DOUGLAS ALEXANDER CLS (CRMC LAB)

The shots I’ve included are a mixture of photographs taken the last three times I visited the Canadian Rockies. They are a combination of shots from Jasper, Banff, and Kootenay National Parks in Alberta and British Columbia, Canada. My visits have included time in early and late fall and in the late spring. Each time of the year has unspeakable beauties to behold. From the colorful meadow below Mt. Robson, which I’m told is very unusual to see the top of, to the gorgeous aspens, alders and other colorful trees with their fall “coats” in full view, every bend in the road shows a magnificence that is found in few other places in the world. The picture of Moraine Lake reflecting the Valley of the Ten Peaks is so beautiful that it is the reverse side of the Canadian 20 dollar bill. Jasper and Banff National Parks are located on the Western border of Alberta. Each National Park is centered around a small town of the same name. While Banff is as cosmopolitan as any fairly large American city, Jasper has a very small town appeal. The only people who are allowed to live in each town are those who either have a business in the town or work for the National Park system. In Banff, a visitor can purchase a mink coat, an expensive diamond ring, or an old master oil painting in addition to the necessities of life. In Jasper, a visitor will see wildlife walking down main street and hear the unbelievable whistle, at midnight, of a 14 point bull elk during the rut season through the open window of your hotel room. There are hundreds of miles of hiking trails throughout the region; however, some are closed at certain times due to grizzly bears and other dangerous animals on the trail. All in all, the trip to this part of North America is well worth the effort. You can even walk out a half mile on the top of the Athabasca Glacier whose 1 X 3 mile, 1000 feet thick, “tongue” is part of the 200 square mile plus glacier field in the middle of the Jasper/Banff National Park boundary. Of course in winter, there is snow skiing in the Lake Louise, Banff, and Jasper areas. If you decide to go, don’t forget to take warm clothing, good hiking boots, and of course your phone or camera.
If you haven’t already, take a look at the new and improved www.communitymedical.org. Community’s newly designed website launched in March and features several enhancements healthcare consumers will appreciate. Improvements include:

• More consumer friendly navigation
• Responsive design for mobile users, now about half of all visitors to our website.
• Robust content management system which paves the way for future improvements
• Spanish content
• Improved functionality of our physician finder
• And an improved hospital pre-registration feature
• Information on discount and charity care policies
• More content about the individual hospital facilities and their programs
• Multiple pathways to access our quality and patient experience measures

We will continue to enhance the content of the website including improved search capabilities, medical library information for healthcare consumers, and further advancing our online physician directory.

The information in the online directory mirrors the information in our medical staff office database. We ask your assistance in ensuring the information in your profile is correct.

You can help us improve our website. Please visit our online physician directory on Community’s website and review your profile. If you would like us to correct an error or request we add your photo, simply click the link “change my profile.” We have included screen shots of directory content about our medical staff.

Thanks for your help in keeping our records current and presenting your information accurately on our website. If you have questions, please call our Medical Staff Office at (559) 459-3948.
Fresno Motorists, Cyclists Can Cooperate to Make Roads Safer

Cooperation key to keeping cyclists out of the trauma center. Dr. William Dominic is still recovering from being hit by a car while cycling. As an avid cyclist he’s shared the road with cars in many cities and as a trauma surgeon at Community Regional he’s seen the results of bicycle/car accidents. He shares his insights on safer cycling in an opinion piece in The Fresno Bee: http://www.fresnobee.com/opinion/readers-opinion/article74238337.html

William Dominic M.D.
People often ask me why I left clinical practice, and whether or not I miss it...complicated reasons that boil down to a single fundamental – I like helping people. When I decided upon a career in medicine, the goal was to help at least a single person every day. Not so hard to do as an obstetrician, but seemed like I topped out at about 42-45 patients a day. In my CMIO role, I get to help hundreds of physicians daily, and that extends to thousands of patients each day – not too shabby, if I may say so. It makes me happy.

Happy, in spite of not always getting what I want for our EPIC system; happy, in spite of your disenchantment with the system for not being more efficient; happy, despite the growing list of changes requested on a daily basis that cannot be fulfilled overnight...because when my team and I collaborate with providers, staff, patients, IT builders, and operations leads to deliver solutions, I am happy. A solution can be as simple as a dot phrase or a new flowsheet row to support better documentation or meet a regulatory requirement. Solutions can also be as complex as implementing new modules, making huge care unit changes, or upgrading the system because the new upgrades offer incremental improvements and new functionality to enable more efficient, high quality care.

I'm in the business of delivering solutions... and to do that, I need to find happiness in consistently moving forward, one foot in front of the other, finding the optimal solutions to meet CMC needs. Those needs vary across the facilities, yet my job is to try to find the solution that fits most. That means I need to understand the needs, the nuances, the frustrations, the limitations. And it means that I need to challenge everyone to think outside the box for creative solutions, to break old habits, to stretch just a little to see up- and downstream from where we are at this moment. I never was one to color within the lines – you see; it made me happy!

So – I'm happy to serve up new modules: Beacon for chemotherapy, live in May; OnBase to ‘replace’ the chaotic Media tab, live in May as well; E-prescribing of Controlled Substances, live by August throughout the house; Radiant for Radiology, live early next year. I'm also happy to say that we’re getting our arms around the sheer volume of change requests coming through Joint Informatics Council, and I’m happy that we’re working to better train everyone in EPIC. We start with the physicians coming in June, and we’ll move across roles as the year progresses.

As I approach the end of my first year here, I can honestly say “I’m happy”. I hope as we continue to move forward together with governance changes, EPIC changes, onboard new residents, and approach the summer, you’ll share some of my happiness.

As always, please feel free to reach out... look forward to hearing from you.
Editor’s Note: This announcement is – and will continue to be – much in the news among Physician Organizations and Societies. As you will remember all this is what is to replace the finally scrapped SGR. There is no free lunch with CMS, and the proposed details are now starting to emerge… The “rule” link leads to a massive document – be forewarned. Note that comments may be submitted until June 27.

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule (MACRA) implementing key provisions of the new physician payment system required by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Section 101 of MACRA repeals the Medicare sustainable growth rate methodology for updates to the physician fee schedule and requires CMS to establish new physician quality and value-based payment programs that start in 2019.

Eligible clinicians will participate in one of two tracks – the default Merit-based Incentive Payment System (MIPS) or alternative payment models (APMs). In the rule, CMS proposes most of the requirements of the MIPS for 2019, including performance measures, data submission mechanisms, reporting timeframes, scoring methodology and various administrative processes.

As part of the MIPS, the agency proposes to replace electronic health record meaningful use requirements for physicians with a more flexible set of “advancing care information” measures. The rule does not propose parallel changes for hospitals. However, the agency does propose to require that all hospitals, critical access hospitals and physicians attest to three statements that indicate they do not engage in information blocking.

CMS also proposes criteria for eligible APMs. Specifically, the agency proposes that an entity that participates in an eligible APM must bear financial risk for any excess Medicare spending over projected expenditures, or be a specified medical home. For 2019 APM incentive payments, eligible models based on financial risk would be Tracks 2 and 3 of the Medicare Shared Savings Program, the Next Generation ACO model, the Comprehensive End-stage Renal Disease Care model, and the two-sided risk model in the Oncology Care program. The newly announced Comprehensive Primary Care Plus initiative would qualify as a medical home.

“We are disappointed by CMS’s narrow definition of alternative payment models, which could have a chilling effect on providers’ ability to experiment with new patient-centered, value-driven payment models,” said American Hospital Association Executive Vice President Tom Nickels in a statement.

Nickels also noted that the proposed rule “fails to recognize the significant resources and risk assumed by the highly motivated, early adopters of alternative payment models.” CMS is accepting comments on the proposed rule through June 27. AHA members can access a Special Bulletin with additional information by going to www.aha.org.

“Achieving success is a challenge, but so is struggling, so you may as well choose success.”

– Rob Liano, writer and consultant
Community Medical Center has been awarded The Advisory Board Company’s 2016 Workplace of the Year Award. Community was one of twenty organizations nationwide to receive the annual award, which recognizes hospitals and health systems with outstanding levels of employee engagement.

The Advisory Board Company defines “engaged employees” as those exhibiting both loyalty and commitment to their employer, as measured in annual employee surveys. These employees are willing to go above and beyond to help their organization succeed. The award recognizes Community’s commitment to creating a best-in-class work environment for its employees.

The Advisory Board Company, a global research, technology, and consulting firm working in healthcare and education industries, conducts and scores Community’s annual employee survey and shares results with Community’s leadership to help enhance the workplace. The company conducts employee surveys for nearly 700 healthcare employers.

“We’re honored to receive this recognition again for the third year in a row. We work hard to show our employees that we value their contribution, and support their well-being and development. That’s why Community attracts the best and the brightest.” said Peg Breen, Senior Vice President of Human Resources.

Community is the largest private employer between Los Angeles and Santa Clara with over 8,200 employees.

“Engaging the workforce is arguably more important now than ever before, with all signs indicating that we are heading into healthcare staffing shortages,” said Steven Berkow, executive director of Survey Solutions at The Advisory Board Company. “With a significant portion of the workforce retiring in the coming years and non-traditional employers encroaching on talent, hospitals and health systems must be laser-focused on engaging their staff. Our award winners have demonstrated an impressive ability to inspire the highest levels of engagement across the country while maintaining remarkably low levels of disengagement.”

Erin Kennedy reported this story. Reach her at MedWatchToday@communitymedical.org
Over the last two months you have received information from Corporate Information Services about serious, real threats to our computer systems. Professional outside hackers are increasingly targeting hospitals. Recent news headlines have been about hospitals locked out of their own electronic systems until they paid hackers’ ransom demands. Those attacks happened after employees opened or clicked links in suspicious emails.

Two New Threats! iPhone Phishing and ‘Whaling’

1

Apple iPhone users are receiving emails or texts stating that their iTunes or Apple accounts have been “restricted in order to safeguard your information.” The email or text urges recipients to “verify and update your account” using the link provided. These are an attempt to gain the recipients’ credentials or to upload ransomware. The only protection from these types of texts/emails is to not click the link and not to respond. Delete the alert.

2

Beware of odd requests from a leader for information. Another new email threat received by many CMC employees appears to come from a senior leader and requests a download of confidential patient or employee information. This new threat has been labeled “whaling” and is a significant enough threat that the FBI has issued an alert to all 50 states. In “whaling”, also known as CEO fraud, the hacker pretends to be an executive of a company and sends an email to a specific individual to wire or transfer money or provide confidential information. These attacks are very targeted – the hacker knows who the senior leader is and creates an email address to mimic that senior leader’s name.

How to spot Whaling: The clue that this is a hacker’s attempt is the return email address to an outside email account such as Hotmail or Google. The examples we have seen pretend to be one of our CEO’s and have a return address to a Hotmail account. Again, these type of attacks can only be successful if the employee who receives the email responds.

Please take basic protection steps to verify the sender of a suspicious email, even if it appears that a colleague or leader sent it. And DO NOT click links in emails from unknown senders.

Continued Vigilance Required On Email

Many of the attempted attacks are relying on hospital employees opening emails that contain software that will take over computer systems (ransomware), spyware, or simply ask for login and password credentials (phishing.) Please do not open or forward these emails to anyone. Delete them. Hackers use these types of emails to learn login credentials. Again, simply delete any email that is suspicious and call the IS Help Desk.

If you would like help in determining whether an email is a hacking or phishing attempt please call the Help Desk at x56560.
We are undergoing a multi-phase construction project to expand our facilities. With the cooperation of our physicians and staff, we’re off to a good start on the Community Regional Medical Center campus. We broke ground for a new Medical Office Building where the old Lot 10 parking lot was. An update on new campus parking offered:

- Lot 16, located on Valeria and E. McKenzie, has 151 new parking stalls. The lot currently remains underused.
- Lot 7, located on Mariposa and Q streets – behind Terry’s House, offers 147 new staff-only parking stalls. The new lot has remained empty since it opened. Please request a parking permit from Security if you wish to park here.

**New Construction**

The following street and sidewalks are now closed for the construction of the new Medical Office Building. The following closures could affect your parking and walking patterns:

- The west side sidewalk on Fresno Street (from Illinois Ave. to the Dialysis Center)
- The north side of Illinois Street (from Fresno St. to Herwaldt Dr.)
- The east side of Herwaldt Drive (from Illinois Ave. to the ACC)

- Herwaldt Drive (from Illinois Ave. to the north entrance of Parking Lot 9 near the ACC).

**Steps to Change Challenge**

Let’s face it, we’re a big campus – and we’re getting bigger. Join our employees in tracking your daily steps for chances to win weekly, monthly and end-of-the-challenge prizes. Earn extra steps from parking further away from the building you enter each day. To join the Fitness Center’s 90-day Steps to Change Challenge you will have to:

Log into Forum (www.mymcmc.com) and go to the Community Regional section under Facilities.

Then click on the Steps to Change Challenge graphic located in the upper, right corner of the page.

Learn more about the challenge and sign up online by clicking “Add new item.” You can earn points just for trying.

Thank you again for your patience and cooperation with CRMC’s many steps to change. We sincerely appreciate your support for Community Regional’s future growth.
In several 2015 issues we introduced readers to TEDMED Talks available on line. TEDMED arose from TED Talks (which have a loyal following, and with which you may be familiar from NPR programming).

TEDMED describes itself as “... a global community of leading doers and thinkers from every walk of life. Our goal is to seed the innovations in health and medicine of today, making the breakthroughs of tomorrow possible. We are best known for our annual three-day gathering that brings together inspiring speakers, influential Delegates and innovative start-ups.

TEDMED curates a unique and provocative program featuring brilliant short talks and stunning artistic performances that reframe the way we think and inspire critical new possibilities for the future of health and medicine. The result is an immersive experience that challenges us to recharge our brains, ignite new thinking, energize our work and enlarge our worldview. We leave TEDMED imagining fresh possibilities and solutions for the future of health and medicine.”

Find the entire menu of short and highly engaging talks from the 2015 conference (and earlier years) here: www.tedmed.com/videos.

Just a few examples:

What if we could re-write the human genome?  
http://www.tedmed.com/talks/show?id=528921  
By UC Berkeley’s Sam Sternberg, research contributor to the revolutionary genome editing tool called CRISPR and expert on the ethics of editing of human cells.

What really happens when you mix medications?  
http://www.tedmed.com/talks/show?id=529433  
By Stanford Professor of Bioengineering and Medicine Russ Altman, who is an expert in drug actions and interactions.

A simple way to break a bad habit  
http://www.tedmed.com/talks/show?id=526819  
By University of Massachusetts psychiatrist and mindfulness researcher Judson Brewer. Dr. Brewer is an expert on the neural mechanisms of mindfulness and how to apply this to eating disorders and substance abuse.

Why your doctor should care about social justice  
http://www.tedmed.com/talks/show?id=527616  
By New York City Public Health Commissioner Mary Bassett, who has a long history of public health advocacy in the US and Africa.

MAY PHYSICIAN PHOTOGRAPHER: DOUGLAS ALEXANDER CLS (CRMC LAB)

Herbert Lake and Mt. Whyte

Peyto Lake
New CDC Guideline for Prescribing Opioids for Chronic Pain: A Strategy to Attack the US Opioid Abuse Epidemic


This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer, palliative care, and end-of-life care. The guideline addresses:

1. When to initiate or continue opioids for chronic pain;
2. Opioid selection, dosage, duration, follow-up, and discontinuation; and
3. Assessing risk and addressing harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences. See CDC on page 12.

Centers for Disease Control and Prevention Recommendations for Prescribing Opioids for Chronic Pain Outside of Active Cancer, Palliative, and End-of-Life Care

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/on-demand (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to 50 morphine milligram equivalents (MME) or more per day, and should avoid increasing dosage to 90 MME or more per day in general and carefully justify a decision to titrate dosage to 90 MME or more per day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/d), or concurrent benzodiazepine use are present.

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); detailed ratings of the evidence supporting the recommendations are provided in the full guideline publication.

Source: JAMA, April 19, 2016, Volume 315, Number 15
Continued from page 11

cferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain (http://stacks.cdc.gov/view/cdc/38025) as well as a website (http://www.cdc.gov/drugoverdose/prescribingresources.html) with additional tools to guide clinicians in implementing the recommendations.

Editor’s Note: The evidence for our current epidemic of opioid abuse is everywhere. Recent highly publicized studies from Princeton University and CDC have shown — for the first time since longevity data have been compiled — a rising death rate among late middle age Caucasian men and women, attributed in part to opioid overdose and suicides fueled in part by the social unravelings of drug abuse. More people died from drug overdoses in 2014 than in any year on record. The majority of drug overdose deaths (more than six out of ten) involve an opioid.1 And since 1999, the rate of overdose deaths involving opioids (including prescription opioid pain relievers and heroin) nearly quadrupled.2 From 2000 to 2014 nearly half a million people died from drug overdoses. 78 Americans die every day from an opioid overdose.

We now know that overdoses from prescription opioid pain relievers are a driving factor in the 15-year increase in opioid overdose deaths. Since 1999, the amount of prescription opioids sold in the U.S. nearly quadrupled,2 yet there has not been an overall change in the amount of pain that Americans report.3,4 Deaths from prescription opioids — drugs like oxycodone, hydrocodone, and methadone — have also quadrupled since 1999.

This major CDC report is highly recommended to readers. Parts of it will also be appropriate for discussions with chronic pain patients, particularly if conflicts or questions develop related to providers’ attempts to follow the guidelines in order to do the right thing for that patient. We have reprinted on the prior page a summary of the 12 items in the Guidelines. There is much helpful information and detail behind this summary information — see the CDC link above or find the CDC report as an open access April 19th JAMA Special Report (Print readers can search JAMA and CDC Guidelines for Prescribing Opioids for Chronic Pain — United States, 2016).

References:

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References:

The take home message ends speculation but of course adds to fears, since at the same time we are hearing how Zika is likely to spread as its host mosquito spreads:

“…On the basis of this review, we conclude that a causal relationship exists between prenatal Zika virus infection and microcephaly and other serious brain anomalies…”

CDC’s Zika website continues to the go-to resource for medical professionals and they lay-public to learn more about Zika.
We are happy to announce we received 16 nominated QI and Innovation projects from the different departments of UCSF Fresno.

Hence everyone is invited to check out these projects in poster format at the 1st Annual QI and Innovation Symposium on May 26, from 4-6 pm at the UCSF Fresno Center, rooms 136 and 137.

Join us as we celebrate the entrants’ collaborative spirit and scholarly work, all in the name of quality improvement, patient safety, and innovation.

There will be plenty of sumptuous hors d’oeuvres courtesy of the UCSF Fresno Resident Council and velvety wine donated by CCFMG.

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

Hope to see you May 26.

Here are the 16 projects and teams, listed in no particular order:

**Leadership Development in Surgery Residents** (Surgery) Tejal Pandya M.D., Amy Kwok M.D., and Rachel Dirks Ph.D.

**Video Review of Medical Resuscitations** (Emergency Medicine) Crystal Ives Tallman M.D., Danielle Campagne M.D., and Stuart Maxwell M.D.

**Dash Diet & Exercise Counseling to Help Manage Hypertension** (Family & Community Medicine) Ashlynn Gordon D.O., Indo Feudale M.D., Mohsin Jawed M.D., Navi Kaur, M.D., and Roger Mortimer M.D.

**Resident Initiated Feedback Sessions to Improve the Quality and Quantity of Formative Feedback** (Internal Medicine) Jarae Ng D.O., Christine McElyea D.O., Ashenafi Legesse M.D., and Ivy Darden M.D.

**Telephone Reinforcement Intervention to Improve Continuous Positive Airway Pressure Compliance in Obstructive Sleep Apnea Patients** (Sleep Fellowship) Mhd-lyad Saadi M.D., Lindsay Kerr, Lynn Keenan M.D. and Paul Mills Ph.D.

**The Effects of a Formal Breastfeeding Curriculum on Resident Education, Clinical Practice, and Breastfeeding Numbers in a Single Residency Program in Central California** (OB-GYN) Courtney Amerin D.O., Amy Evans M.D., Ednann Naz M.D. and Christopher Downer M.D.

**Payer Mix of Patients Transferred to a Level I Trauma Center; A Mutidisciplinary Comparison** (Orthopaedic Surgery) Cody Pehrson M.D., and Eric Lindwall D.O.

**Social Media – An Effective Method for Attracting the Modern Residency Applicant** (Pediatrics) Clarisse Casilang M.D., and Soniya Mehra M.D.

**Daytime Versus Nighttime Cholecystectomy: A Comparison of Outcomes** (Surgery) Sammy Siada D.O., Shaína Schaetzl M.D, Huy Hoang M.D. Fatima Wilder M.D. and James W. Davis M.D.

**Standardized EKG Teaching in a Pediatric Residency** (Pediatrics) Rachel Manalo D.O. and Paul Francis M.D.


**Effectiveness of Providing Immediate Postpartum Long-Acting Contraceptives in Preventing Unintended Pregnancies** (Obstetrics & Gynecology) Mai Tran M.D. M.P.H., and Mallory Kremer M.D.

**The Effect of High Visibility Infection Control Signs on Contact Precaution Compliance** (Internal Medicine) Nitín Thinda M.D., Srilatha Venepally M.D., Shilpi Gupta M.D., Paul Goebel M.D., and Jian Huang M.D.

**Educating Hypertensive Patients About Dash Diet** (Family & Community Medicine) Jose Buenrostro M.D., Satjit Sanghera M.D., Mario Gutierrez M.D., Michelle Lin M.D., and Juan Carlos Ruvalcaba M.D.

**Heart Pathway Project: Low-Risk Chest pain in the ED** (Emergency Medicine) Nicole Wojtal M.D., Jeffrey Uller M.D., Jennifer Tryteen PharmD., Ednann Naz M.D., Elisa Brown, R.N. M.S.N.-C.N.S., and Tom Utecht M.D.

**Ground Level Falls in the Elderly: Always A Traumatic Event?** (Surgery) Emaad Farooqui M.D. and Nancy Parks M.D.
April was STD (sexually transmitted disease) Prevention Month. It reminds us all how destructive these illnesses can be to our individual and collective health. Nothing can increase our awareness of, and draw our attention to, these illnesses more than the devastating effects some of them have on our unborn and newborn babies as they are transmitted from an infected mother.

Between 2012 and 2014 the rate of congenital syphilis (CS) increased 38% in the U.S. and the number of cases in 2014 was the highest since 2001. This was driven by a 22% increase in primary and secondary syphilis in men and women. In Fresno County, since 2012 both the annual number of new cases of primary and secondary syphilis in men and women, and the annual number of cases of infants born to mothers infected with syphilis, has increased 10-fold.

At a glance, these are just numbers of varying interest to many reading this. But let me illustrate the public health impact of this outbreak with a composite patient drawn from the many medical records I’ve reviewed over the last many months.

Jane is a 35 year-old woman whose chaotic life is driven by her addiction to methamphetamine. She doesn’t have a stable residence and has never been employed for any extended period of time. Her social network consists of individuals whose lives are also centered around their addictions, and intimacy for her comes in the form of casual sexual encounters, usually during drug induced highs.

Jane has three children. They live in three separate foster homes. She is now pregnant with a fourth child and is being seen in a local emergency department because she is in labor. She is at 30 weeks gestation. She has early latent syphilis and chlamydia, but doesn’t realize it because the one visit she made to her prenatal care provider, fairly early in her pregnancy, failed to engage her in her health care. Feeble attempts to have her return for follow up were unsuccessful.

The positive at high-tier RPR reported by the lab to the Public Health Department prompted communicable disease investigators to search for her. However, with stretched resources, their standard efforts to locate and speak with her failed as well.

See Syphilis on page 15
Syphilis

Continued from page 14

Jane delivers an extremely ill, methamphetamine addicted, premature infant with obvious signs and symptoms of congenital syphilis.

In the United States, a case of CS is a sentinel event reflective of numerous missed opportunities for prevention within our public health and health care systems.\(^1\) There are two major opportunities to prevent CS: primary prevention of syphilis among women of reproductive age and men who have sex with women; and prevention of mother-to-infant transmission among women already infected with syphilis.\(^2\)

Over the past several months, the Fresno County Department of Public Health (FCDPH) has responded to this outbreak with a range of interventions, such as:

-  Case prioritization by infectiousness and risk to infants
-  Intensive training of additional health department staff who investigate cases
-  Expanding education and resource outreach to health care providers
-  Official designation of Fresno County as an area of high syphilis morbidity with implementation of a requirement for additional screening of women for syphilis during pregnancy
-  Convening statewide experts on STDs to discuss successes, challenges, best practices, and actionable response

Despite these interventions to address this outbreak, FCDPH resources to locate, evaluate, identify contacts of, and treat individuals reported to the department with lab results indicative of syphilis have been exceeded. For this reason, temporary assistance from the California Department of Public Health (CDPH) and the Center for Disease Control and Prevention (CDC) has been requested and granted to our Department.

Concurrent with these efforts, and in addition to other interventions, health care providers are being asked to:

-  Screen ALL patients for STDs and test those at high risk
-  Treat ALL patients found to have syphilis immediately and according to CDC guidelines. Please contact FCDPH at (559) 600-3434 if any assistance is required
-  Treat sexual partners of patients with syphilis immediately and according to CDC guidelines
-  Test ALL pregnant women for syphilis three separate times during their pregnancy (at the initial prenatal visit, again at 28 to 32 weeks gestation, and again at delivery)
-  Strongly encourage ALL pregnant women to follow through on ALL prenatal care visits. Please offer your patients referral to FCDPH Public Health Nursing Programs or call 559-600-3330 if any assistance is required
-  Assist county, state, and federal disease investigator staff in their efforts to obtain necessary information on your patients diagnosed with, or suspected of having syphilis. Remember that information obtained for public health issues such as this are not subject to HIPAA restrictions.

References


CMC Labs:  
Our 2016 Customer Survey Needs Your Input

The CMC system laboratories (CRMC, Clovis and Fresno Heart) are requesting feedback from the Medical Staff regarding your perception of, and level of satisfaction with, laboratory services. All three CMC laboratories work diligently to provide quality services to patients and providers in pursuit of exceptional care. The laboratories monitor a large number of internal metrics to track the quality of laboratory performance. But feedback from the consumers of our services is critical; without it, we have an incomplete picture of our operations and our needs for improvement. Please take a little time – it should take less than 5 minutes – to let us know how we are doing. We want to hear the good, the bad, and the ugly. The first step to improvement is knowing of the opportunities from the customer’s perspective. You can take the brief survey here. (Print readers can find it at top left on the lab’s CMC Forum page (Forum < Departments < Laboratory).

Thank you in advance.
Jack was one of my favorite patients. He exuded a confidence that defied logic. He also had a great sense of humor. He had multiple medical issues including advanced liver disease. I met him in my continuity clinic when I was a resident and he followed me into my palliative care clinic. He admittedly had the worst looking labs I had ever seen but he remained stable for years while under the care of several excellent specialists. His platelet count was dangerously low and this precluded his eligibility for any surgical interventions so his treatment focus was quality of life rather than curative.

Eventually complications from acute liver failure required admission to our teaching hospital and he decided to enroll in hospice. Even though he was not a candidate for liver transplant he made trips to the major university that specialized in liver diseases every three months. Jack got labs and tracked the results from his computer at home. He liked for me to visit him at his house and I had the pleasure of meeting his family. His mother was especially lovely. I remember coming by once to see Jack and he wasn’t home. His mother and sister took me all over the house showing me pictures of Jack and telling me how proud they were of him. His mother told me how they had lost a daughter to a drunk driving incident, and also showed me a picture of herself with one of our country’s most iconic presidents, Ronald Reagan. Jack’s mother was one of the many women that galvanized the movement to create Mothers Against Drunk Drivers. She guided me to a picture of Jack in his early years, a studio portrait during his senior year of high school. Jack was strikingly handsome and had a Hollywood appearance. I would not have been able to say that was the Jack I knew, before his liver and immune system declined. It struck me that I had judged Jack. I am not saying that I didn’t respect or give him the best care possible. However, his illness clouded my ability to see who he was, what his dreams were, and what the future held for him when he was young. Shame washed over me momentarily but gratitude slowly emerged having been given an opportunity to see Jack on a different level as well as understand that his family had been through horrible tragedy.

One of the best hospice nurses I know, Weatherly Emory, managed Jack’s care at his home. She was outspoken with a great clinical intuition. Her care for Jack was outstanding, but she struggled at times when Jack talked about building a new house. Prior to Jack’s last hospitalization, he had plans to build a house. He talked about that more than anything. Weatherly would talk with me about his denial and whether he truly accepted his prognosis. She also didn’t understand why he went every three months to the university hospital for blood work. What I came to realize is that Jack had hope. His focus on building the home helped him cope with what he ultimately knew would be his final curtain call. Jack was bright. He knew what the end would be, but he had hope and I realized it was not for me to dash it.

We rarely talked about his prognosis. Weatherly insisted, however, that I talk with him to make sure he knew he had a terminal condition. During my conversation with Jack I realized immediately he knew his time was limited but he chose to focus on the possibilities, while still accepting hospice services. He chose to be hopeful. Being on hospice or accepting palliative care service does not mean giving up hope. It may require redefining your priorities. Jack was not in denial. He was choosing to see his transition from this world to the next with a different lens. I always think of Jack when new nurses get concerned about denial. I smile and repeat the lesson Jack gave to me.

Several years after Jack passed away I learned that he gave a door from an old house to Weatherly. It was a special gift, and one that holds special meaning to her. She still has that door and is looking to find it a home. I know Jack would smile deeply knowing that he probably helped us more than we helped him.

The Door of Hope

Patrick J. Macmillan M.D.
Medical Director, Palliative Care Services, Community Regional Medical Center
Chief of Hospice and Palliative Medicine, UCSF Fresno Medical Education Program

When we are no longer able to change a situation, we are challenged to change ourselves.”
– Viktor E. Frankl, Man’s Search for Meaning
A 60 Second Refresher on Argatroban

Submitted by Curtis Takemoto, Pharm.D.
CRMC Medication Safety Specialist

The following are a few questions and answers about the anticoagulant argatroban.

What is argatroban and what are the indications for use? Argatroban is a direct thrombin inhibitor with the following indications:
- Treatment and prophylaxis of thrombosis in adults with heparin induced thrombocytopenia (HIT)
- As an anticoagulant in adults with or at risk of HIT undergoing percutaneous coronary intervention (PCI)

How is argatroban administered?
- Argatroban is manufactured as a 250 mg/2.5 ml vial. The medication must be diluted 100-fold to a final concentration of 1 mg/1 ml (250 mg/250 ml).
- For use in HIT the initial dose is 2 mcg/kg/min as a continuous infusion. No bolus dose is indicated.
- For use in HIT in patients with moderate to severe hepatic impairment (Child-Pugh classes B and C) the dose is 0.5 mcg/kg/minute.
- For use in PCI, the dose is 25 mcg/kg/min and a bolus of 350 mcg/kg infused over 3-5 minutes.

Is there an order set (OS) for argatroban? Yes under Argatroban Infusion in Epic.

Does argatroban require the use of an infusion pump? Yes.

Is there an antidote for argatroban for excessive anticoagulation? No. In general, discontinuation of argatroban or decreasing the dose controls the bleeding. In the studies cited by the manufacturer, the PT returned to baseline with 2-4 hours.

Is there a dosage adjustment for patients with renal insufficiency? No adjustment is needed. Argatroban is metabolized via hydroxylation in the liver. The elimination half-life of argatroban is 39-51 minutes. In patients with hepatic impairment, the elimination half-life in increased to 181 minutes (Child-Pugh score of greater than 6).

If there are any more questions about argatroban, please contact the Department of Pharmacy at your CMC Acute Care Facility.

Remember that Community’s clinical resource update.com has very helpful information on the newer anticoagulant drugs including management of hemorrhagic complications and (where relevant) lab testing and emergency reversal of effects.

Metformin-Containing Products and Renal Functions

By Curtis Takemoto, Pharm.D.
CRMC Medication Safety Specialist

Introduction: On April 8, 2016 the Food and Drug Administration (FDA) released revised recommendations on the use of metformin-containing products in patients with reduced renal function. The following is a very brief overview of these changes.

What did the FDA do? The FDA was asked to review newer studies on the use of metformin in patients with reduced renal function.

What did the FDA discover? The FDA concluded from the review from these studies that metformin may be safely be used in patients with mild to moderate renal impairment.

What are the revised recommendations?
- The FDA will require all manufacturers to change the labeling to reflect the new information to indicate that metformin may be used in patients with mild to moderate renal impairment.
- To change from serum creatinine to the glomerular filtration rate estimating equation (eGFR), which better estimates the renal function in patients with renal compromise. The reason for this change is that eGFR is a combined assessment of serum creatinine, age, gender, race and weight.

What are the labeling recommendations?
- Before initiating metformin, obtain an eGFR.
- Metformin is CONTRAINDICATED in patients with an eGFR less than 30ml/minute/1.73m2
- The medication of NOT recommended in patients with an eGFR between 30-45 ml/minute/1.73m2.
- An eGFR should be assessed at least annually; however more frequent evaluation is recommended in patients at an increased risk of development of renal impairment (e.g. elderly). Metformin should be discontinued if the eGFR drop below 30 ml/minute/1.73m2.
- Discontinue metformin at the time of or before iodinated contrast imaging in patients with an eGFR between 30-60 ml/minute/1.73m2, patients with a history of liver disease, alcoholism, heart failure of in patients who will receive intra-arterial iodinated contrast.
- Re-evaluate the eGFR 48 hours after the procedure. Metformin may be re-started if renal function is stable.

See Pharmacy Corner on page 18
Within Community Medical Centers, the use of metformin or metformin-containing products is limited to on the acute care rehabilitation (Leon Peters-6W) and behavioral health (CBHC).

The Black Box Warning list will be revised to note the FDA changes.

When does the change go into effect? The FDA has stated “health care professionals should follow the latest recommendations when prescribing metformin-containing medicines in patients with impaired kidney function.”

Based on this verbiage, it appears that these changes are effective now.

If there are any questions, please contact the Department of Pharmacy at your Acute Care Facility.

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A new report finds that while insurance coverage and financial stability have improved in the Fresno region, one of the poorest areas of the state, this growth has compounded existing capacity constraints and access challenges in the health care system.

It finds that many of the previously uninsured were able to enroll in Medi-Cal under the Affordable Care Act (ACA). The program now covers 41% of the population in the region, compared to 27% for California as a whole, since the January 2014 ACA coverage expansions – exceeding expectations of providers and Medi-Cal managed care plans alike.

Among the other key findings:

• Rural Health Clinics continue to grow, exacerbating competitive tensions with some Federally Qualified Health Centers.
• In a notable shift from previous rounds of this study, physicians in Fresno County have started to consolidate into larger, more integrated medical groups.
• With the gains in Medi-Cal coverage and additional financial subsidies, the major hospitals and community health centers have generally experienced improvements in financial status.
• Providers are taking on more risk in a market that has historically been almost exclusively fee-for-service.
• Medi-Cal now covers more than 40% of the population in the Fresno region, compared to 27% for California as a whole.

Additional information includes: Medi-Cal now covers more than 40% of the population in the Fresno region, compared to 27% for California as a whole.

The issue brief, part of the regional market report series, is an update to a previous report published four years ago. Regional market reports for the San Francisco Bay Area, Sacramento, and Riverside/San Bernardino were published earlier in 2016. Over the next few months, CHCF will provide updates for Los Angeles, Orange County, and San Diego.

These reports are published as part of the CHCF California Health Care Almanac, an online clearinghouse for key data and analysis examining California’s health care marketplace. Find all Almanac reports at [www.chcf.org](http://www.chcf.org) or search “Fresno: As uninsured rates falls, capacity constraints grow”.

For more information, contact, Steven Birenbaum, CHCF, Senior Communications Officer, (510) 587-3157, or email: sbirenbaum@chcf.org.

Here is a link to the full menu of regional reports. We are not alone in our issues: [http://www.chcf.org/almanac/regional-markets](http://www.chcf.org/almanac/regional-markets)

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**Pharmacy Corner**

*Continued from page 17*

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Based on this verbiage, it appears that these changes are effective now.

If there are any questions, please contact the Department of Pharmacy at your Acute Care Facility.
CRMC Surgery Scheduling: New Hours of Operation and 3-Day Block Release

**Hours of Operation:** CRMC Surgery Scheduling is pleased to announce new hours of operation which began April 16. Surgery Scheduling will now be open 7 days a week:
- Monday thru Friday: 0600-1700
- Saturday & Sunday: 0600-1430

The change, which includes a later work day, will help accommodate our physicians, anesthesia providers and clinical staff with confirming a date and time for their case requests. Same-day case requests will continue to be handled by the Surgery Day Charge RN. After-hour case requests will also remain the same (leave voice mail message at 459-6336).

**3-Day Block Release:** In an effort to improve services and efficiencies in the surgery department, changes to the existing block release will go into effect on June 1. We are confident the new changes to the OR Block release will provide “predictability” to our existing OR schedule. Standardized block release and scheduling rules based on case classification will allow the OR to optimize the schedule for the day of the procedure and ensure that block time is available for urgent and emergent cases. Some highlights of the changes are as follows:

**Changes to the “Patient Class”**
- **Elective** – Standard elective surgical procedures must be booked a minimum of 3 business days in the future (all elective patients will be scheduled for a pre-admission testing appointment)
- **Ambulatory Urgent** – Ambulatory cases defined as “Urgent” will be allowed to book available blocks within the 3 business day release window. There are no longer 24 hour “courtesy holds”
- **Inpatient Urgent** – All inpatient Urgent and Emergent procedures will be allowed to book within the 3 business day release window
- **Inpatient Emergent** – Same as “Item C”

Our goal is to improve efficiency for all, while not compromising patient care or customer satisfaction. We appreciate your continued patronage to CRMC and look forward to working collaboratively to achieve our goals.

If you have any questions or concern, please contact Maria Garcia-Falcon, CRMC Surgery Scheduling Manager at 459-2609 or via email at mgarcia@communitymedical.org, Dr. Mark Kestner at 459-2455 or email mkestner@communitymedical.org, or Matthew Crenshaw, Director-Performance Improvement at 459-7413 or email mcrenshaw@communitymedical.org.

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**GI Bleed Documentation**

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

Avoid need for clarification later-on by documenting the source of GI Bleed. Enhanced documentation for GI Bleed = assigning codes that accurately reflect the patient’s severity of illness and risk of mortality.

A cause-and-effect relationship, whether known or suspected, must be stated for GI bleed and any GI conditions, such as those that may be found during an EGD or colonoscopy.

GI bleed should be linked to any of the following sources – remembering that it may your best estimate:
- Gastritis
- Duodenitis
- Ulcer
- Esophageal varices
- Diverticulosis

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

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

Submitted by Sandra Sidel R.H.I.A., C.C.S., HIM Coding Educator

<table>
<thead>
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<th>Prior ICD-9 Documentation</th>
<th>Improved ICD-10 Documentation</th>
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</thead>
<tbody>
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<td>45 year old female with GI bleed. EGD performed, gastric ulcer was found</td>
<td>45 year old female with GI bleed. Gastric ulcer found on EGD. Bleeding likely due to gastric ulcer.</td>
</tr>
</tbody>
</table>

The following documentation improvements are needed for ICD-10:
Source, cause-and-effect relationship
Editor’s Note: This month’s Choosing Wisely has great recommendations from the American Academy of Otolaryngology – Head and Neck Surgery Foundation. We asked Benjamin J Teitelbaum M.D., F.A.C.S., Central California Ear, Nose & Throat, Fresno, for his comments on this topic. His comments follow each numbered thing that should be questioned.

Don’t order computed tomography (CT) scan of the head/brain for sudden hearing loss.
Computed tomography scanning is expensive, exposes the patient to radiation and offers no useful information that would improve initial management. CT scanning may be appropriate in patients with focal neurologic findings, a history of trauma or chronic ear disease. Sudden hearing loss is a medical emergency. Examine the ears to determine if there is a cerumen impaction or an obvious middle ear effusion. If these conditions are absent, an urgent referral to an otolaryngologist is indicated. Prompt treatment with systemic steroids for sudden idiopathic sensorineural hearing loss improves the likelihood of meaningful recovery.

Don’t prescribe oral antibiotics for uncomplicated acute tympanostomy tube otitis.
Oral antibiotics have significant adverse effects and do not provide adequate coverage of the bacteria that cause most episodes; in contrast, topically administered products do provide coverage for these organisms. Avoidance of oral antibiotics can reduce the spread of antibiotic resistance and the risk of opportunistic infections. You can never go wrong by starting topical antibiotic ear drops when a patient has a draining ear. Oral antibiotics are unnecessary unless there is concomitant cutaneous cellulitis. When there is a tympanic membrane perforation or a tympanostomy tube in place, ototoxic topical antibiotics like Cortisporin should be avoided in favor of topical quinolone products.

Don’t prescribe oral antibiotics for uncomplicated acute external otitis.
Oral antibiotics have significant adverse effects and do not provide adequate coverage of the bacteria that cause most episodes; in contrast, topically administered products do provide coverage for these organisms. Avoidance of oral antibiotics can reduce the spread of antibiotic resistance and the risk of opportunistic infections. Similarly, oral antibiotics are usually unnecessary for acute otitis externa (aka Swimmer’s Ear). Start the patient on a topical ear drop that contains a combination of antibiotic and steroid (Ciprodex). Cleaning the ear canal with gentle suction may be necessary if there is no improvement after a few days of topical treatment.

Don’t routinely obtain radiographic imaging for patients who meet diagnostic criteria for uncomplicated acute rhinosinusitis.
Imaging of the paranasal sinuses, including plain film radiography, computed tomography (CT) and magnetic resonance imaging (MRI) is unnecessary in patients who meet the clinical diagnostic criteria for uncomplicated acute rhinosinusitis. Acute rhinosinusitis is defined as up to four weeks of purulent nasal drainage (anterior, posterior or both) accompanied by nasal obstruction, facial pain-pressure-fullness or both. Imaging is costly and exposes patients to radiation. Imaging may be appropriate in patients with a complication of acute rhinosinusitis, patients with comorbidities that predispose them to complications and patients in whom an alternative diagnosis is suspected. The diagnosis of acute bacterial sinusitis is based on clinical findings of at least 2 of the following symptoms for 7-10 days without spontaneous improvement: purulent rhinorrhea, facial discomfort, and nasal congestion. Plain sinus x-rays are never indicated, and CT of the sinus is unnecessary unless there is failure of empiric treatment or complications such as cellulitis.

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.
Don’t obtain computed tomography (CT) or magnetic resonance imaging (MRI) in patients with a primary complaint of hoarseness prior to examining the larynx.

Examination of the larynx with mirror or fiberoptic scope is the primary method for evaluating patients with hoarseness. Imaging is unnecessary in most patients and is both costly and has potential for radiation exposure. After laryngoscopy, evidence supports the use of imaging to further evaluate 1) vocal fold paralysis, or 2) a mass or lesion of the larynx.

Patients with unexplained hoarseness for 1 month or more should have a laryngeal exam. Imaging studies should not be obtained until the larynx has been visualized.

Don’t place ear tubes in otherwise healthy children who have had a single episode of ear fluid lasting less than 3 months.

Ear fluid of short duration is likely to resolve spontaneously. The child should be monitored to ensure resolution of the fluid. In children with comorbid conditions or speech delay, earlier tube placement may be appropriate.

Most middle ear effusions will resolve spontaneously, and therefore observation is all that is required. Antibiotics are not indicated unless there are signs of inflammation such as otalgia or erythema. Ear tubes are not indicated until middle ear fluid has been present for at least three months.

Don’t order imaging studies in patients with non-pulsatile bilateral tinnitus, symmetric hearing loss and an otherwise normal history and physical examination.

The utility of imaging procedures in primary tinnitus is undocumented; imaging is costly, has potential for radiation exposure and does not change management.

Most patients with tinnitus or symmetric hearing loss do not need imaging. An ear exam and audiogram are indicated, and often no further workup is needed.

Don’t order more than one computerized tomography (CT) scan of the paranasal sinuses within 90 days to evaluate uncomplicated chronic rhinosinusitis patients when the paranasal sinus CT obtained is of adequate quality and resolution to be interpreted by the clinician and used for clinical decision-making and/or surgical planning.

Computerized tomography scanning is expensive, exposes the patient to ionizing radiation and offers no additional information that would improve initial management. Multiple CT scans within 90 days may be appropriate in patients with complicated sinusitis or where an alternative diagnosis is suspected.

The best time to obtain a diagnostic CT of the sinuses is after the failure of maximal medical management with antibiotics and topical nasal steroids. Response to treatment can be assessed based on symptomatology, and follow up imaging is rarely needed.

Don’t routinely use perioperative antibiotics for elective tonsillectomy in children.

Oral antibiotics may have significant adverse effects and do not provide demonstrable benefit after tonsillectomy. Avoidance of oral antibiotics can reduce the spread of antibiotic resistance and the risk of opportunistic infections.

The role of perioperative antibiotics needs to be reevaluated for many head and neck operations. Too often, antibiotics are given in the OR as a matter of protocols that have not been vetted by surgeons.

Don’t routinely perform sinonasal imaging in patients with symptoms limited to a primary diagnosis of allergic rhinitis alone.

History, physical examination and allergy testing are the cornerstones of diagnosis of allergic rhinitis. The utility of imaging for allergic rhinitis is unproven. Allergic rhinitis is suspected when the symptoms of congestion, rhinorrhea, sneezing and itching are present. Imaging is unnecessary for these patients. Empiric treatment with oral antihistamines, topical antihistamines, or topical nasal steroid sprays will usually be successful.
The San Joaquin Valley of California with an estimated population of 4 million, has been the epicenter of the worst air pollution indices for several decades in the US. Although there has been a significant decline in PM10, CO, and sulphur dioxide concentrations, the ambient PM2.5 and ozone levels have been consistently well above the national standards set by the US Environment Protection Agency. Valley topography and higher summer temperatures and subsidence inversion has contributed to this calamity. The American Lung Association State of the Air report has consistently ranked Valley cities as having among the highest number of unhealthy days of PM2.5 and ozone in the country. To compound these staggering statistics, climate change caused by increasing levels of "super pollutants" (global warming effect increased by a 1000 fold compared to carbon dioxide) such as black carbon from forest fires, incomplete combustion of fossil fuels and residential and agricultural burning is significant. Methane emissions from oil and gas production and agricultural industry is also a major source of super pollutants. Highly potent hydrofluorocarbons, factory made gases used in air conditioners, refrigeration and other applications (which also deplete the ozone layer), further compound the problem.

This pervasive situation has increased health care utilization due to the exacerbation of chronic lung diseases such as asthma and COPD throughout the Valley. Figure 1 shows the population at risk for airway-related disease exacerbation in large cities of Valley. Unfortunately, the population taking the brunt of air pollution are those from poor socio-economic status living closer to highways. Figure 2 shows the increasing density of F/U Asthma Ed Patients.
number of hospital admissions related to higher PM2.5 level in Fresno. The population living near areas with high traffic density experienced the highest number of ER visits for respiratory related illness. Health care utilization is likely to increase with the deterioration of worsening air quality compounded by climate change, increasing population, and uncontrolled development in the Central Valley. Considering all these evidence, it’s critical that we adopt all tangible solutions to control PM2.5 and Ozone levels in the short and long term for the most affected parts of California.

California has been on the cutting edge for air pollution and climate change research in addition to setting up public policy to combat air pollution and climate change. To this end, we should be putting our support behind Senate Bill 1383 authored by Senator Ricardo Lara. SB 1383 designed to control super pollutants, which will go a long way in alleviating climate change and removing harmful pollutants that keep the Valley communities from the healthy air they deserve.

Design Work Begins for $65 Million Cancer Center

The Community Medical Centers Board of Trustees authorized architectural design and other preconstruction work for a regional cancer treatment and research center—the first of its kind in the San Joaquin Valley.

An aerial of the Clovis Community Medical Center looking south, towards Herndon, shows where the regional cancer center is proposed to be built on the north side of the hospital campus.

The center will be designed to serve the entire Community system and patients throughout the Valley—combining services and expertise provided in multiple locations including Community Regional Medical Center in downtown Fresno, the California Cancer Center in north Fresno and Clovis Community Medical Center.

The envisioned center will be located on the Clovis Community campus, adjacent to Highway 168. The facility will be three stories tall and nearly 100,000 square feet, at an estimated cost of $65 million.

“The center will provide comprehensive outpatient treatment for cancer of all kinds in a single location, improving coordination of care and creating a seamless experience for patients,” said Tim Joslin, Community’s President and CEO. “This is the best-practice way to combat cancer.”

The center would also conduct cancer research in partnership with the University of California, San Francisco Medical Center, with the goal of becoming a “Designated Cancer Center” by the National Cancer Institute. Ten such centers exist in California, but none in the San Joaquin Valley.

“This cancer center couldn’t come at a better time,” said Michael Peterson, M.D., Associate Dean and Chief of Medicine at UCSF Fresno Medical Education Program. “With new cancer cases projected to increase by 45% nationwide by 2030, this will be a recognized best-practice location—elevating cancer treatment, research and ultimately positive patient outcomes.”

Projections for the Valley show a nearly 300% increase in the need for cancer surgical and radiation treatments within the next decade, said Paul Ortiz, Community’s vice president of cancer services. “Cancer will affect us all,” he said.

Community has a history of being on the forefront of cancer care locally, starting in 2005 with the world’s first “Generation 4” CyberKnife for noninvasive laser treatment of hard-to-reach tumors—especially prostate and lung cancers so prevalent in the Valley. More recently in 2014, Community invested $6 million in linear accelerators at the California Cancer Center.

Funds to build the regional cancer center are expected to come from Community’s operations and from fund raising.

“What excites me most is that the vision for this project centers on our patients,” said Christopher Perkins M.D., board-certified medical oncologist. “The goal is to build a world class cancer treatment facility to keep patients closer to their homes and their families’ support. Currently, patients too often seek treatment at cancer centers hundreds of miles away.”

Dr. Uma Swamy, radiation oncologist at Community’s California Cancer Center, said cancer requires multiple types of treatments, lab work and follow up from many providers. “When all of it is in one place, patients can get their care faster and easier. And that’s a huge benefit for providers and for patients,” she said.

“A regional center like this provides three main advantages for Valley patients,” said Dr. Uzair Chaudhary, an oncologist/hematologist with UCSF Fresno and Community Regional. “The center will give Valley patients access to disease-specific, comprehensive, multi-disciplinary teams. So a patient who is diagnosed with a lung nodule or prostate cancer will see a team of lung cancer experts or prostate cancer experts,” he said. “Number two, patients will have access to innovative clinical trials and research, so they don’t have to seek that outside the Valley. And number three, we want to treat patients as a whole, so we will have all the ancillary help they need— for instance physical therapy, social supports, nutritional counseling and alternative therapies.”
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 03/29/2016 to 04/12/2016. 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.

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<td></td>
<td>• Removed “Core Measure Required” language</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed lipid management medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed duplicate orders when compared to Adult Admission Shell Z</td>
</tr>
<tr>
<td>1318</td>
<td>Intravenous Immunoglobulin-Adult</td>
<td>Biennial Review:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Minor modifications to frequency of pre-meds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Deletion of “universal” from title</td>
</tr>
<tr>
<td>1253</td>
<td>Neuromuscular Blockade Infusion Critical Care</td>
<td>Change Request:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inclusion of alternative sedation medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clarification of indication and titration parameters within medication administration instructions</td>
</tr>
<tr>
<td>1572</td>
<td>Pneumonia Med/Surg Module Z</td>
<td>Multidisciplinary Review:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated based on most recent Evidence Based Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Complete review and update of antibiotics for Community Acquired Pneumonia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed duplicate orders when compared to Adult Admission Shell Z</td>
</tr>
<tr>
<td>1208</td>
<td>Post Op Neuro Orders</td>
<td>Biennial Review:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated catheter care orders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated PRN medications for single select and preference select</td>
</tr>
<tr>
<td>1401</td>
<td>Post Op Spine Orders</td>
<td>Epic change only: Single select for antiemetics and diphenhydramine</td>
</tr>
<tr>
<td>585</td>
<td>Pre-Interventional Endovascular Orders</td>
<td>Change Request:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Default route for lidocaine to intradermal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Add saline lock order</td>
</tr>
<tr>
<td>1460</td>
<td>Termination of Pregnancy</td>
<td>Biennial Review:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated lab orders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated oxytocin and misoprostol orders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed morphine PCA orders and replaced with “Refer to PRL305 Patient Controlled Analgesia”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clarified single select orders for antiemetics and diphenhydramine</td>
</tr>
<tr>
<td>1247</td>
<td>Therapeutic Apheresis</td>
<td>Change Request: Updated orders for new contract</td>
</tr>
<tr>
<td>1636</td>
<td>Tilt Table Procedure</td>
<td>Biennial Review</td>
</tr>
</tbody>
</table>
ANNOUNCING UPDATED ORDER SETS BEING RELEASED, continued

<table>
<thead>
<tr>
<th>Epic PRL#</th>
<th>Order Set Name</th>
<th>Reason for Retirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1622</td>
<td>Diabetes Insulin infusion</td>
<td>Biennial Review: Zero usage in the past year</td>
</tr>
<tr>
<td>1634</td>
<td>Mediport Care</td>
<td>Biennial Review: Zero usage in the past year</td>
</tr>
<tr>
<td>1620</td>
<td>Post Cardiothoracic Surgery Insulin Sliding Scale</td>
<td>Biennial Review: Zero usage in the past year</td>
</tr>
<tr>
<td>642</td>
<td>Post-Op Penile Prosthesis Short Stay Discharge Orders</td>
<td>Biennial Review: Zero usage in the past year</td>
</tr>
<tr>
<td>521</td>
<td>Universal Nuclear Medicine Radiology</td>
<td>Biennial Review: Zero usage in the past year</td>
</tr>
<tr>
<td>616</td>
<td>Universal Nuclear Medicine Radiology – Outpatient</td>
<td>Biennial Review: Zero usage in the past year</td>
</tr>
</tbody>
</table>

**Order Set Update: Warfarin (COUMADIN) Reversal Orders [PRL1323]**

Coumadin Reversal Best Practices have evolved. New pharmacologics and increasing awareness of the downside to patients of plasma transfusion should be familiar to all providers who manage this common clinical situation. This an ideal scenario for a standardized order set.

There has been a significant update to Community’s Warfarin (COUMADIN) Reversal order set which will be released in Epic on Tuesday, May 10, 2016. The updated order set is broken down into two major categories for warfarin (COUMADIN) reversal treatment: Non-Urgent Reversal and Urgent/Emergent Reversal. This is a change from the previous treatment sections that were based on INR results and bleeding status. The reversal agents in the order set include Vitamin K (oral and IV), FEIBA (Factor VIII Inhibitor Bypassing Activity) and Fresh Frozen Plasma along with situational guidelines on when to utilize each product as well as recommended doses. The updates are in alignment with 9th Edition of the American College of Chest Physicians Clinical Practice Guidelines, published in 2012.

**MAY PHYSICIAN PHOTOGRAPHER: DOUGLAS ALEXANDER CLS (CRMC LAB)**

Athabasca River, downstream from falls
Your Community at Work: The Power of a Gift

By Erin Kennedy, Senior Communications Specialist

The current edition of “Your Community at Work,” the Community Medical Centers corporate social responsibility report, highlights the power of gifts – many of them from our generous physician partners – which have helped millions of our patients over the past decade. The two-page April edition also outlines our needs for future donations to continue to provide top healthcare for Valley families and to expand our facilities. The Valley’s population is projected to increase nearly 18% over the next 10 years and 36% by 2036 – nearly twice as fast as the rest of California. And most of that population growth will be among the elderly, a group more likely to need hospital and cancer care. But the largest single age group in our region will continue to be children under age 5.

“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/Community-at-Work 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 and content developer.

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 – the only organization to have that distinction. 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. You can click through the “Your Community at Work” archive by year and by month to find printable PDF versions as well as the larger individual online stories.

Print readers: Go to Communitymedical.org > Community Involvement (on the top tab) > Your Community at Work (on the right side menu in the page)
Hispanic Medical Conference
Title: “22nd Annual Hispanic Medical Conference”
Date: Saturday, May 7, 2016
Speakers: Various
Time: 8:00am-1:30pm
Place: Veterans Memorial Auditorium
Contact: Yolanda Cervante, (559) 266-8300 or yrcervantes@avancehh.com
CME: 5 CME

CCMC Perinatal M & M
Title: “The Infant of a Diabetic Mother: Fetal Effects and Neonatal Challenges”
Date: Tuesday, May 10, 2016
Speakers: Anand Rajani M.D.
Time: 12:30pm-1:30pm
Place: CCMC Outpatient Care Center Conference Room
Contact: Rebecca Avila, (559) 324-4937
CME: 1 CME

Cardiology in the Valley
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

CRMC Perinatal M & M
Title: “Cases from Fetal Conference”
Date: Wednesday, May 18, 2016
Speakers: Cory Airheart M.S., L.C.G.C., Drs. Maries Joseph and Krishna Rajani
Time: 12:30pm-1:30pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 136
Contact: Bernadette Neve, (559) 459-7059
CME: 1 CME

CCMC Presents
Title: “Allergy Update 2016”
Date: Tuesday, May 24, 2016
Speakers: A.M. Aminian M.D.
Time: 12:30pm-1:30pm
Place: H. Marcus Radin Conference Center The Palm Room
Contact: Jessica Lipsius, (559) 324-4002, or jilipsius@communitymedical.org
CME: 1 CME

Please also see the enclosed individual flyers for more on these & other upcoming local CME activities to meet your CME needs.
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)
Tuesday May 10, 2016
12:30-1:30 p.m

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

Principal Discussant
Dr. Anand Rajani

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 the fetal effects of a diabetic mother.
2) Gain insight into the potential problems related to infants of diabetic mothers
3) Learn, better understand and incorporate into patient care the knowledge of infants of diabetic mothers, improving diagnostic methods and patient outcomes.

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

Continental breakfast & lunch will be provided

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
Wednesday, May 18, 2016 from 12:30pm – 1:30pm

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

Case Presentation
Genetic Counselor: Cory Airheart, MS, LCGC

Principal Discussants
Genetics: Dr. Maries Joseph
Genetic Counselor: Cory Airheart, MS, LCGC
Neonatology: Dr. Krishna Rajani

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 fetal genetics.
2) Gain insight into fetal genetics, 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.

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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.
DATE:  
Tuesday, May 24, 2016  
12:30 pm - 1:30 pm  
Lunch will be provided

LOCATION:  
H. Marcus Radin Conference Center  
The Palm Room

ATTENDEES WILL:  
• Gain a better understanding of the societal impact of allergic rhinitis and its co-morbid conditions to improve patient outcomes.  
• Discriminate between pharmacologic and non-pharmacologic treatment options for managing allergic rhinitis to improve patient safety.  
• Improve patient outcomes by learning future treatment options for allergic disorders and apply that knowledge in practice.

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, A.M. Aminian 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: Teva – Speaker’s Bureau and AstraZeneca – Speaker’s Bureau. Activities Director, Hemant Dhingra, MD has no Commercial Disclosure to make. Planner, Jessica Lipsius has no Commercial Disclosures to make.
CME Dinner Lecture
Evidence Based Advancement in Managing Thyroid Nodules and Thyroid Cancer

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

DATE/TIME:
May 24, 2016
Tuesday: 6:30 pm – 8:30 pm

SPEAKER:
Christina Maser, M.D.
Endocrine and General Surgeon
Assistant Clinical Professor, UCSF at Fresno
Medical Director, University Surgical Associates
University │ Surgical Associates

JOIN US TO:
1. Gain understanding on administering the initial evaluation of thyroid nodules and apply new guidelines to improve patient care.

2. Learn and better understand the role of genetic markers in management of thyroid nodules.

3. Be more aware and understand the importance of the initial screening and long term management of thyroid cancer.

CME 1.0

ADDITIONAL INFORMATION:
Dinner will be provided (Vegetarian options available)

TARGET AUDIENCE:
Primary Care Physicians, Family Practice, General Practice, Endocrinologists, General Surgeons, Oncologist, PA-C’s, NP’s and all Allied Health Professionals who work in primary care field.

TO RSVP:
Email: Ric Morales, Director - Physician Relations
Rmorales3@communitymedical.org or ph. (559)459-6211

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: Christina Maser, M.D. and event planners Ric Morales have no disclosures to make.
CME Dinner Lecture
Cystic Fibrosis Disease Spectrum and State of the Art Therapies

**LOCATION:**
The Petroleum Club
5060 California Ave., Bakersfield, CA

**DATE/TIME:**
May 26, 2016
Thursday: 6:30 pm – 8:30 pm

**SPEAKER:**
Paul Do, M.D. - Pediatric Pulmonologist
John Moua, M.D. - Pediatric Pulmonologist
UCSF │ University Pediatrics Specialists, Fresno

**JOIN US TO:**
1. Gain better understanding and put into practice knowledge of the spectrum of disease and the general types of genetic defects that occur in Cystic Fibrosis patients
2. Become aware of the new State of the art therapies for Cystic Fibrosis and apply to improve patient care.

**ADDITIONAL INFORMATION:**

**TARGET AUDIENCE:**
Pediatricians, Family Practice Physicians, Nurse Practitioners and Physician Assistants.

**TO RSVP:**
Email: Ric Morales, Director - Physician Relations
Rmorales3@communitymedical.org or ph. (559)459-6211

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: Paul Do, M.D. and John Moua, M.D. and event planner Ric Morales have no disclosures to make.
**2016 CENTRAL CALIFORNIA TRAUMA SYMPOSIUM**

**Thursday, May 26, 2016**  
**7:00 AM – 5:00 PM**

**LOCATION:**  
Fresno Convention Center-Exhibit Hall  
848 M Street  
Fresno, CA

**COST:**  
$95/person  
Breakfast, lunch, and afternoon snack provided. Free parking included.

7.5 BRN and EMS credits provided

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 7.5 AMA PRA Category 1 Credit(s) TM. 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.

**SPEAKERS:**  
Jim Davis, MD, Jerry Jurkovich, MD, David Turay, MD, Patil Armenian, MD, Michael Allshouse, DO, Danielle Campagne, MD, Lois Blough, RN, Jennifer Hubbard, MD, Amy Kwok, MD, Nancy Parks, MD, Jordan Lilenstein, MD, Steven Riccoboni, MD.

**TARGET AUDIENCE:**  
Emergency physicians, trauma surgeons, neurosurgeons, critical care nurses, emergency room nurses, emergency medical providers, respiratory therapists, intensivists, researchers and scientists in the field of critical care and trauma.

**ATTENDEES WILL:**

1. Have a better understanding and implement current trends in trauma and critical care management in the emergency and ICU settings, and apply this to achieve better outcomes.

2. Acquire specific training techniques and new metrics for teaching and monitoring resuscitation performance, and be able to add this competency to one’s practice.

3. Be able to identify early intervention and new therapies in the management of trauma patients, put that knowledge into practice and show how this can improve patient outcomes.

**Coordinating Organizations**

To register, visit: [https://2016traumasymposium.eventbrite.com](https://2016traumasymposium.eventbrite.com)  
Phone: (559) 459-5130
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>0700-0800</td>
<td>Registration/Breakfast/Vendor Booths</td>
</tr>
<tr>
<td>0800-0830</td>
<td><strong>Introduction to Trauma</strong>&lt;br&gt;Lois Blough, RN</td>
</tr>
<tr>
<td>0830-0930</td>
<td><strong>Pelvic Injuries</strong>&lt;br&gt;Jim Davis, MD</td>
</tr>
<tr>
<td>0930-0945</td>
<td>Break/Vendor Booths</td>
</tr>
<tr>
<td>0945-1045</td>
<td><strong>Lessons Learned from 2500 Trauma Deaths</strong>&lt;br&gt;Jerry Jurkovich, MD</td>
</tr>
<tr>
<td>1045-1145</td>
<td>Research Podium Presentations</td>
</tr>
<tr>
<td>1145-1245</td>
<td>Lunch/Vendor Booths</td>
</tr>
<tr>
<td>1245-1345</td>
<td><strong>Toxicology in Trauma</strong>&lt;br&gt;Patil Armenian, MD</td>
</tr>
<tr>
<td>1345-1445</td>
<td><strong>Lessons Learned from Loma Linda</strong>&lt;br&gt;David Turay, MD</td>
</tr>
<tr>
<td>1445-1500</td>
<td>Break/Vendor Booths</td>
</tr>
<tr>
<td>1500-1600</td>
<td><strong>SHOW SOME RESTRRAINT PLEASE!</strong>&lt;br&gt;Automobile safety and injury in children passengers&lt;br&gt;Michael Allshouse, DO</td>
</tr>
<tr>
<td>1600-1700</td>
<td><strong>Wilderness Case Study</strong>&lt;br&gt;Danielle Campagne, MD and Steven Riccoboni, MD</td>
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</tbody>
</table>
ADVANCED FETAL MONITORING:
A STANDARDIZED APPROACH

SPEAKER:
Lisa Miller, CNM, JD – Professional Education Center

SAVE THE DATE

DATE:
Friday, June 3, 2016
7:30 am - 11:30 am
Breakfast will be provided

LOCATION:
H. Marcus Radin Conference Center
The Palm Room

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

CME: 4.0 – applied for

RSVP:
Jessica Lipsius at:
(559) 324-4002
jlipsius@communitymedical.org
San Joaquin Valley, Geriatrics Interdisciplinary Group

Recognizing Elder Abuse; Keeping our Elders Safe, It Takes a Community!

Speaker

Diana Homeier, MD
Assistant Professor of Clinical Family Medicine
Director of the Geriatric Medicine Fellowship Training Program, Keck School of Medicine of USC

Date, Time and Location

Wednesday, June 15th, 2016 from 12:00pm – 2:00pm
11:30 am: Boxed Lunch and Senior Service Information Tables
12:00pm-1:00pm: Keynote Speaker (no food in Auditorium)
1:00pm-2:00pm: Roundtable Resource Group Discussion
UCSF Fresno Auditorium and Breakout Room 137

Moderators

Alex Sherriffs, MD, UCSF Fresno, Alzheimer's & Memory Center
Adriana Padilla, MD, Family and Community Medicine, UCSF Fresno

Objectives

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

• Identify and understand the three major red flags of potential elder abuse and incorporate into practice
• Gain knowledge in the interpretation of a Cognitive Screen and use this knowledge in practice
• Identify three resources in elder abuse determination and resolution, thus improving patient care

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 2.0 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. Certificates available upon signing in.

Disclosures: Activity Director, Adriana Padilla has no disclosures, Moderator, Alex Sherriffs, MD has no disclosures, Speaker Diana Homeier, MD has no disclosures.
Save the Date
Perinatal M & M Presents:

“Neonatal Herpes”
Wednesday, June 15, 2016 from 12:30pm – 1:30pm
UCSF – Fresno, Room: 136

“Congenital Malformations of the Lung”
Wednesday, August 17, 2016 from 12:30pm - 1:30pm
UCSF – Fresno, Room: 136

“What’s New in NRP”
Wednesday, September 21, 2016 from 12:30pm – 1:30pm
UCSF – Fresno, Room: 136

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

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

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.
Endocrinology Month

Tuesday, May 3, 2016
12:30-1:30pm
“I have a lump in my throat’ – Approach to Thyroid Nodules”
Animesh Sharma, M.D.

Tuesday, May 10, 2016
12:30-1:30pm
“We’re All in this Together: Patient and Family-Centered Rounds”
Mike Weisgerber, M.D./ Heather Toth, M.D.

Tuesday, May 17, 2016
12:30-1:30pm
“Short Stature Disorder”
Sarah Brickey, M.D.

Tuesday, May 24, 2016
12:30-1:30pm
“Genetic Testing for the Everyday Clinician”
Aaina Kochhar, M.D.

Tuesday, May 31, 2016
12:30-1:30pm
“EMRT Code Blue” (not videoconferenced)
Mary Jo Quintero, RN

Thursday, May 5, 2016
12:30-1:30pm
“Congenital Hypothyroidism”
Swati Banerjee, M.D.

Thursday, May 12, 2016
12:30-1:30pm
No lecture scheduled

Thursday, May 19, 2016
12:30-1:30pm
“Schwartz Rounds”
Linda Keele, M.D.

Thursday, May 26, 2016
12:30-1:30pm
“Optimizing Bone Health in Children”
Animesh Sharma, M.D.
May 2016

May 5
“Emerging Neuromodulation Technologies in Psychiatry”
Ian A. Cook, M.D.
Director, UCLA Depression Research & Clinic Program
Professor of Psychiatry and of
Bioengineering Neuromodulation Division
Semel Institute for Neuroscience & Human Behavior at UCLA

May 12
No Grand Rounds – Resident Open Meeting

May 19
TBD
Christine Obata, MD
Assistant Clinical Professor
Department of Psychiatry

May 26
“Coming of Age in the 21st Century”
Karen Kraus, MD
Associate Clinical Professor
Department of Psychiatry

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CONTINUING MEDICAL EDUCATION May 2016 Page 1

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CONTINUING MEDICAL EDUCATION  May 2016  Page 2
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**Memo**

- **30**
  - Memorial Day Holiday

**Holiday**