaxing evening of food, fun, and beverage!
Initial Appointment to the Medical Staff
effective March 10, 2016

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

Desiree Crane D.O.
Department: Emergency Medicine
Specialty: Emergency Medicine

Renee Kinman M.D.
Department: Pediatrics
Specialty: Pediatric Endocrinology

UCSF Fresno Names Associate Dean

Congratulations to Dr. Michael W. Peterson on his appointment as Associate Dean of University of California, San Francisco's Fresno Medical Education Program.

Dr. Peterson has served as interim associate dean since January 1, 2015. He's been Chief of Medicine at UCSF Fresno for 14 years, and he serves as Vice Chair in the Department of Medicine at UCSF.

“I have every confidence that Dr. Peterson will lead UCSF Fresno with vision, vigor and commitment,” said Dr. Talmadge E. King Jr., dean of the UCSF School of Medicine and Vice Chancellor for Medical Affairs. “He will continue to be a trusted leader within the Department of Medicine and the School and will continue to extend UCSF's mission in Fresno and the San Joaquin Valley.”

His appointment was effective April 1.

“Too many people are quick to dream big, but slow to act on it.”

– Edmond Mbiaka, writer

Initial Appointment to the Medical Staff

effective March 10, 2016

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

David Balabanis C.R.N.A.
Department: Surgery
Specialty: Anesthesiology

Jennifer Le N.P.
Department: Pediatrics
Specialty: Pediatrics

Scheree Lau L.C.S.W.
Department: DOCS
Specialty: Psychiatry

Shelli Chittum N.P.
Department: Surgery
Specialty: Neurosurgery

Elton Tripp P.A.
Department: Surgery
Specialty: Orthopedic Surgery

William Ritchey C.R.N.A.
Department: Surgery
Specialty: Anesthesiology
The National Resident Matching Program announced today that the 2016 Match Day for graduating medical students was the largest on record, with 42,370 registered applicants and 30,750 positions filled. The number of United States medical school seniors grew by 221 to 18,668, and the number of available first-year positions rose to 27,860, which is 567 more than last year. “Match Day,” an annual rite of passage for future physicians, is the system through which medical school students and graduates obtain residency positions in U.S. accredited training programs.

Despite the high numbers of candidates matching with residency programs this year, hundreds of qualified California students must leave the state to study elsewhere due to a lack of funding for graduate medical training, highlighting the need to pass Senate Bill 22.

“Each year, California is fortunate to have thousands of ambitious medical students apply for residencies across the state, eager to improve the health of their communities,” said Steven E. Larson, M.D., MPH, president of the California Medical Association. “Many of these physicians-in-training will one day be the backbone of health care in our state. But sadly, some will be forced to head elsewhere, since current funding levels are not high enough to ensure enough residency spots in California. The data tells us that if a medical student is forced to leave the state to complete his or her training, it is more likely they will stay and practice out of state, despite our desperate need for more physicians, particularly in primary care.”

California has lost tens of millions of dollars in funding for primary care physician training. In 2016 alone, more than $40 million of funding for the training of California’s primary care physicians is expiring.

To help combat a physician shortage in the state and protect patients’ access to care, the state legislature is currently considering SB 22, which would direct state funds to new and existing graduate medical education primary care physician residency positions and support training medical school faculty.

“Solving California’s dire physician shortage is critical to the health care for all Californians,” said Senator Richard Roth, author of SB 22. “I introduced Senate Bill 22 to fund additional medical residency positions throughout our state’s medically underserved areas, especially in Inland Southern California and the Central Valley. Studies have shown that if we train tomorrow’s doctors in the areas that need them most, they are more likely to continue serving those areas, helping alleviate critical physician shortages and ensuring equal access to health care.”

SB 22 has passed the Senate and is expected to be taken up by the Assembly Health Committee in June.

Editor’s Note: We asked UCSF Fresno Associate Dean Michael Peterson M.D. to comment on how Match Day went down for the UCSF-Fresno training program and also to comment on the constraints in California’s training positions evident above and in our March newsletter, which outlined what Community Medical Centers is doing to encourage expanded public support for post-graduate training. For those who are interested in SB 22 (discussed in the CMA article), here is a link. Print readers can easily find it on line by searching bill number and author name Roth.

Dr. Peterson’s comments:

“In the annual cycle of a GME program, there are two very important dates. The first occurs in December when fellowship subspecialty programs learn if they have “matched” with candidates for subspecialty training. The second is in mid-March when residency Match Day occurs and programs learn if they have filled their residency positions. UCSF Fresno did very well in the match in 2016, filling all 78 residency positions for the seventh year in a row and filling 15 fellowship positions. Since 30-40% of UCSF Fresno’s graduates stay within the Central Valley, the match is a critical first step in recruiting the best and the brightest physicians to our region. UCSF Fresno was established in 1975 as one of the first regional campuses in the U.S. The goal of the program was and is to address the healthcare needs of the region. One of the limits on our ability to recruit additional candidates into our residencies is financial. Most residency positions are funded through federal pathways: VA, Medicare and HRSA. Medicare is by far the biggest funding vehicle for GME, but GME slots were “capped” in 1997 as one of the components of the Balanced Budget Act of 1997. Fresno is “capped” far below the total number of residents being trained, and the balance is funded from CRMC revenues. Thus, we support any programs that could provide additional funding for residency positions. One of the effective ways for us to help address the physician shortage is to increase the number of physicians being trained in our region.”
The Best Kind of Winner

By Christa Short, Director of Terry’s House

Last year’s Terry’s House Vacation Getaway Giveaway was one for the books when grand prize winner Dr. John Scholefield won the Hawaiian Island, Maui, trip for two!

“I participated in the raffle because I love Terry’s House and everything they have done and continue to do for patient families – it’s really a win-win,” Scholefield said.

All of our clinical staff, like Dr. Scholefield, work tirelessly to help their patients survive. Whether it be from a tragic accident, heart attack, stroke or a baby born too young – they are there. And Terry’s House is there to support their families.

But we can’t do it alone. To keep Terry’s House running for families who have loved ones healing at Community Regional, we depend strictly on donations from our donors, local fundraisers and the help of our own annual fundraiser – This year’s Terry’s House Vacation Getaway Giveaway!

And, in honor of our fifth anniversary this year, participants have not one, not two or three, but FIVE chances to win the trip of a lifetime!

“The trip was absolutely perfect – my wife and I had a seamless experience… everything about it was just wonderful,” Scholefield said. “What probably made it even better is knowing that we contributed to such a vital facility this Valley needs. That, I think is the best kind of winner.”

Almost $100,000 was raised last year to support the ongoing operations of Terry’s House – let’s do it again! Purchase your raffle ticket TODAY for just $20 by calling 559.459.7200.

To learn more about how you can help Terry’s House, call Community Medical Foundation at 559-459-2670 or visit .

Up to 5,000 tickets will be sold. Drawing will be held on July 21, 2016. Need not be present to win.

A Message from Mary Contreras R.N. – Community’s Just-Retired CNO

I’m sure many of you know I retired on April 4 from my position as Senior Vice President/Chief Nursing Officer after working more than 36-1/2 years as an R.N. at Community.

During these years, I had the opportunity to work with many members of Community’s medical staff. I have great memories of working with many of you – from my early years as a staff RN in Med Surg and ICU at Sierra Community Hospital, to my time as a staff educator during the 80s which included providing CPR classes to MDs, and finally as a nurse leader since the 90s.

As Community’s Chief Nursing Officer I have appreciated your support of our nurses, who work tirelessly to provide great care to our patients in all of CMC’s facilities. Through the collegial relationships we’ve developed with you, our medical staff, we’ve been able to improve the safety and quality of our care.

I’m also proud to have worked with our facility nurse leaders to ensure the patient is at the center of our decisions and create an environment where professional nursing and clinical excellence have thrived. I know you will continue to work with your nursing colleagues, now led by Wanda Holderman RN, Chief Clinical Integration Officer who has taken on my CNO role.

I have enjoyed working with all of you. I especially want to thank Dr. Jeff Thomas and the Medical Executive Committee for recognizing me at the February MEC. Thanks for the memories!

Mary
Hopefully you have heard about the new committee structure that is being introduced at CMC called Clinical Consensus Groups (CCGs). The concept and design of CCGs has been presented at multiple corporate and facility meetings including Facility Executive Committees, QPSC, and Quality Council, but we also wanted to provide some answers to frequently asked questions for you as a resource. The structure has been approved by the Medical Executive Committee and we are excited to have started our inaugural CCG for Oncology in February. Additional CCGs will be developed in the coming months, more to come! FAQs:

What is a Clinical Consensus Group (CCG)?
A CCG is a multi-disciplinary group that develops system-wide care standards within a given clinical area. The current CMC Corporate Critical Care Committee exemplifies many of the characteristics of a CCG. The initial focus for CCGs will be the inpatient environment.

Why implement CCGs?
CCGs leverage clinical expertise in development of clinical pathways and care standards with the aim to produce the best possible performance in quality, efficiency and resource utilization. Systems such as Banner Health Care have demonstrated the benefits of physician-led groups to establish consensus for appropriate care.

How are topics selected for CCGs?
Each CCG will determine the appropriate areas of focus. Data from Medical Decision Support will be available to support prioritization of projects. Examples of clinical pathways that may be developed include the treatment of nausea and vomiting in patients receiving chemotherapy or the initial management of a patient presenting to the ED with active seizures. Topics may range from streamlining Epic processes for cumbersome workflows to implementing safeguards to reduce the risk of an adverse safety event.

What is the governance structure for CCGs?
CCGs are CMC system based committees organized under the auspices of the Medical Staff. The Medical Executive Committee has delegated the oversight of CCGs to Quality Council (QC). Individual CCGs may be led by physician or physician/clinician (e.g. nurse, pharmacist) co-chairs. CCGs will have the responsibility and the authority to approve policies, procedures, guidelines, order sets, and clinical pathways for their clinical areas.

How is membership selected?
Physician chairpersons will be appointed by the Medical Staff President with input from Department Chairs and facility Leadership. Medical Directors will be considered for these roles, but ultimately individuals will be selected based on the needs of the group and appropriate fit. Additional physicians will be included on each committee with the goal of ensuring diverse representation. Facility Chief Nursing Officers will nominate nursing and ancillary staff membership. Individual CCGs will determine the need for additional members as appropriate. A corporate Quality Performance Improvement staff member will support CCG activities (e.g. meeting scheduling, minutes, policy and procedure development).

How is the work reported?
Chairs will report on a scheduled basis to Quality Council.

What CCGs are currently active?
Oncology CCG is the first CCG to be developed and had their first meeting on February 24, 2016. Additional CCGs will go live in the coming months.

If there is not a CCG live yet for my clinical service area, how does this affect me?
Until a CCG is live for your clinical service area, it is business as usual in your current structure which may include COTs, Service Lines, and other types of committees. During the planning phase of CCG implementation for each area, stakeholders will evaluate their pre-existing committees for any structure changes needed to best incorporate the CCG.

The overriding priority of CCGs is exceptional patient care. The guidance, support and enthusiasm of the CMC Medical Staff are absolutely essential for this initiative. Please feel free to contact me with any questions.
You’ve been hearing a theme from me of late – change is the only constant. And just like the seasons, change is afoot at CMC in many places. We’re building at both campuses, we’re working on new modules in EPIC (see last month’s column for more info), we’re gearing up for new resident and fellow onboarding in June… and perhaps of most interest to all of you, we’re getting much closer to electronic prescribing of controlled substances (EPCS).

As of now, we are able to print C-II’s on special paper at both ED’s. We’ve been asked to look at expanding to also print C-III-V’s; but the caveat in the request was if we could bring EPCS live quickly, perhaps we could forgo the expense and effort to expand printing capabilities and locations. Well, I’m pleased to say that we’re now on course to get EPCS live in the near future. We’ve already begun the work to build the functionality in EPIC, we’re looking ahead to pilot implementations in both an ambulatory setting and an ED setting, then will work to bring it house-wide.

We anticipate the first pilot, currently scheduled for the ACC Internal Medicine, to start around the beginning of the summer; this will allow time for us to get training created in HLC (both for new prescriptions AND the refill process), plan for provider sign up with identify verification (DEA number) and token activation, and ensure we have a robust process in place for identification of the patient’s desired pharmacy at registration. We would plan on a 2-week pilot before moving to the second pilot location, Clovis ED.

You may wonder why we’re starting with a non-surgical centric location – analysis of the volumes of prescriptions (including refills) shows that due to the refills, Medicine actually has a huge number of controlled prescriptions. We then wanted to move to an ED environment, realizing that EDs have the second largest volume of prescriptions.

If all goes as planned, we would hope to be able to offer the functionality to everyone by late summer/early fall. Please know that if you want to be enrolled, you will be expected to complete the online training course; we are working to set up an enrollment process that is easy and timely – hopefully setting up kiosks in the doctors’ lounges at each facility.

Finally, to bring you a tiny teaser around the OnBase project (the new and improved alternative to the media tab), I wanted to share a couple of highlights of the patient viewer window:

**Things to note:**
- more intuitive ‘tabs’ for getting to the right document quickly
- filter on a single document type
- filter on single facility
- filter on date range
- and the ability to set up a ‘personal’ tab for the things you refer to repeatedly that may live on multiple tabs.

More information to come, I promise!

As always, please feel free to reach out… I look forward to hearing from you.
“Mobility is Medicine”
Physician Order Changes to Facilitate Early Mobility

Why are the changes needed?
We are starting an early mobility program corporate wide in an effort to get every patient up within 24 hours of admission who doesn’t have a clinical reason for absolute bedrest. Our goal is to mobilize every patient that is able at least twice daily. Outcomes to be reviewed will be reduced ventilator days, ICU days, hospital length of stay, deconditioning, and hospital acquired conditions.

How are we going to do that?
We are adopting the Bedside Mobility Assessment Tool (BMAT) that will allow nursing staff to appropriately assess the patient’s mobility level at the bedside and determine equipment to safely lift/transfer/mobilize the patient.

Physician Order Changes:
Currently there are approximately 25 activity orders in EPIC. We would like to significantly reduce that number knowing there are a few orders that are specifically used for certain patient populations such as bedrest with bathroom privileges only for high risk pregnancy and logroll for spinal cord injuries.

The 3 primary activity orders would be:

Strict Bedrest: New bedrest orders are needed to identify reasons for a patient’s non-participation in early mobility. The new order would require completion of one question that identifies the reason for bedrest. These orders can be saved to your favorites as you currently do. These patients will still be turned every 2 hours, have ROM exercises and/or started on CLRT.

Bedrest
Selection Prompt: Hemodynamically unstable, unstable spinal cord injury, unstable fractures, elevated ICP, active bleeding, evidence of active myocardial ischemia, FiO2 >60 or peep >10, open chest/abdomen, impending withdrawal of care, severe agitation uncontrolled by meds, MEWS 4 or greater in a non-ICU setting, TBI Brain rest, obstetrical complications

Bedrest then Mobility: This order allows the provider to instruct the nurse to keep the patient on bedrest for either 12 or 24 hours and then begin to mobilize. This order can also be used if you are admitting a patient and want to delay mobility until they are placed in a room on the floor or until the patient has rested.

Bed rest, then advance activity as tolerated
Selection Prompt: Advance activity as tolerated in 12 or 24 hours

Order to Mobilize: This order instructs the nursing staff to mobilize the patient according to their ability. The goal would be for the patient to be in a chair for all meals and mobilize in the hallway at least twice daily.

Progress Mobility As Tolerated

Champions for the Project (please contact any of the champions if needed): Kim Pope Director, Critical Care Services CRMC; Erin Summers, Director Inpatient & Emergency Services CCMC; Crystal Teague, Director Med-Surg Services CRMC; Kelly Darakjian, Manager Inpatient Services FHS; Andrea Lee-Higgins DNP, CNS, FHS; Elizabeth Fuchser CNS, Med-Surg CRMC; Janet McQuillan, Med-Surg Nursing Specialty Expert CCMC; Matthew TeNyenhuis PT, Manager Acute Care Rehab CRMC; Adam Sheppard MPT, Supervisor Acute Care Rehab CCMC

Heads Up…
ACT Team Changes Name to Rapid Response Team on April 18

Submitted by Kim Pope and Eric O’Connell, Code Blue Committee Chairs

Currently the ACT (Acute Changes Team) is activated by staff when they believe their patient is becoming clinically unstable which mobilizes a team of experienced staff to the bedside to assess and assist with interventions if needed. The mobilization of this team can be heard as an overhead announcement for ACT Team to Room XXX. On April 18 the name will be changed to Rapid Response Team in order to standardize the language to a nationally recognized name as well as standardize the language across our CMC facilities. You will then hear Rapid Response Team to Room XXX. The response will be the same just the name of the team changed.

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Zika Virus Update

Readers and patients will find much information at CDC’s web site. The home page of the CDC site is devoted to Zika now, with major coverage of Zika and pregnancy. Much of the content is targeted at the lay public. CMC’s www.uptodate.com resource also has comprehensive Zika information, which is updated very frequently and includes topic discussions for patients.

Important Reminders for Accurate Urine Testing

Submitted by Corporate Quality Performance Improvement

Urine specimens MUST have the correct test label
- Lab performs tests based on the test label applied to specimens.
- If the provider orders a “urinalysis” (UA) the label will ONLY be for a UA. (No culture or other test will be run.)
- If the provider orders a UA and then adds a “culture if indicated” (UACIF) order, the specimen MUST be re-labeled with the UACIF test label. (Otherwise ONLY the UA will be run.)

Changes to urine specimens already sent to Lab require a phone call to Lab
- If the provider changes the order for a specimen that is already in the Lab, you MUST call the Lab ASAP to notify them.
- For example, if a specimen is sent to the Lab for a UA and the provider adds a urine culture order for that specimen, you MUST call the Lab to notify them that testing orders for that specimen have been changed.
- If the specimen was sent in a specimen cup > 2 hours before, it is best to send a new specimen to minimize potential for a false positive culture (unless antibiotics were started in the interim).
- The Lab will ONLY perform the test printed on the specimen label, unless you call to alert them the order has been modified.

Urine specimens that test positive do NOT automatically prompt the Lab to perform a urine culture.
- No culture will be performed unless either culture or UACIF have been ordered. In the case of the UA-CIF order, the UA must meet criteria (related to nitrite, bacteria, WBC, leukocyte esterase).

Urine specimens MUST be sent to the Lab as soon as possible.
- CMC specimen cups do NOT contain preservative. Specimens left at room temperature for more than 2 hours have a higher risk of contamination and/or bacterial overgrowth. Bacteria can double every 20 minutes when a urine specimen is unpreserved!
- If a delay in transporting the specimen to Lab is anticipated, keep the specimen refrigerated.
- Using a special preservative tube (BD Vacutainer “gray top”) minimizes sample contamination and allows up to 48 hours of stability without refrigeration. (Note: this is being trialed in select units)
ANNOUNCING UPDATED ORDER SETS BEING RELEASED

Submitted by Clinical Informatics/Clinical Content Team

Please see below for a list of Order Sets that were released into production between 03/01/2016 to 03/15/2016. 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>
| 304       | Post Op Cardiothoracic Surgery         | Comprehensive Multidisciplinary Review  
- Added SvO2 monitoring and Pacemaker settings  
- Updated lab orders  
- Updated orders to chest tube care  
- Modified starting range of sedatives and all vasoactive infusions  
- Revised vasoactive titration parameters and added cardiac index  
- Language added for pharmacy to adjust antibiotic dosing based on renal function  
- Placed medications in categories  
- Language added for MRSA negative patients  
- Revised Zofran order  
- Revised potassium coverage  
- Updated blood sugar management  
- Added IP consult to Hospitalist for Diabetic Management  
- Epic change only: Allow multiple selection of antiplatelet medications |
| 1404      | Intracranial Mass Effect without       | Duplicate capnography order in Epic deleted  
- CPAP Monitor Adult |
| 1342      | ICU Medical Admission Stroke Post      | Pilot RN Urinary Catheter Removal Project for CRMC MICU to begin on 03/01/16 and end on 03/14/16. The pilot order panel is available to CRMC 2Central/2East on 02/16/16 and ends on 03/14/16. |
| 1472      | ICU General Medical Admission          | Pilot RN Urinary Catheter Removal Project for CRMC MICU to begin on 03/01/16 and end on 03/14/16. The pilot order panel is available to CRMC 2Central/2East on 02/16/16 and ends on 03/14/16. |
| 1596      | Adult Organ Donor Order                | Updated with correct Mechanical Ventilation and respiratory orders |
| 1346      | NICU Admit Orders                      | Multidisciplinary Review:  
- Time frame changed for newborn screen  
- Removed calcium from overnight TPN orders  
- Clarified hepatitis B vaccine section based on maternal status  
- Added topical medications |
| 1211      | Pediatric Neuromuscular Blockage       | Added BIS monitoring information |
| 20        | Post-Op C Section                      | Epic change only: Diet order to cascade open |
| 1416      | Pre Cath Lab Procedural (AMB)          | Added saline lock order |
| 1080      | Pre-Cath Lab Procedural                | Added saline lock order |
| 1375      | Pre-Op Cardiothoracic Surgery          | Multidisciplinary Review:  
- SCIP antibiotics updated and gentamicin added  
- MRSA screening orders updated  
- Pre-op education added  
- Hypoglycemia Management orders updated  
- Buckberg’s Solution updated |
| 572       | Subcutaneous Insulin Orders for Non-Pregnant Adults | Epic change only: TPN order removed and replaced with a reference to the Adult TPN order set |
ANNOUNCING UPDATED ORDER SETS BEING RELEASED, continued from page 11

The following order sets have been retired

<table>
<thead>
<tr>
<th>Epic PRL#</th>
<th>Order Set Name</th>
<th>Reason for Retirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1388</td>
<td>Acute Agitation Orders Emergency Department</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>1611</td>
<td>Bronchoscopy Orders</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>1638</td>
<td>BVA Blood Volume Analysis</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>1616</td>
<td>CHIP Ace Inhibitor Monitoring</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>1618</td>
<td>CHIP Natrecor IV Therapy</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>1615</td>
<td>CHIP-Carvedilol Monitoring</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>1179</td>
<td>Dacrocystorhinoplasty Pre-Admit – patient in office or clinic</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>1171</td>
<td>Dacrocystorhinoplasty Pre-Op – patient in hospital</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>1215</td>
<td>Perflutren Administration Orders</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>1629</td>
<td>Pre Medication Form for Imaging Procedures</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>927</td>
<td>Pre Op AV Access Thrombectomy Revision</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
<tr>
<td>581</td>
<td>Vasoactive Adult Infusion Orders for PICA</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
</tbody>
</table>

APRIL PHYSICIAN PHOTOGRAPHER
MARK CUNNINGHAM M.D., F.A.C.S.
Austin Reed wakes up every morning early enough to go through an hour-long routine that keeps him alive. The 27-year-old broadcaster straps on a vest that vigorously shakes his lungs to break up the thick mucus making it hard to breathe. Then he coughs and coughs and coughs until the mucus comes out. He also inhales several medications and takes a couple handfuls of pills – at least seven every time he eats to help digest his food. He repeats the routine at night.

Austin has cystic fibrosis. “It’s a battle every day… It’s like a second job,” he says of his health routine.

Cystic fibrosis is a rare genetic disorder that makes all the secretions in his body thick, gumming up the works in his lungs, his pancreas and his liver. When Reed was born most cystic fibrosis patient died before reaching college. Now the life expectancy is closer to 40. More than half the cystic fibrosis patients in the U.S. today are adults.

And with adulthood, cystic fibrosis patients in the Valley used to face the challenge of finding an expert to care for their complex medical needs. Once they aged out of the care of pediatric experts at the local children’s hospital, patients had to drive to the Bay Area or Los Angeles or further to find medical care. Now, that care is close to home.

Community Regional Medical Center has begun the only accredited adult and pediatric cystic fibrosis program between San Francisco and Los Angeles. UCSF Fresno recruited internal medicine specialist Dr. David Lee from Brown University to head the new program, which does newborn screening for the disease and treats patients from birth throughout their life.

The UCSF Fresno Cystic Fibrosis Program takes a team approach to care with respiratory therapists, nutritionists, pulmonologists, gastroenterologists and social workers seeing each patient during checkups. As an accredited program, patients will have access to local and national research on the disease. Dr. Lee says the number of cystic fibrosis patients in the Valley mirror the number of cystic fibrosis patients in San Francisco.

Having an adult cystic fibrosis program in Fresno was huge for Reed, who recently moved here from the East Coast. When Reed and his wife decided to have children they began looking for jobs closer to her parents in Madera County. He was thrilled to get a job locally with MeTV but hesitated wondering about the availability of medical experts.

“I’ve been in small broadcast markets and if I got sick or got pneumonia, I’d have to drive three or four hours to the nearest CF clinic,” he said. “I wasn’t sure there would be any doctor in the Central Valley that knew anything about cystic fibrosis. I found out Dr. Lee treats CF patients here and not just kids – and there’s an accredited adult program. We could conceivably be here forever now.”

Reed has found not only care in close proximity but an expert that he’s close to. “Dr. Lee has been a force of encouragement for me. I can call him any time or text him. We meet for coffee,” he said, adding that Dr. Lee even has texted him the same evening with results of a lung scan just so he wouldn’t worry. “Never had this kind of care in my life.”

Dr. Lee says being involved and close to his patients is necessary to make sure they stay healthy with such a complex disease. It was this very intense involvement that drew him to specialize in cystic fibrosis when he was finishing his internal medicine residency. His first patient with the disease was a 25-year-old woman on hospice with a 5-year-old son. “She taught me so much about her disease and herself. I helped her learn to face death so she could live. Every day I went to her and encouraged her to get out of her hospital bed and go through her treatments so she could spend one more day with her son. She ended up living a year and a half instead of three months. It profoundly changed me.”

Since then Dr. Lee has brought that same intense focus and involvement to Fresno.

“Having a doctor who knows about cystic fibrosis and having this relationship with him gives me hope that I can live longer,” says Reed. He and his wife are expecting twins.

See Cystic Fibrosis on page 14
Cystic Fibrosis

Continued from page 13

soon so he and Dr. Lee are collaborating to beat that usual life expectancy.

There is always hope, Dr. Lee says. “My oldest patient in New England was 67 years old so there is certainly hope for living to old age. Here in the Valley I have a patient, who is a biologist, patients who are parents, a broadcaster, and several college students. My work is helping them find the balance between the daunting, daily responsibility of caring for their health and living fully.”

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

See Palliative Care on page 15
he went with home hospice.

After probing some about his mental state and concluding he was not suffering from major depressive disorder or was actively 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 filed. 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

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New Joint Commission Standards for Healthcare Interpreting Services

By Parminder Grewal, Manager Support Services, CRMC

Community has made changes to its interpreting and translation services in order to meet new and revised language-specific standards of The Joint Commission. Specifically, healthcare organizations are required by The Joint Commission to identify all staff providing bilingual services and require competency assessments of those individuals.

Why is this so important?

Not only will this language service enhancement improve the quality of encounters with limited-and non-English speaking patients, it will reduce the chances of medical errors related to language barriers. Community is calling this service Care and Conversation.

Here are 4 things you need to know about accessing interpreting services:

Community staff providing language services are now required to undergo competency testing before providing any language service.

There are two tiers of language competency for Care and Conversation:

Tier 1 – Certifies the staff member as a “Bilingual Communicator” to provide in-house courtesy language resources. A Tier 1 competency level allows for any staff member to interpret and translate in non-patient care encounters only.

Tier 2 – Certifies the clinical staff member as a “Bilingual Patient Care Communicator”. A Tier 2 competency level allows that clinical professional to interpret and translate in patient care encounters. Members of the medical staff will of course mostly utilize our Tier 2 Patient Care Communicators.

You can easily identify a certified bilingual communicator in a unit by their orange badge rider marked “Tier 1” or “Tier 2” Communicator.

Continue use of other language resources, but only if no certified bilingual communicator is available. If a certified

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**Languages**

Continued from page 16

bilingual communicator/tiered staff member is not available in your unit, please proceed with accessing interpreter services through the Health Care Interpreter Network (HCIN). HCIN, Community’s remote telephone and video interpreting service, is not being replaced. However, for the best overall patient encounter, the first choice language service should always be a live, in-unit, certified bilingual clinician whenever possible.

**Accessing other language resources:**
- From the interpreter phones available on the unit, dial 15 to connect to HCIN.
- Use an HCIN provided video unit (as available on the unit).
- To page an in-house interpreter, dial 15 and press #. Face-to-face communication is available for requests that meet the criteria.
- For ASL needs:
  - Use the ASL tab when connected to HCIN through the video unit.
  - For an ASL onsite interpreter, dial 15, then press 0. (Charges will be transferred to unit.)

Thank you for your commitment to providing excellent patient care. If you have any questions about Community’s new language certification process, please contact your site interpreting services manager:
- CRMC and FHSH – Parminder Grewal, Support Services at 559-459-2364 or Ext. 52364
- CCMC – Jennifer Adams, Nursing Administration Staffing & Interpreter Services at 559-324-3968 or Ext. 43968

**AIDS Documentation**

Submitted by Sandra Sidel R.H.I.A., C.C.S. and Silva Seferyan, R.H.I.T., C.C.S.

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

California state law instructs that HIV positive (+) infection status cannot be coded. Only confirmed cases of fully developed AIDS can be coded.

For patients who have the fully developed syndrome, one of these two terms must be used:
- AIDS
- HIV Disease

In addition, a cause-and-effect relationship must be stated for conditions due to AIDS.

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

**Introducing the New CRMC-UCSF Fresno Quality Improvement and Innovation Symposium**

Submitted by Dominic Dizon M.D.

Mark your calendars for May 26, 2016. CRMC and UCSF Fresno have teamed up to bring us the First CRMC-UCSF Fresno Quality Improvement (QI) and Innovation Symposium. It will be held at the UCSF Fresno Medical Education and Research Center. This multi-department, general poster competition will highlight the best and most promising Quality Improvement and Innovation projects from all eight departments of the UCSF Fresno Medical Education Program.

Each department has nominated two of their best projects completed by resident physicians or fellows who have engaged in QI projects during the academic ear 2015-2016. These may have improved systemic processes, operational workflows, paradigms, diagnostics and therapeutic algorithms, or innovations projects, in the disciplines of digital medicine, information technology, and precision medicine. Each nominee received a $250 cash prize.

At the symposium in May, the top three teams will receive prize awards in the amounts of:
- 1st Prize = $2000
- 2nd Prize = $1000
- 3rd Prize = $500

The goal is to encourage and award those projects promoting collaboration between the teaching program and the hospitals. Pilot projects with great potential for applications on a larger scope will also be looked at favorably.

Watch for details of the various projects nominated by the departments in upcoming issues of Physicians’ Edition.

Dominic Dizon M.D.
Editor’s Note: Implementation of the Affordable Care Act (ACA) helped lower the uninsured rate in California from 16% in 2013 to 11% in 2014, but 3.8 million Californians under 65 remained without coverage. A new report from the California Healthcare Foundation’s California Uninsured project explores the data in more detail. Clearly this information is highly relevant to the Central Valley. The Central Valley’s residual uninsured rate is considerably higher than the California average. The likelihood of remaining uninsured in 2014 was much higher among lower income, Latinos, non-citizens, and young adults – all of whom are over-represented in our population. Print readers can easily find it by searching “CHCF and California’s Uninsured: Coverage Expands, but Millions Left Behind.”

Among the key findings from the new report:

From 2013 to 2014, the percentage of Californians who had individually purchased insurance or Medi-Cal increased.

Californians age 21 to 24 experienced the largest drop of any non-elderly age group in the percentage that was uninsured, from 25% in 2013 to 16% in 2014.

Of the state’s remaining uninsured, 1 in 4 was between the age of 25 and 34, and more than half (57%) were Latino.

Within the employed population, more than 2 million workers, about 1 in 8, were uninsured.

This report – several key figures from which are reprinted at right – is part of the CHCF California Health Care Almanac, an online clearinghouse for key data and analysis examining California’s health care marketplace.

### California’s Uninsured Coverage Sources and Trends:
From 2013 to 2014, the uninsured rate in California dropped five percentage points. This decrease was mainly due to increases in Medi-Cal (3.4 percentage points) and individually purchased insurance (4.6 percentage points).

### California’s Uninsured by Family Income:
Californians with family incomes under $25,000 experienced the largest drop in the likelihood of being uninsured from 2013 to 2014. Still, about 1 in 5 Californians with incomes under $25,000 was uninsured compared to about 1 in 15 with incomes of $75,000 or more.


### California’s Uninsured by Race/Ethnicity:
Latinos experienced the largest drop in percentage points in the uninsured rate from 2013 to 2014. However, they remain the ethnic group with the greatest likelihood of being uninsured.

Editor's Note: This month’s Choosing Wisely has great recommendations for cost effective evaluation and management of sleep disorders. We asked Lynn Keenan M.D., Clinical Professor, UCSF Sleep Studies, NaPro Technologies, University Centers of Excellence Provider to comment. Her specific comments follow:

Regarding #1: if the chronic insomnia is mostly difficulty getting to sleep, rather than staying asleep, focus on sleep hygiene and Cognitive Behavioral Therapy (CBT-I). If the patient has more difficulty staying asleep, especially if snores, it may be undetected sleep apnea waking them up. A polysomnography is helpful in that situation. In the past, Fresno did not have readily available resources to offer CBT-I, but under the guidance of Dr. Hersevoort, our psychiatry sleep attending, the sleep fellows now run a cognitive behavioral class for insomnia every 1-2 months at University North Medical Specialty Center. This has helped many patients with severe insomnia.

Regarding #4: RLS can be a cause of significant insomnia. It does not need a polysomnography test for diagnosis if there is history of discomfort in legs giving the urge to move, the symptoms improve with movement, and the condition is worse at night or with rest. If the patient has these symptoms, checking for iron deficiency is recommended. Also avoid antihistamines at night and possibly try vitamin E and magnesium in the evening, or a dopamine agonist like pramipexole.

Regarding #5: titration studies are definitely not needed in asymptomatic patients with stable weight, especially since nearly all PAP machines now record respiratory data so we have feedback as to control of the sleep disordered breathing. However, insurance companies do not always follow common sense. Medicare, MediCal and some other insurances require a new study within 6 months of replacing a malfunctioning machine, even if the disorder was controlled prior to the machine breaking.
Central Valley Research Gets National Exposure

Submitted by Rais Vohra
Department of Emergency Medicine
California Poison Control Center

UCSF Fresno and the California Poison Control System were well represented at this year’s Annual Scientific Meeting of the American College of Medical Toxicology. The conference was held in Huntington Beach, and several students from the Central Valley were able to travel to Southern California for “Spring [Research] Break” and soak up the academics along with the sunshine. Congratulations to these dedicated young researchers – their projects related to pediatric poisonings from mushroom ingestions and anesthetic teething gels will help us develop strategies to prevent or treat these types of cases in the future. Here are a couple of these UCSF Fresno poster abstracts.

Uncomfortably Numb: Pediatric Exposures to Topical Benzocaine Preparations Reported to a Statewide Poison Control System

By Jennifer Koike and Kevin Le, University of California, San Francisco School of Pharmacy, San Francisco CA; and Serena Huntington and Rais Vohra, California Poison Control System at Valley Children’s Hospital, Madera CA

Background: Topical benzocaine is a local anesthetic used to relieve pain caused by burns, wounds, insect bites, mouth or gum irritation, and teething.

- Benzocaine toxicity can result in methemoglobinemia and secondarily cause cyanosis, dyspnea, syncope, seizures, and coma.
- The broad availability of over-the-counter topical benzocaine preparations may pose as a great health hazard for the pediatric population.
- Current research is limited to:
  - Few case reports documenting incidents of children becoming cyanotic with methemoglobin levels ranging from 39% to 69.9%

See Tox Tidbits on page 20
Tox Tidbits

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One retrospective review highlighting the prevalence of minor adverse effects

The purpose of this retrospective case series is to characterize the incidence and clinical severity of pediatric exposures to topical benzocaine.

Methods:
• CPCS electronic database was queried from January 2004 to December 2014
• Inclusion Criteria: all cases involving exposures to topical benzocaine in patients less than 18 years old who reported to a healthcare facility
• Exclusion Criteria: all cases involving information calls, non-human exposures, non-healthcare facility exposures, non-benzocaine products, co-ingestants
• Data abstraction following the National Poison Data (NPDS) Coding User’s Manual Version 3.0 consisted of demographic information and clinical outcomes
• Descriptive analysis and frequencies used to characterize study population and clinical outcomes related to topical benzocaine exposures

Results: CPCS database query resulted in 157 pediatric benzocaine exposures, with 58 cases meeting exclusion criteria.
• The age range was 1 month to 12 years, with a median age of 1 year.
• The majority of exposures (98%) occurred in children 5 years of age and younger.
• Unintentional exposure was the cause of most cases (88.9%).
• Oral ingestions was the most common route of exposure (88.9%).
• Benzocaine concentrations ranged from 7.5% to 20%, with the majority of exposures involving the 20% formulation.
• Ninety cases (91.8%) had no adverse effects or minor adverse effects following exposure (75.5%, n=74 and 16.3%, n=16 respectively), 3 cases had moderate effects, and 5 cases had major adverse effects.
• Methemoglobin levels were reported in 4 of the 5 cases with major effects, and were 20.2%, 40%, 48%, and 55%.
• Four of the five cases with major effects involved parents or caregivers administering the product to the child.
• Dispositions for each set of outcomes are shown in Table 1 and reported adverse effects are shown in Table 2.

Conclusions: The wide availability of topical benzocaine products marketed towards pediatric populations poses a great health hazard due to its toxicity risk associated with methemoglobinemia. Although most cases were treated and released from the emergency department with minimal complications, a few cases had major adverse effects that were life-threatening and required immediate medical attention. Most cases in this study were the result of unintentional exposures to benzocaine products; however

See Tox Tidbits on page 21
the majority of cases showing major effects were due to intentional administration by a caregiver or parent which suggests that in order to reduce the incidence of topical benzocaine toxicity in children, the general public should be well-educated regarding the appropriate clinical indication, concentration, and application instructions associated with these products.

In April 2011 the Food and Drug Administration released a drug safety communication regarding the potential for serious side effects, including methemoglobinemia associated with the use of topical benzocaine products. Our data showed a decline in the number of benzocaine exposure cases called into the CPCS in the years following the release of the FDA drug safety communication as illustrated in Figure 1. However, this study indicates the need for further education of parents and caregivers regarding the appropriate pediatric indications and application instructions for benzocaine-containing products.

**Limitations:** As a retrospective review, many variables could not be controlled in this study, and the data collected was not recorded with our study parameters in mind making it impossible to draw conclusions regarding causation. One particular drawback to this study is the loss of information in reported cases. Many cases either did not include the information of interest for this study, or the information was incomplete.

**References:**


**Mushrooms:** Accidental, Recreational, and Intentional Overdoses in California Children

**Tom Pritsky, Ashmeet Goraya,**
UCSF Fresno Summer Biomedical Institute; **Rais Vohra**
UCSF Fresno Department of Emergency Medicine
California Poison Control System at Valley Children's Hospital, Madera CA; and **Serena Huntington and Richard J Geller**
California Poison Control System at Valley Children's Hospital, Madera CA

**Background:** Mushrooms are ubiquitous hazards in California, with a variety of toxic effects depending on species. Accidental exposures to mushrooms due to exploratory ingestions are common in children. While the amounts ingested (one mouthful or less) are typically nonhazardous, there are occasionally cases of accidental, recreational or intentional ingestions by children with severe outcomes.

**Methods:** Mushroom exposure cases were identified in the California Poison Control System (CPCS) electronic database by substance-based coding or free text search from 2004-2014. Collected data included information on specific agents, clinical presentation, laboratory and imaging abnormalities, clinical course, therapies, and outcome in each case.

**Results:** 1418 cases identified
41% Female / 59% Male
Bimodal age peaks (1 & 16 years)
Teens: more serious effects
GI effects were most common. There was one liver transplant, in a teen. 2.4% exposures occurred in institutional facilities, and 1.2% in autism-spectrum children.

**See Tox Tidbits on page 22**
Tox Tidbits

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Discussion: This large series of pediatric mushroom exposures demonstrates that exposure to mushrooms in young children is largely benign and very preventable, as it occurs mainly at home where adult supervision can be reinforced. Older children and teens are at risk for moderate or severe effects in the context of recreational or self-harm behavior.

Conclusion: This large series of pediatric mushroom exposures demonstrates that exposure to mushrooms in young children is largely benign and very preventable, as it occurs mainly at home where adult supervision can be reinforced. Older children and teens are at risk for moderate or severe effects in the context of recreational or self-harm behavior.

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CRMC Presents:
UCSF Fresno Department of Medicine

Title: “Pulmonary Vascular Disease, Interstitial Lung Disease and Asthma”
Date: Tuesday, April 5, 2016
Speakers: Drs. Tim Evans, Vijay Balasubramanian, and J. Joseph Vempilly
Time: 7:30am Breakfast, 8:00am-9:00am Lecture
Place: UCSF Fresno Center Auditorium
Contact: Monica Sozinho at 559-499-6421 or msozinho@fresno.ucsf.edu
CME: 1 CME

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UCSF Fresno Neuroscience Department

Title: “Neuroscience Patient Case Presentation: Young Woman with Autoimmune Encephalitis”
Date: Wednesday, April 6, 2016
Speakers: H. Terry Hutchison M.D., Ph.D.
Time: 7:15am-8:15am
Place: Central California Neuroscience Institute-East Medical Plaza – NORC Conference Room, 3rd Floor
CME: 1 CME

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UCSF Fresno Psychiatry Department

Title: “Circuits, Symptoms and Brain Development in Psychosis”
Date: Thursday, April 14, 2016
Speakers: Cameron S. Carter M.D.
Time: 4:00pm-5:00pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 116
CME: 1 CME

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CRMC Perinatal M & M

Title: “Thrombophilia”
Date: Wednesday, April 20, 2016
Speakers: Drs. Rebecca Murphy, Krishna Rajani, and Cynthia Curry
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: “Necrotizing Pancreatitis”
Date: Thursday, April 21, 2016
Speakers: John Stivers M.D.
Time: 12:00pm-1:00pm
Place: CRMC-Sequoia East Conference Room
Contact: Kelley Montgomery at 559-459-3722 or KMedico@communitymedical.org
CME: 1 CME

UCSF Fresno Department of Medicine
Title: “Air Pollution and Climate Change Symposium”
Date: Saturday, April 23, 2016
Speakers: Various
Time: 7:30am-2:00pm
Place: UCSF Fresno Center Auditorium
Fees: $50 after March 4
Register: www.fresno.ucsf.edu/conferences/air2016
Contact: Monica Sozinho at 559-499-6421 or msozinho@fresno.ucsf.edu
CME: 5.5 CME

CME Dinner Lecture
Title: “Update In NeuroSurgery: Neurocritical Care”
Date: Thursday, April 14, 2016
Speakers: Arash Afshinnik M.D.
Time: 6:30pm-8:30pm – dinner provided
Place: Ruth’s Chris Steak House Fresno, CA
RSVP: Kimberly Goldring at 559-460-4613 or Kgolding@communitymedical.org
CME: 1 CME

CME Dinner Lecture
Title: “Update on Pediatric Gastroesophageal Reflux”
Date: Tuesday, April 26, 2016
Speakers: Michael Haight M.D.
Time: 6:30pm-8:30pm Dinner Provided
Place: Vintage Press, Visalia, CA
RSVP: cmersvp@communitymedical.org
Contact: Ric Morales 559-459-6211 or Rmorales3@communitymedical.org
CME: 1 CME

Save the Date
Title: “22nd Annual Hispanic Medical Conference”
Date: Saturday, May 7, 2016
Speakers: Various
Time: 8:00am-1:30pm
Place: Veterans Memorial Auditorium
Contact: Yolanda Cervantes at 559-266-8300 or yrcervantes@avancehh.com
CME: 5 CME Applied For

Title: “11th Annual Cardiology in the Valley Symposium”
Date: Saturday, May 14, 2016
Speakers: Drs. John Ambrose, Ralph Wessel, Sundararajan Srikanth, Teresa Daniele, and Vijay Balasubramanian
Time: 7:00am-1:30pm (continental breakfast and lunch provided)
Place: UCSF Fresno Center Auditorium
Contact: Monica Sozinho at 559-499-6421 or msozinho@fresno.ucsf.edu
CME: 5.5 CME Applied For

Please also see the enclosed individual flyers for more on these & other upcoming local CME activities to meet your CME needs.
PHYSICIAN PHOTOGRAPHER
APRIL 2016

APRIL PHYSICIAN PHOTOGRAPHER
MARK CUNNINGHAM M.D., F.A.C.S.
See page 2 for details
Pulmonary Medicine Update

Tuesday, April 5, 2016
7:30-8:00am – Breakfast | Room 137
8:00-9:00am – Lecture | Auditorium

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

For the physicians and staff located in VACCHCS, the Grand Rounds lecture can be viewed via live stream in room LC2-34.

1.0 AMA PRA Category 1 Credit(s)™

Target Audience: All CMC and VA Medical Staff Physicians including UCSF Fresno House Staff Physicians, Residents, Fellows, Clinical Staff, and Allied Health Care Providers.

Learning Objectives

Upon completion of this activity, participants will:

1. Apply new recommendations on the management of interstitial lung disease, pulmonary vascular disease and asthma in order to improve patient outcomes.
2. Review new developments in interstitial lung diseases, pulmonary vascular disease and asthma and apply that knowledge into practice.
3. Review newer medications for interstitial lung diseases, pulmonary vascular disease and asthma and apply into patient care.

Disclosures: Presenter Dr. Tim Evans, Dr. Vijay Balasubramanian, Dr. Joseph Vempilly, Program Director Dr. Robert Libke, and Planner Monica Sozinho 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.

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

For more information: (559) 499-6421 | msozinho@fresno.ucsf.edu
H. Terry Hutchison, MD, PhD will present:

“Young Woman with Autoimmune Encephalitis”

LIVE PATIENT PRESENTATION: PLEASE BE ON TIME

Learning Objectives:  
1.0 AMA PRA Category 1 Credit(s)™

1. Attendees will learn, better understand, discuss and incorporate into patient care the knowledge of the definition of non-convulsive status epilepticus.
2. Attendees will learn, better understand, discuss and incorporate into patient care the knowledge of the controversies of the treatment options for non-convulsive status epilepticus.

Location:
Central California Neuroscience Institute  
East Medical Plaza - NORC Conference Room, 3rd Floor  
2335 E. Kashian Lane, Suite 301  
Fresno, CA 93701

Contact:  
Natasha Saleem, Administrative Assistance – UCSF Neurology  
559-459-6394 | nsaleem@fresno.ucsf.edu

Please let us know if you are interested in hosting a future Neuroscience Patient Case Presentation.
Ruth’s Chris Steak House  
7844 N. Blackstone Ave., Fresno

April 14, 2016  
Thursday – 6:30 pm – 8:30 pm

Arash Afshinnik, M.D., NeuroIntensivist  
University │ Neurosciences Institute

1. Gain better understanding of the role of NeuroIntensivist in a comprehensive neuroscience institute and utilize this knowledge to achieve better patient outcomes.

2. 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.

CME 1.0

Dinner will be provided (Vegetarian options available)

Critical Care, ER Physicians, Primary Care Physicians, Internal Medicine, Family Practice, and Oncologist, PA-C’s, NP’s, RN’s and all Allied Health Professionals who work in primary care field.

Email: Kimberly Goldring, Physician Relations at Kgoldring@communitymedical.org or 559-260-4613

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: Speakers: Arash Afshinnik, M.D. and event planners Kimberly Goldring have no disclosures to make.
Perinatal M & M Presents:

“Thrombophilia”

Wednesday, April 20th, 2016 from 12:30pm – 1:30pm

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

Case Presentation

Obstetrics: Dr. Rebeca Murphy
Neonatology: Dr. Krishna Rajani

Principal Discussants

Neonatology: Dr. Krishna Rajani
Genetics: Dr. Cynthia Curry

Target Audience

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

Objectives

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

1) Apply to practice, current clinical evidence and guidelines relating to thrombophilia.
2) Gain insight into thrombophilia, 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.
## Symposium Topics

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<td>Opening Remarks</td>
<td>Michael W. Peterson, MD&lt;br&gt;Associate Dean UCSF Fresno&lt;br&gt;UCSF Professor of Clinical Medicine at UCSF Fresno</td>
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<td>Air Pollution and its Impact on Airway Disease</td>
<td>Jose Joseph Vempilly, MD&lt;br&gt;UCSF Professor of Clinical Medicine at UCSF Fresno</td>
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<tr>
<td>Air Pollution and its Impact on Systemic Disease</td>
<td>Daya Upadhyay, MD&lt;br&gt;UCSF Associate Professor of Clinical Medicine at UCSF Fresno</td>
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<td>Air Pollution in the US: The Best and Worst Over the Past 10 Years</td>
<td>Bonnie Holmes-Gen&lt;br&gt;Senior Director, Air Quality &amp; Climate Change, American Lung Association in California</td>
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<td>State of Air in the Central Valley Over the Past Decade</td>
<td>Samir Sheikh, Bsc, MBA&lt;br&gt;Deputy Pollution Control Officer&lt;br&gt;San Joaquin Valley Air Pollution Control District</td>
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<tr>
<td>Climate Change and Effects on Human Health</td>
<td>William Rom, MD, MPH&lt;br&gt;New York University</td>
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<tr>
<td>Climate Change: The Consequences for the Next Century for Business as Usual Strategy</td>
<td>Helene G. Margolis, MA, PHD&lt;br&gt;University of California, Davis</td>
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<tr>
<td>Solutions for Reducing the Burden of Global Air Pollution</td>
<td>Joel D. Kaufman, MD, MHP&lt;br&gt;University of Washington</td>
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Course Director: Jose Joseph Vempilly, MD  
Co-Director: Daya Upadhyay, MD  
CME: 5.5

Early Registration Fee: $25  
(By April 8, 2016)  
After April 8th, Registration Fee: $50

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

To Register Visit: 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
CME Dinner Lecture
Update on Pediatric Gastroesophageal Reflux

SPEAKER: Michael Haight, M.D.
Pediatric Gastroenterologist

DATE/TIME: Tuesday, April 26, 2016
6:30 pm - 8:30 pm

CME 1.0
Dinner provided (Vegetarian options available)

ATTENDEES WILL:
1. Gain a better understanding and apply in practice how an initial evaluation for pediatric patients with GER is best done.

2. Identify and apply in practice the current knowledge of medications and treatments for GER.

TARGET AUDIENCE:
Pediatricians, Neonatologists, Primary Care Physicians, Physician Assistants and Nurse Practitioners.

RSVP: cmersvp@communitymedical.org
or contact Ric Morales at Rmorales3@communitymedical.org
Ph. (559) 459-6211

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

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

Disclosures: Speaker: Michael Haight, M.D. and event planner Ric Morales have no disclosures to make.

www.CommunityRegional.org
Save the Date
Saturday, May 7, 2016
22nd Annual Hispanic Medical Conference
Targeting Health Issues Affecting The Hispanic Community

Topics will include:
- Rheumatoid Arthritis
- Scars & the Modern Treatment
- Allergies in the Central Valley
- Pain Management & Drug Dependency
- New Malpractice Concerns & How to Avoid Them
- Cancer & Diabetes

(Time: 7:30 am - 1:30 pm
Location: Veteran’s Memorial Auditorium
2425 Fresno Street
Fresno, CA 93721

To register please call (559) 266-8300
No charge to attendees

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

UCSF Fresno Department of Internal Medicine Presents

2016 11th Annual Cardiology in the Valley Symposium

Course Director: John A. Ambrose, MD, FACC

Saturday, May 14, 2016
7:00AM–1:30PM

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

CME: 5.5 (Applied for)
Category 1 Credits
Fees: No Charge

Topics:
- Dual Anti-Platelet Therapy (DAPT) duration of therapy in CAD/PCI
  John A. Ambrose, MD, FACC, UCSF Professor of Clinical Medicine at UCSF Fresno
- Bridging therapy in patients receiving anticoagulation
  Ralph Wessel, MD, UCSF Associate Clinical Professor at UCSF Fresno
- Hypertension—How low do we go & what about diastolic pressures?
  Sundararajan Srikanth, MD, UCSF Associate Clinical Professor at UCSF Fresno
- Appropriateness criteria for non-invasive testing in chest pain/CAD patients
  Teresa Daniele, MD
- Pulmonary Hypertension—Appropriate work-up/management
  Vijay Balasubramanian, MD, UCSF Associate Clinical Professor at UCSF Fresno

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

Disclaimers:
Presenters John A. Ambrose, Ralph Wessel, Sundararajan Srikanth, Teresa Daniele, Vijay Balasubramanian and planners Monica Sozinho have no commercial disclosures to make. All potential contents of interest will be resolved prior to this event.

Accreditation:
Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. Community Medical Centers designates this live activity for a maximum of 5.5 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.

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

REGISTER ONLINE AT:
www.fresno.ucsf.edu/conferences/cardiology2016

Sponsored by

More Info: Monica Sozinho at msozinho@fresno.ucsf.edu or 559-499-6421
Emergency Medicine Month

Tuesday, April 5, 2016
12:30-1:30pm
“The Story of a Fall”
Kelly Kriwanek, M.D.

Thursday, April 7, 2016
12:30-1:30pm
“Abdominal Surgical Emergencies”
Vivian Nwosu, M.D.

Tuesday, April 12, 2016
12:30-1:30pm
“Head Injuries and Concussion”
Janice Kezirian, M.D.

Thursday, April 14, 2016
12:30-1:30pm
“Pediatric Sepsis”
Myra Lezine, M.D.

Tuesday, April 19, 2016
12:30-1:30pm
“TBA”
Eric Schmitt, M.D.

Thursday, April 21, 2016
12:30-1:30pm
“TBA”
Beena Kazi, M.D.

Tuesday, April 26, 2016
12:30-1:30pm
“Acute Ataxia”
Trisha Beck, M.D.

Thursday, April 28, 2016
12:30-1:30pm
“Pediatric Eye Emergencies”
Kelly Ochoa, M.D.
Department of Surgery
Trauma Critical Care Conference
Thursday 12p.m-1p.m
April 2016

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<tr>
<th>Date</th>
<th>Topic</th>
<th>Location</th>
<th>Speaker</th>
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<tr>
<td>04/07/16</td>
<td>Appropriate use of Albumin</td>
<td>Seq. East</td>
<td>Melissa Reger, PharmD</td>
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<tr>
<td>4/14/16</td>
<td>Combined ED/Surgery Conference</td>
<td>Seq. East</td>
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<tr>
<td>4/21/16</td>
<td>Necrotizing Pancreatitis</td>
<td>Seq. East</td>
<td>John Stivers, MD</td>
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</table>
| 4/28/16 | The Future of Critical Care Medicine       | Seq. East| Mediator: Rachel Caiafa, MD
Webcast: Professor Jean- Louis Vincent, MD, PhD |

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

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

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

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April 2016

April 7
No Grand Rounds – Resident Open Meeting

April 14
“Circuits, Symptoms and Brain Development in Psychosis”
Cameron S. Carter, MD.
Professor of Psychiatry and Psychology
Director, Behavioral Health Center of Excellence
Director, Imaging Research Center and Center for Neuroscience
Director, Early Psychosis Clinical and Research Programs
University of California, Davis

April 21
M&M Presentation

April 28
TBD
Karen Kraus, MD
Associate Clinical Professor
Department of Psychiatry

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This credit may also be applied to the CMA Certification in Continuing Medical Education.
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<tr>
<td>6:30 – 7:15 am Ortho Surg.-Foot/Ankle/Hand SPOC</td>
<td>7:00 – Orthopedic GR UCSF Rm. 136</td>
<td>7:30 – Surgical Grand Rounds CRMC-Sequoia West Conf. Rm</td>
<td>8:00 – Hematology Conference UCSF Rm 116</td>
<td>8:30 – Surgery Clinical Case Rev. CRMC-Sequoia West Conf. Rm</td>
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<td>8:00 – 9:00 am Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>7:15–8:15 am Neuroscience Pt. Case Present. NORC Conf. Rm</td>
<td>7:30 – HPB Planning Conf. CRMC-Sequoia West Conf Rm</td>
<td>8:00 – Emergency Medicine UCSF Rm 137</td>
<td>8:30 – Surgery Clinical Case Rev. CRMC-Sequoia West Conf. Rm</td>
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<td>12:00 – 1:00 pm Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>7:30–8:30 am Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>8:00 – Cardiac Cath &amp; Intervention Cath Lab</td>
<td>12:00 – 1:00 pm Critical Care/Trauma CRMC-Sequoia East Conf Rm</td>
<td>8:30 – OBGYN Residency GR UCSF Rm 116</td>
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<td>12:00 – 1:00 pm Brain Tumor/Cyberknife Conf. Lower Level-Rad-Onc</td>
<td>4:00 – 5:00 pm Psychiatry GR, UCSF Rm 116</td>
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<td>7:00 – Orthopedic GR UCSF Rm. 136</td>
<td>7:30 – Chest Conference UCSF # 116</td>
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<td>7:30 – HPB Planning Conf. CRMC-Sequoia West Conf Rm</td>
<td>8:00 – Emergency Medicine CRMC-Sequoia East Conf Rm</td>
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<td>12:00 – 1:00 pm Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>7:30–8:30 am Cardiac Cath &amp; Intervention Cath Lab</td>
<td>8:00 – 11:45 am Cardiac Cath &amp; Intervention Cath Lab</td>
<td>12:00 – 1:00 pm Critical Care/Trauma &amp; Emergency CRMC-Sequoia East Conf Rm</td>
<td>8:30 – OBGYN Residency GR UCSF Rm 116</td>
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As of 3/18/16