I loved the point-and-shoot (P&S) cameras because of their light weight and ease of use, and I wondered why some people still carried large, bulky cameras. All that changed when I was introduced to digital single-lens reflex (DSLR) cameras about three years ago by our internist friend, Kevin Nguyen, MD. At a family event, he shot with a DSLR while I used a P&S, and we compared the pictures afterwards. The following week, I bought a DSLR and have not turned back.

I taught myself the various functions of the DSLR camera with online materials. I found bird photography quite challenging and fell in love with its ephemeral beauty. About 90% of my photography subjects are birds, and I go out to the fields whenever I can. Serious bird photography requires a long focal lens and a camera with fast and accurate autofocus system combined with high frame rate, about 10 frames per second. It also demands great patience in the photographer. It’s not uncommon to wait hours on end to capture just the right moment of the birds, because a second chance may not come. I began by taking pictures of perched birds. As time has gone on I have gotten better and I can now try to take pictures of birds in flight or in the midst of some other actions.

Alongside enjoying my family with four children and bird photography, I also practice anesthesiology full time and have been with CMC 18 years and counting.
The 2nd Annual Medical Staff Spring Fling occurred last week with rave reviews from attendees. Historically, the medical staff event has been a holiday season gathering, but with an increasingly busy December schedule for many, the decision was made to move it to a pre-summer date. I guess the word got out this year, as the attendance of around 350 was double last year’s total.

The theme was “Changes in Latitude” and most who came caught the “Caribbean attire recommended” on the invitation. Guests were treated to original Caribbean dishes from the chef at Five Restaurant, a select menu of tropical cocktails, and an amazing steel drum musician who kept the evening going. There was great representation from all of our facilities and administration.

The mixer is designed to show appreciation for the medical staff and allow for members to relax and enjoy the casual company of colleagues. It looks like based upon this year’s response, we’re going to have to find a larger venue for next spring in hopes that ALL medical staff members will be able to attend! We thank our friends Pat and Marina LaRocca at Five restaurant for allowing us to invade their space and turn it in to our tropical paradise.
Initial Appointment to the Medical Staff
effective May 12, 2016

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

Kam Lun Au M.D.
Department: Medicine
Specialty: Internal Medicine

Paul Brakeman M.D., Ph.d.
Department: Pediatrics
Specialty: Pediatric Nephrology

Ananthakrishna Chilukuri M.D.
Department: Radiology
Specialty: Tele-radiology

David Dalzell M.D.
Department: Radiology
Specialty: Tele-radiology

Silvester Kagunye M.D.
Department: Surgery
Specialty: Anesthesiology

Cynthia Myers M.D.
Department: Pediatrics
Specialty: Pediatrics Cardiology

Anne Prentice M.D.
Department: Surgery
Specialty: General Surgery

Emily von Scheven M.D.
Department: Pediatrics
Specialty: Pediatric Rheumatology

Initial Appointment to the Medical Staff
effective May 12, 2016

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

Raha Borazjani P.A.
Department: Surgery
Specialty: General Surgery

Jennifer Minassian P.A.
Department: Emergency Medicine
Specialty: Emergency Medicine

Crystal Miranda P.A.
Department: Surgery
Specialty: Cardiothoracic Surgery

Josette Salas C.R.N.A.
Department: Surgery
Specialty: Anesthesiology

Frederick Wu P.A.
Department: Emergency Medicine
Specialty: Emergency Medicine

JUNE PHYSICIAN PHOTOGRAPHER
HUA PHAM M.D.

Tern catching a fish
Clovis Community Medical Center and Fresno Heart & Surgical Hospital both earned Healthgrades® Outstanding Patient Experience Award TM for delivering care in a way that patients consistently say is amazing. The recognition puts the two Community Medical Centers hospitals in the top 10 percent in the nation for patient experience.

“We built a hospital designed for comfort and privacy and our physicians and staff focus on delivering truly exceptional care. I’m proud of this acknowledgement of our wonderful employees and physicians,” said John R. Kass, RN, chief operations officer at Clovis Community. “Locally we’ve been voted “Best Hospital” three years in a row, so we know our patients are recommending us after their experience here. It’s really nice to have that recognition from a national health ratings agency.”

Healthgrades recognized 448 hospitals nationwide this year for creating a top patient experience, with quiet, clean surroundings, good communication to patients and staff that is warm, friendly and responsive. Healthgrades evaluated 3,858 hospitals and based the 2016 Patient Experience Award on patient survey data collected by the Centers for Medicare and Medicaid Services (CMS), covering admissions from April 2014 – March 2015. Patients are asked to rate their stays as part of the Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS.

The federal HCAHPS initiative gathers patient responses to 32 survey questions related to physician and nurse communication, speed of responsiveness, hospital cleanliness and noise levels, medication information, pain management and post-discharge care instructions. The survey, which is reported publically, is designed to collect data so health consumers can make objective and meaningful comparisons among hospitals on issues that are important to patients.

“Consumers are increasingly using patient experience and satisfaction as a measure to both evaluate hospitals and to select where they want to obtain care,” said Evan Marks, Healthgrades chief strategy officer. “We commend those hospitals that have achieved the Healthgrades 2016 Outstanding Patient Experience Award for delivering superior patient care experiences during their hospital stay.”
Just a few weeks ago, I had the privilege of celebrating the 10th anniversary of the Marjorie E. Radin Breast Care Center at Clovis Community Medical Center with all who made it possible. Such an extraordinary group of leaders, physicians, donors and staff!

What began as an ambitious idea was made possible through a donation from the Radin Foundation and other generous donors – changing the lives of so many Valley women and men seeking the very best in breast care services. From screenings to diagnosing and treating those with breast cancer all in one place, the Radin Breast Care Center has performed more than 85,000 mammograms and its multidisciplinary clinic has treated about 1,500 patients since opening in 2006.

“I don’t think even the Liaos knew what impact that donation by the Radin Foundation would have on this region... A building is a building, but it’s the people that really make the experience.”

– Dr. Judy Champaign, who has been at the Radin Center since the beginning.

I want to once again thank the Radin Foundation and all who support the Radin Breast Care Center for creating this gem for people in the Central Valley.

But we aren’t done! We need your help now more than ever to advance this vital work. You may have recently heard about Community’s plans to build a $65 million regional cancer and research center on the Clovis Community campus.

Our goal is to take the model of the Marjorie E. Radin Center and construct a world-class cancer center – one that provides all outpatient cancer services in one place to improve delivery of care in the Valley and reduce the amount of people who have to leave their homes and loved ones to get the care they need.

In the words of Marjorie E. Radin:

“If you are going to grow and achieve – you must learn to expand.
Love, give and graciously receive.”

To support the Marjorie E. Radin Breast Care Center and the future of cancer care, call Community Medical Foundation at 559-459-2670 or email foundation@community-medical.org.
It is OK Not to Be OK, Even for Doctors!

Physicians in America are reporting increasing levels and frequency of stress and burnout. Several recent studies have investigated issues such as substance abuse, burnout, medical errors, suicide risk, and disruptive behaviors among physicians. The findings consistently display an upward trend for all of these issues. In 2015, 45.6% of doctors said they suffer severe stress and/or burnout. This is an increase from 37.7% in 2011. That is a 21% increase in the experience of stress and/or burnout in just four years. Over 50% of the factors that contribute to disruptive behavior by doctors is attributed to work related issues. Alarmingly problems with work were three times more likely to have contributed to a physician’s suicide than a non-physician’s. Research over the past 10 years consistently shows that doctors minimize the impact of stress on their mental and physical health, and infrequently take time off away from work.

The article referenced below provides interesting thoughts and helpful ideas on the tendency for physicians to expect too much of themselves without doing an adequate job of taking care of themselves. In fact, acknowledging that “it is OK not to be OK” can open doors to better self-care which will enable the doctor to enjoy meeting the challenges of a rewarding medical practice.

Editor’s Note: Guidance on life balance for busy physicians and their families is an ever-green topic, and thanks to Well Being Committee Chair Dr. Adams for the above introduction. Some readers may be familiar with the on-line publication Physician Family. A recent essay titled “It’s OK not to be OK” was written by “certified life coach for physicians” (who knew?) Maria Lesetz. Print readers can find it by searching the publication and article titles above.

In the article the author states that to deal with burnout in all its forms, physicians have to shed the idea that they have to be “invincible.”

“Physicians have told me that if they even addressed the topic of burnout, it was seen as a symptom of weakness,” she notes. “Expressing your feelings is one of the most important action steps to take if you want to maintain great health, both physically and emotionally.”

She said challenging the culture of invincibility would benefit physicians, their families and the profession as a whole.

Lesetz suggests several action items to begin building balance and wellness:

- **Create a “best year yet” plan to set goals for the road ahead, both personally and professionally.** Doing so can support balance and set the tone for your life.
- **Don’t medicate... meditate.** Bringing mindfulness techniques to your daily routine will combat reliance on such things as prescription drugs and alcohol to deal with stress. A short break is all that is needed to practice meditation and mindfulness, she said.

If you build habits of presence into your daily routine, it will profoundly impact how you feel on the inside.

- **Family members of physicians should offer their physician loved one the chance to make a stress-free transition from work to home each day by letting them unwind in their own way.** Family members also can help reach out to others if troubling signs, such as burnout or addiction, begin to appear in their physician loved one.

“The bottom line is, it’s OK to not be OK,” Lesetz said. “It only takes one courageous action step to turn the course of your life around.”

“Life is bristling with thorns, and I know no other remedy than to cultivate one’s garden.”

– Voltaire, writer and philosopher
As we mentioned last month, these arcane-sounding acronyms will soon shape a sizable part of the financial and reporting relationship between most US physicians and Medicare. Similar major transformations away from volume-based payment are also developing in the private sector and Medicaid.

Last month we told you that the proposed MACRA (Medicare and Access and CHIP Reauthorization Act) Final Rule for Physician Payment is available for review and comment until June 27. We again provide a link to it above.

This month we have three helpful references for those wanting to learn more without wading through the 962 page document. Specialty societies are also carefully reviewing it and sharing information, of course.

Resources:
• An open access opinion piece in JAMA by former CMS senior leaders Drs. Mark McClellan and Jeffrey Clough is titled “Implementing MACRA: Implications for Physicians and for Physician Leadership.” Print readers can easily find it online.
• Health IT consulting firm Saignite has published a comprehensive and well written “10 FAQ about the Merit-Based Incentive Payment System (MIPS)” It is a great introduction to a very complex topic. Print readers can easily find it online.
• CMS has published a PowerPoint tutorial on MACRA which is reasonably easy reading. Print readers can search “CMS and the Medicare Access and CHIP Reauthorization Act of 2015 Path to Value.”

If you need further incentive (did we say that word?) to learn more, here is the MIPS timeline (taken from CMS).
The only way to make sense out of change is to plunge into it, move with it, and join the dance.

– Alan Watts

The only way to make sense out of change is to plunge into it, move with it, and join the dance. And here we are, closing in on summer… which marks my one year anniversary with CMC! It’s been a great year, meeting new people, learning about the organization, building the Informatics team… and while summer typically brings a justification to breathe just a little more easily, a sense of slowing down and enjoying lazy days with warm (ok, hot!) weather, let me assure you that we, Informatics, will NOT be slowing down!

OnBase, the new document imaging solution is now live with relatively few hiccups. The few that came up are being resolved as I write… hopefully, you’re finding it easier to use the Patient Viewer window on the media tab with clearly defined tabs to review any scanned documents. The two issues that merit mention:
• Specialist OnCall Consults that are scanned in are not linking to a Consult Note Type
• This is being investigated. They ARE found on the media tab at this time.
• Slight delay in scanning ECG/EKG scans
• HIM is scanning these separately from the rest of the patient chart post-discharge. Clinicians may see other patient encounter records released in Epic prior to the ECG/EKG document type. Delay is minutes to a few hours.

Radiant, the new Radiology system is currently in progress, with a tentative go live of next summer… the teams are working on clear workflows, identifying significant naming convention changes for orders, and impacts for results routing.

E-prescribing of Controlled Substance (EPCS) has a pilot ongoing as I write – first with ACC Internal Medicine users, then with Clovis ED users. If those go well, we anticipate being able to open up the functionality to everyone sometime late summer. Be on the lookout for information about getting ‘identity-proofed’ through Medical Staff Office… and know that we will be using that time to validate the information we have on file about you – office addresses, faxes, emails, etc., just so we can stay current. You’ll also get instructions on how to download a soft token application to your smart phone to use.

A few other things are on the horizon… the EPIC 2015 and 2016 upgrades (timeline decisions to be made soon), improved education and training for onboarding staff and physicians, looking at additional EPIC modules to support additional specialty groups within CMC, continued completion of the current pipeline of change requests from Joint Informatics Council.

And now, I’m off to slip on some sandals and enjoy the sunshine… more to come!
As always, please feel free to reach out… I look forward to hearing from you.
The rooms were filled with music, food, and wine, as the judges and participants inquired about the different projects displayed in poster format at the event.

One of the aims of the symposium was to ensure people know that UCSF-Fresno, CRMC, and CMC are synonymous with the words “quality improvement”, “innovation”, and “collaboration”. These are words ingrained in our DNA and words we live by every day.

At the end of the day, cash prizes and trophies were presented to the winners.

Third place went to the Department of OB-GYN, Drs. Mai Tran and Mallory Kremer for their project, “Effectiveness of Providing Immediate Postpartum Long-Acting Contraceptives in Preventing Unintended Pregnancies”.

First place went to the Department of Surgery and Drs. Emaad Farooqui, Nancy Parks and Rachel Dirks for their project, “Ground Level Falls in the Elderly: Always a Traumatic Event”.

Second Place went to the Department of Emergency Medicine, Jennifer Trytten, Elisa Brown and Drs. Nicole Wojtal, Jeffrey Uller, Tom Utecht, and Ednann Naz, for their project, “Heart Pathway Project: Low-Risk Chest Pain in the ED”.

Thanks again to all the residents, fellows and attending physicians who participated in the event, submitted posters and helped make this first symposium such a memorable evening for all of us.

See you next year!

“Success is stumbling from failure to failure with no loss of enthusiasm.”

– Winston Churchill
Many readers will remember Emily Friedman, who spoke at 3 of our Winter Symposium events in earlier years. Emily was not a physician but she was raised in a physician’s family and became an observer of and commentator on the medical world at-large. She had an incisive and clever mind, an endless appetite for whatever the world could teach her, and a knack for identifying contradictions, ethical gaps, and missed opportunities in US health care and health policy. She was a widely quoted columnist and blogger, and had been one of the 100 most influential individuals in US health care several times. She passed away in mid-May in her hometown of Chicago.

One of the (many) things she was passionate about was public health and the social determinants of health. We have reprinted below one of her last blog posts. Those who knew Emily will agree she pulled no punches and will imagine how she might have orally delivered the pithy message below. This essay emphasizes Fresno County Public Health Officer Dr. Ken Bird’s essays in our recent issues about the high-level importance of Public Health investment.

Thank you Emily Friedman, for enriching our Winter Symposium events and for challenging CMC medical audiences to do – and be – better.

Originally published on April 5, 2016

**Before It’s Too Late: Defending Public Health**

*by Emily Friedman*

Public health has been consistently underfunded and neglected in this country. Will the interest in population health and the emergence of new infectious threats change that?


Our health care system has become infatuated with the concept of population health – even the insurers are expressing interest, although that appears to be rooted in financial concerns (it’s less expensive to insure people if they are in good health) – and yet we continue to underfund, disdain and sometimes even dismiss the work of public health professionals and their agencies, even when they are the ones on the front lines of stopping these plagues before it’s too late.

**The tragedy in Flint**

It’s already too late in Flint. Hundreds of children have been poisoned and will have to be monitored for the rest of their lives for brain and neurological problems caused by contaminated water from the Flint River. The city, which is deeply in debt and whose population is largely African-American, was switched by an “emergency manager” appointed by the state from Lake Huron water to river water in order to save money. Residents soon noticed that the water smelled odd and came in a variety of colors. They were told not to worry. Flint is now a disaster area. When Flint officials tried to reconnect their water supply to the Detroit system, the new emergency manager refused the request. Flint was finally reconnected to the Detroit water system in October, but the damage was done. In addition to lead levels, there was evidence of Legionnaire’s disease in some residents, 10 of whom died.

I can’t help but wonder if this had happened in, say, the wealthy suburb of Grosse Pointe, Mich., something might have been done to stop this tragedy. As award-winning documentary filmmaker Michael Moore – a native of Flint – wrote in Time magazine on Feb. 1 of this year, “When the governor found out, he kept quiet and let the poor of Flint continue drinking the poison. Marie Antoinette would have been proud. Except this time no one offered any cake. ‘Let them drink the Flint River’ has a nice ring.”

The governor of Michigan said he was real sorry.

**Other plagues**

Politicians have their foibles and preferences and priorities. What the American public has is a neglected public health system. Whether it’s the U.S. Public Health Service, the Centers for Disease Control and Prevention or state and local public health departments, they are our first line of defense. And yet they have to scratch for money.

The CDC – a spectacular and elite agency that is called on by many nations to investigate and curb outbreaks of infectious disease – has already produced an easy-to-use test for Zika virus, which isn’t bad, considering the virus just became a problem a few months ago. The CDC predicts 3 million to 4 million cases of Zika virus in the Americas within a year – a happy thought with the Olympics being held in Brazil.

Because the population who were at Ground Zero when AIDS emerged – that is, gay men – were not popular with See Friedman on page 12
Friedman

Continued from page 11

political leaders at the time, the epidemic was ignored, and the world has paid the price. According to the Stephen Lewis Foundation, most of an entire generation in some parts of Africa has died. Grandmothers are raising their grandchildren, as there is no one left alive to do it other than them.

Tuberculosis is making a comeback. And the new strains are much more virulent and more resistant to existing antibiotics than the previously extant ones.

The Chipotle restaurant chain either didn't wash its vegetables or didn't care where they come from. The bugs don't care; they're just trying to make a living like the rest of us.

It's gotten to a point, with me, that I only drink bottled water and won't eat lettuce or any other fresh fruit or vegetable unless I have washed it personally. I have had all the episodes of food poisoning I care to experience, not to mention a bout of norovirus that was unforgettable. I can't imagine how dreadful it must be to get that disease on a cruise ship. And, in fact, some of Chipotle's suppliers also provide food to cruise lines. It's swell to proclaim that you are using foods free of genetically modified organisms and pesticides, but could you please check for bacteria and viruses?

The need for robust public health services

The first state public health department was founded in Massachusetts in 1889, but the roots of public health go back much further than that, to hospitals for merchant seamen that were built as early as 1799. The idea behind this, not surprisingly, was that port cities (Hawaii also established a public health department early on) received visits from hundreds of merchant seamen who could have been carrying any one of a number of diseases.

Acknowledging that health care professionals had to be trained in the techniques of public health – such as they were back then – Johns Hopkins University established the first formal school of public health in the United States in 1916, soon followed by Harvard University and the University of Michigan.

We’ve been fighting over how much power public health authorities should have ever since. Generally speaking, public health agencies are the only powers that can impose quarantine, which goes back to the time when that was our only protection against infectious disease. Public health agencies can encourage better health habits – don’t use tobacco, keep your weight down and so forth – but these are suggestions. There are also middle grounds where public health meets law enforcement – you can drink alcohol to excess if you want, but you cannot legally drive a motor vehicle if you are in that state. If you want to be promiscuous, we cannot stop you, but if you have AIDS or another sexually transmitted disease, use a condom. One of my mentors, a public health professional of the highest order, one day just went out and closed all the gay baths in his city in order to stop the spread of AIDS. It was probably illegal, but he was not in the habit of taking prisoners, and he wanted to prevent the kind of epidemic that had occurred in New York City, Los Angeles and San Francisco.

We fight over fluoridation of water, use of vehicle seat belts and helmets, immunization and numerous other activities involving the public’s health that produce a collision of individualism and community. And we will keep on doing so.

The challenge that most public health agencies face is that if they are good at what they do, no one notices. It is very difficult to prove a negative. As I often tell the audiences to whom I speak, no one is going to make the news by pointing someone out and saying: “Look! She doesn’t have measles!”

Public health work is, by its nature, mostly silent and unnoticed, which is why it is chronically underfunded and unappreciated. Its professionals do inspections, monitor food quality, watch for disease outbreaks and conduct laboratory analysis, and the rest of us don’t notice. And then someone gets salmonella from the local delicatessen and everyone has kittens.

The aspect of community

In a brilliant article in the Hastings Center Report in December 1985, Dan E. Beauchamp laid out the argument that public health lies at the heart of community, that it is one of those rare activities that supersedes the American embrace of individualism. In the article, he quotes Lemuel Shattuck, a Massachusetts legislator and early public health pioneer, who wrote in 1850:

“The condition of perfect public health requires such laws and regulations as will secure to man associated in society the same sanitary enjoyments that he would have as an isolated individual; and as will protect him from injury from any influences connected with his locality, his dwelling house, his occupation, or those of his associates or neighbors, or from any other social causes. It is under the control of public authority, and public administration; and life and health may be saved or lost, and they are actually saved or lost, as this authority is wisely or unwisely exercised.”

We are all members of the human community, and there are times when we must make minor sacrifices – stopping at traffic lights, not socializing if infected with a contagious disease, being a responsible firearms owner – in order to protect the entire community. It really does not seem to be a lot to ask.

Partnerships and public health

If we really are serious about population health – and I

See Friedman on page 13
am not entirely convinced that we are – then we had better understand that public health is population health, and our public health folks are better at it than most of the private sector.

There are hospitals and health systems that have partnered with and championed public health agencies, and they should be congratulated for that effort. We are only going to stop unnecessary death and disability if we are all in this together. Just ask the people of Flint.

As Beauchamp also wrote, “In political individualism, seat belt legislation, or signs on the beach restricting swimming when a lifeguard is not present restrict the individual’s liberty for his or her own good. In this circumstance, the appropriate language is ‘the life you save may be your own.’ But in the second language of public health, these restrictions define a common practice that shapes our life together, for the general or the common good. In the language of public health, the motto for such paternalistic legislation might be, ‘The lives we save together might include your own.’

Our public health colleagues devote themselves to protecting the rest of us. It’s time we made a commitment to protect them.
More on Opioid Abuse in the USA

Editor’s note: Last month we featured the new CDC Guidelines for Prescribing Opioids for Chronic Pain. (Find those guidelines here; print readers can find them by searching the guideline title and CDC).

There continues to be much emphasis in the medical and lay press on how we as physicians can address this many years-in-the-making crisis (with the help of appropriate data bases and other necessary structure around us, of course). And all this was before Prince’s opioid-related death.

The American Medical Association has stepped up impressively with many resources and a commitment to the problem. At the day-to-day level, strong communication between physicians and patients at risk for or suffering from substance abuse is vital. This piece from AMA Wire (5/2/2016; used with permission), offers advice and links to resources:

**How to Talk About Substance Use Disorders with Your Patients**

Though it can be difficult, it’s essential for physicians to speak with their patients about substance use disorders, proper use of opioid medications and medication-assisted treatment – doing so can be a key component to both pain management and overdose prevention. Find out how one physician in San Francisco approaches the conversation around preventing and treating substance use disorder with his patients while avoiding stigma in the process.

With 78 people dying from prescription opioid and heroin overdoses each day in the United States, having the conversation about the risk of substance use disorders and the need for treatment for those who have one is critical for patient safety.

“It’s a challenging conversation to have,” said Phillip O. Coffin, MD, director of substance use research at the San Francisco Department of Public Health and an internal medicine and infectious disease specialist. “I struggle with it myself all the time.” But there are ways to approach the topic with your patients and partner with them in preventing misuse and overdose, or in getting treatment for a substance use disorder.

**3 core components to the conversation**

Dr. Coffin’s expertise includes HIV management, viral hepatitis care, and substance use disorder treatment and research. Some of his patients have substance use disorders that involve prescription opioid medications or heroin, and he is working hard to make sure they are provided the best treatment possible.

“There is no easy answer,” he said of his approach to the discussion of substance use disorders. “It’s really about exploring it with the individual patient.”

Dr. Coffin offered these three elements that should be part of the conversation about substance use disorders to avoid the stigma that could be a roadblock to patients taking the appropriate steps for their health:

1. **Honesty.** “The most important piece of the story is to always be forthright and honest with your patients about the issues you’re addressing,” Dr. Coffin said. “It’s about patient-centered care, [and] it’s quite rare that patients are coming in looking to reduce their opioid dose.”

2. **Medication-assisted treatment.** For patients with a substance use disorder, Dr. Coffin said he will “almost uniformly offer them buprenorphine and try to encourage them. There may be no interest initially, and it may take months or even years of speaking with patients to get them to consider and actually engage in a transition from full agonists or street opioids to buprenorphine.”

   “I have seen remarkable success with this approach, but it can take a long time of working with a patient,” he said. “For example, you may have, or have inherited, a patient on opioid medications for pain who is very high risk for overdose, who has multiple unprescribed opioids and stimulants in urine studies and has raised concerns about medication diversion,” he said. “If you discontinue opioids but are able to keep the patient engaged, you spend time really worrying about the welfare of the patient because they’ve resumed or increased heroin use, and their life is more chaotic.”

3. **Opioid agonists or street opioids to buprenorphine.**

   “Every time you see them, you talk about buprenorphine, and each time they come back they have something positive to say about buprenorphine,” he said. “Sometimes what they come back with is what you told them six months ago, and other times what they’ve heard from talking to other people who have taken buprenorphine. Like with other therapies – such as insulin – over time you can eventually help them make a transition.

   “I can’t emphasize enough how transformative buprenorphine maintenance can be,” Dr. Coffin said. “It can be a remarkably powerful intervention, and it also happens to be quite good for pain management. Not to say you do the prescription and then the problem is no longer an issue at all. Insulin for a person with severe diabetes remains a good analogy; Buprenorphine requires ongoing management, but it solves so much of the core problem.”

See Opioid page 15
3. Treat substance use disorder as a disease. “You can treat patients with buprenorphine in the context of other substance use disorder treatment – behavioral or cognitive behavioral psychological therapy,” he said, “but it also has been shown to be highly effective when implemented in a regular medical setting with the counseling that you get from a primary provider.”

“It is important that you talk with your patient about their substance use on a regular basis when you prescribe them buprenorphine,” Dr. Coffin said. “You don’t just have them come in, renew their prescription, talk to them about their other medical conditions and ignore their substance use. You have to sit down and talk about it.”

“When I’ve started seeing patients already on opioids for pain who have multiple risks, opioid use disorder or concerning findings on urine toxicology, it’s really hard to do a 15-minute visit and actually address the issue,” he said. “The visits tend to be long and resource heavy, and hard to complete without a strong supportive team approach to care.”

“When you bring buprenorphine into the picture,” he said, “substance use becomes one of the three or four issues that you talk about in a patient visit and that, frankly, makes it much more like other diseases that a primary care doctor manages.”

“You want to ask them how they’re doing with their medication,” Dr. Coffin said. “Are they tolerating it, are they having any side effects, are they getting what they need out of the medication? Are they using any heroin?… And if the answer is ‘a little bit,’ then you ask them what you can do together to decrease how often that happens.”

“Think of it a lot like talking to a patient with diabetes about their sugar intake per day,” he said. “What can we do to try to reduce that and help you keep your disease under control?”

Reducing the stigma of substance use disorders and enhancing access to treatment for those who have a disorder is one of the five things physicians can do to prevent opioid abuse, recommended by the AMA Task Force to Reduce Opioid Abuse, which physicians convened to help the nation move closer to the goal of ending the opioid epidemic.

For more on efforts to end the opioid epidemic:

- Learn how President Obama’s opioid initiatives align with the Task Force’s recommendations.
- Read a call to action for physicians to turn the tide of the opioid epidemic.
- Find out what.

(Print readers can access these helpful links through this article on line. Search AMA Wire and article title)
To Use or Not to Use? Thiazolidinediones in Heart Failure

By Laurie Wright, Pharm.D., PGY1 Pharmacy Resident and Tamar K. Lawful, Pharm.D., Transitions of Care Clinical Pharmacist

Background. There has been interest in whether thiazolidinediones (TZDs), an antidiabetic class of medications, cause more benefit or harm when used in patients with heart failure. Potential benefits may include a decrease in certain risk factors for cardiovascular disease. Risks include the development of fluid retention, which may cause or exacerbate heart failure. Assessing hospital readmission rate associated with the use of TZDs is also an important consideration when evaluating this therapeutic option in heart failure patients.

Thiazolidinediones. TZDs are used as monotherapy or in combination with other medications for glycemic control in patients with type 2 diabetes. TZDs increase sensitivity to endogenous insulin by acting as agonists of peroxisome proliferator-activated receptor-gamma (PPAR). PPAR receptors are found in many tissues throughout the body, including the liver, skeletal muscle, and adipose tissue. The activation of these receptors results in an increased production of certain genes that play a crucial role in the control of glucose transport and metabolism. In addition to increasing glycemic control, TZDs can have a beneficial effect on several risk factors associated with cardiovascular complications, including blood pressure, lipid levels, endothelial function, fibrinolytic status, and inflammatory biomarkers. Current TZDs available in the United States include pioglitazone (Actos®) and rosiglitazone (Avandia®).

Weighing the Benefits and Risks of TZDs. Patients with type 2 diabetes have an increased risk of developing microvascular and macrovascular complications, including cardiovascular diseases. Because of the potential impact of TZDs on cardiovascular risk factors, there is interest in the use of these agents to reduce the risk of cardiovascular disease in type 2 diabetes patients in addition to improving glycemic control. However, the benefits of TZDs should be weighed against risks of therapy when deciding which patients are appropriate candidates for TZDs. One important risk to consider is the TZD side effect of fluid retention, reported by approximately 5% of patients taking rosiglitazone and more than 10% of patients taking pioglitazone. Because of this edema, in case reports and clinical trials both medications have been associated with newly developed heart failure and/or exacerbations of known heart failure. Studies have also shown that TZD use in heart failure patients have increased hospital readmission rates when compared to placebo and to an active control. This is particularly important to consider given the high rate of hospitals admissions in general attributed to heart failure, including over 1 million hospitalizations annually, a one-month readmission rate of 25%, and a six-month readmission rate of more than 50%.

TZD Association with Heart Failure. Key pieces of literature demonstrating the association between the use of TZDs and heart failure are described in Table 1.

Guideline Recommendations. In 2003, the American Diabetes Association (ADA) and the American Heart Association (AHA) published a consensus statement regarding the use of TZDs in congestive heart failure. This consensus statement identified heart failure risk factors in TZD patients (Table 2). In the 2013 Guideline for the Management of Heart Failure, the AHA and the

See Pharmacy Corner page 17
**Pharmacy Corner**

Continued from page 16

**TABLE 2:**

<table>
<thead>
<tr>
<th>Risk Factors for Heart Failure in TZD Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of diastolic or systolic heart failure</td>
</tr>
<tr>
<td>Prior myocardial infarction</td>
</tr>
<tr>
<td>History of symptomatic coronary artery disease</td>
</tr>
<tr>
<td>Hypertension</td>
</tr>
<tr>
<td>Left ventricular hypertrophy</td>
</tr>
<tr>
<td>Significant aortic or mitral valve heart disease</td>
</tr>
<tr>
<td>Advanced age (&gt; 70 years)</td>
</tr>
<tr>
<td>Long-standing diabetes (&gt; 10 years)</td>
</tr>
<tr>
<td>Preexisting edema or current treatment with loop diuretics</td>
</tr>
<tr>
<td>Development of edema or weight gain on TZD therapy</td>
</tr>
<tr>
<td>Concurrent insulin therapy</td>
</tr>
<tr>
<td>Chronic renal failure (creatinine &gt; 2 mg/dL)</td>
</tr>
</tbody>
</table>

American College of Cardiology Foundation recommend that drugs known to be potentially harmful in patients with heart failure with reduced ejection fraction (HFrEF), including TZDs, should be withdrawn or avoided (Class III recommendation, Level of Evidence: B). This guideline also recommends TZDs be avoided in patients with New York Heart Association (NYHA) Class II through Class IV heart failure, and identifies the use of TZDs as a common factor that precipitate acute decompensated heart failure. The ADA 2016 Standards of Medical Care in Diabetes similarly recommends against the use of TZDs in all patients with symptomatic heart failure (Level of Evidence: A).9

**Warnings from the Manufacturers.** Both pioglitazone and rosiglitazone have Black Box Warnings to notify patients and providers of the following: TZDs may cause or exacerbate heart failure in some patients; patients should be monitored closely and if they develop signs or symptoms of heart failure the TZD dose should be reduced or discontinued altogether; use of a TZD is not recommended in patients with symptomatic heart failure, and the initiation of a TZD is contraindicated in patients with NYHA Class III or IV heart failure (Figures 1 and 2).1,2

**Summary:** Despite the potential beneficial effects of TZDS on several cardiovascular risk factors, the risks of new onset or exacerbation of existing heart failure and increased heart failure hospital admission rates outweigh the benefits for certain patients. Specifically, TZDs should not be initiated in type 2 diabetic patients who concurrently have symptomatic heart failure (NYHA Class II – IV).1,5,9 Use of TZDs should also be avoided or withdrawn in all patients with HFrEF.7 All patients who are prescribed rosiglitazone or pioglitazone should be monitored closely for signs and symptoms of heart failure. If these symptoms develop and cannot be attributed to an alternative heart failure risk factor, therapy with TZD should be discontinued.

**References**
Antimicrobial Stewardship
Program Requirements Based on
Senate Bill 1311

By Kailee Shearer, Pharm.D., P.G.Y.1. Pharmacy Resident,
Stephanie Holcomb Pharm.D., M.H.A.,
and Marisa Méndez Pharm.D., M.P.H., B.C.P.S.

Antimicrobial Stewardship Programs. On April 13, 2016, the Infectious Diseases Society of America (IDSA) and the Society of Healthcare Epidemiology of America (SHEA) published an updated guideline regarding the implementation of effective antimicrobial stewardship programs (ASPs). According to these two professional organizations, as well as the Pediatric Infectious Diseases Society (PIDS), an ASP is defined as the “…coordinated interventions designed to improve and measure the appropriate use of [antibiotic] agents by promoting the selection of the optimal [antibiotic] drug regimens including dosing, duration of therapy, and route of administration.”1 As an essential component to healthcare quality, patient safety and public health, ASPs are designed to optimize clinical outcomes for patients while minimizing toxicity and adverse events associated with antimicrobial use, such as Clostridium difficile diarrheal infections and the continued emergence of multidrug resistant organisms.1,2 As healthcare systems continue to advance with new technology and clinical knowledge, implementation of effective ASPs will be at the forefront of improving patient outcomes.

California Senate Bill 13113. Approved September 29, 2014; act added to the California Health and Safety Code (CA HSC) section 1288.85
In September 2014, California made history by becoming the first state to pass a law requiring all general acute care hospitals to adopt and implement an ASP with the specific requirements listed below:

In order to help facilitate the completion of requirements with this new law, the California Department of Public Health (CDPH) developed an ASP Toolkit with recommendations and examples for ASP program implementation.4 An effective ASP was defined as a program containing the following 11 elements:

<table>
<thead>
<tr>
<th>Basic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implementation of an institution-specific ASP policy and/or procedure</td>
</tr>
<tr>
<td>• Creation of a physician-supervised multidisciplinary antimicrobial stewardship committee or workgroup</td>
</tr>
<tr>
<td>• ASP leadership support provided by a physician or pharmacist with antimicrobial stewardship training</td>
</tr>
<tr>
<td>• Regular reporting of ASP activities to hospital quality improvement committees</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intermediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Development of an annual antibiogram using Clinical Laboratory Standards Institute guidelines, distribution to the staff with follow-up education</td>
</tr>
<tr>
<td>• Development of institutional guidelines for the management of common infection syndromes</td>
</tr>
<tr>
<td>• Monitoring of antibiotic usage patterns by the facility by defined daily dosing (DDD) or days of therapy (DOT) to determine importance of resistance</td>
</tr>
<tr>
<td>• Provision of regular education on antimicrobial stewardship to hospital staff and committees</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Annual review of antimicrobial formulary with changes based on local antibiogram</td>
</tr>
<tr>
<td>• Prospective audits of antimicrobial prescriptions are performed and interventions/feedback is provided to prescribers</td>
</tr>
<tr>
<td>• Implementation of formulary restrictions requiring preauthorization</td>
</tr>
</tbody>
</table>

The Antimicrobial Subcommittee is currently leading a corporate initiative to establish an advanced ASP. As Community Medical Centers continues to expand services, ultimately encountering more complex and diverse patients, appropriate use of antimicrobial agents will be vital to optimizing patient care outcomes and ensuring the continuation of top quality healthcare services.

References:
Immature Platelet Fraction: An Aid in Diagnosis, Work-Up, and Management of Thrombocytopenia

Clarke Harding M.D.,
CCMC Laboratory Medical Director and
Calvin Chen D.O.,
CRMC Hematology Section Medical Director

Clinicians are familiar with reticulocyte counts as an indicator of erythropoiesis and have long used this parameter to assist in the differential diagnosis of anemia. In similar fashion, young platelets released from the bone marrow have increased RNA content, which degrades over the first 24 hours of circulation. Thus, the proportion of reticulated platelets – known as Immature Platelet Fraction (IPF) – in the peripheral blood is a marker of thrombopoiesis. Modern hematology analyzers quantify IPF as a percent of total platelet count (this population is identified by staining reticulated platelets with an RNA dye and identifying them with flow cytometry). As discussed below, the IPF can assist the clinician with diagnostic and therapeutic decisions.

Both CCMC and CRMC laboratories will begin reporting IPF in June 2016 following installation of a new hematology analyzer at Clovis and upgraded software shared by both laboratories.

Normal individuals have a stable IPF, which ranges from 1% to 7.5%. Patients with intact bone marrow function respond to peripheral thrombocytopenia with increased thrombopoiesis and release of greater numbers of reticulated platelets. This is reflected by an increased IPF. Those with a compromised bone marrow have no, or little, increase in IPF. Peripheral thrombocytopenia can therefore be classified into two broad categories based on the IPF:

1. those due to accelerated destruction of platelets (indicated by an elevated IPF); and
2. those due to hypo-production (indicated by a normal or minimally elevated IPF).

The Table, above right, (modified from ref 1) shows examples of IPF values in patients with thrombocytopenia related to destructive and impaired production etiologies. In this study an IPF > 9% was 100% specific for platelet destruction as the etiology for thrombocytopenia.

Another established use of IPF is predicting platelet recovery following myeloablative chemotherapy. In the recovery phase, IPF typically begins to rise two to three days prior to recovery of the platelet count. This early indication of platelet recovery may be helpful when deciding if prophylactic platelet transfusion is necessary, opening the option to defer transfusion if the IPF indicates recovery of platelet count is imminent.

IPF is potentially useful in other conditions, pending further studies. In patients with thrombotic thrombocytopenia purpura sustained treatment may be needed if the IPF remains elevated but there is no platelet recovery. Pregnant women with pre-eclampsia in the third trimester pregnancy often have markedly elevated IPF and this may be useful in early diagnosis or monitoring. Recent reports indicate IPF rises early in the course of sepsis and may be helpful in early diagnosis.

CCMC and CRMC laboratories will perform IPF reflexively on all CBC’s when the platelet count is less than 50,000/uL. The result will be included with the remainder of the CBC parameters. IPF testing will not change turnaround times for the CBC and does not add cost to the test.

For additional information contact:
Clarke Harding M.D.; CCMC Laboratory Medical Director 324-3758 charding@communitymedical.org
Calvin Chen D.O., CRMC Hematology Section Medical Director 459-6563 chen2@communitymedical.org
David Slater M.D., CRMC Laboratory Medical Director 459-6563 dslatermd@communitymedical.org

References:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mean IPF%</th>
<th>Range</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>3.1</td>
<td>1 - 7</td>
<td>2.8 – 3.5</td>
</tr>
<tr>
<td>Autoimmune thrombocytopenia</td>
<td>15</td>
<td>3.6 – 35.4</td>
<td>12.7 – 17.2</td>
</tr>
<tr>
<td>DIC</td>
<td>9.5</td>
<td>2.3 – 18.6</td>
<td>7.5 – 11.5</td>
</tr>
<tr>
<td>Myelosuppressive Chemo</td>
<td>4.1</td>
<td>1.2 – 10.9</td>
<td>3.6 – 4.5</td>
</tr>
<tr>
<td>Aplastic anemia/PNH</td>
<td>6.1</td>
<td>3.9 – 8.8</td>
<td>3.2 – 8.9</td>
</tr>
</tbody>
</table>
Single-Unit RBC Transfusion – the First Choice for Many Patients

Submitted by CMC Transfusion Committee

A reminder that for patients not acutely bleeding, single-unit RBC transfusion should be considered as a first choice (though clearly it will not always be the best choice). Many hospitals have converted a large fraction of their non-OR, non-ED RBC transfusions to single unit (and studies have shown that only a small minority of those patients go on to receive more RBCs within 24 hours).

We have previously run the American Society of Hematology’s Choosing Wisely list in this publication – but it is worth reminding our busy medical staff (in our hospitals which together transfuse an average of 70+ units of RBC daily) of the ASH’s #1 Choosing Wisely recommendation:

A reminder to readers: Blood utilization is benchmarked at all 3 CMC hospitals. The “opportunity” numbers in the 2015 pie charts above are the “average” between our use of blood and the mean of a multi-million transfusion national data set. And this is key – for the same volume-adjusted MS-DRGs as our own use.

The data above exclude “outlier” transfusions – which involve usually high volume blood loss and extraordinary cases. What’s left is highly enriched for less acute transfusions,

See Transfusion on page 22
In Western society, patient autonomy is central to medical decision-making. However, that is not necessarily the case in other cultures; and given our increasingly culturally diverse population, we often encounter the family that wishes to shield the patient from bad news. Whilst one may argue the benevolence of such an approach, my sixteen-year experience as a Palliative Care physician has left me with the impression that most competent patients do indeed wish to be informed and often already have a sense of the gravity of their condition.

During my Palliative Care fellowship at McGill University, in cosmopolitan Montreal, I had a unilingual Greek gentleman on the Palliative Care unit who was aware he had lung cancer but the daughters insisted that he not be informed that he had brain metastases as they felt it would depress him. The patient would routinely guard his room during ward rounds. One day, when I entered his room I found that his daughter had briefly stepped away. The patient looked at me straight in the eye, pointed at his head and asked me “no fix?” I simply nodded my head and he understood.

The other day I was asked to consult on a unilingual Vietnamese lady who suffered from end stage Congestive Heart Failure, along with multiple co-morbidities. She had undergone monthly hospitalizations, during each of which she declined further. I typically utilize a live interpreter for my complex discussions but since one was not available I had to make do with telephone/video services. The patient’s son, who was a medical assistant, was present along with the patient’s primary care physician, the daughter, niece and cousin. They had requested to meet me outside the patient’s room and did not wish to include the patient. The son was very polite and stated he understood when it was explained that his mother had the right to her medical information.

The family wanted to know, if I didn’t mind, where I was from. When I answered “Sri Lanka”, they all visibly relaxed as if I were one with them. They then proceeded to show me their medallions of the Buddha. When we concluded the meeting, the patient and family were all smiling. As I closed the door behind me the room was filled by a sense of peace and contentment. In that moment she reminded me of my own grandmother, whose end-of-life suffering led me to what I do today.

My maternal grandmother, a math and science teacher, was the most altruistic person I have known. She would tutor struggling students at her home without seeking financial compensation. In her later years she had a hand in raising all her grandchildren whether they resided in Sri Lanka or abroad. Wherever she was needed, she would go. She taught us that the most precious things we owned were our reputations and integrity and not material wealth. She practiced what she preached, wore simple white sarees and gave away her worldly possessions to the needy. Her diet had been deficient in iodine and she developed an enlarging goiter. In middle age she underwent thyroid surgery. However, her post-operative care did not include thyroxine supplementation and the goiter recurred after several years and compressed her trachea and paralyzed her recurrent laryngeal nerve. In Sri Lanka, the default treatment choice tends to be the most aggressive as Palliative Care is virtually non-existent.

She developed stridor and on our overseas telephone calls she would tell me she was ready to die. However, she deferred medical decision making to the family. She underwent surgery, was in the ICU, had a tracheostomy that she disliked and was finally discharged after about 2 months. Being the fiercely independent lady she was, she insisted on going back to her home instead of staying with family. There she died in her sleep, at 83 years of age.

My grandmother’s end of life journey led me to choose a career in Palliative Care. I wonder whether I let her down by not arguing the benevolence of such an approach, my sixteen-year experience as a Palliative Care physician has left me with the impression that most competent patients do indeed wish to be informed and often already have a sense of the gravity of their condition.
Transfusion

Continued from page 20

which is where “why give two when one will do” is targeted. Much of the RBC opportunity on page 20 is due to giving more than one RBC unit when one may have been adequate (by inference, the more conservative option had been chosen at many other hospitals).

By the way – take a look at those other slices of pie, too. All 3 CMC hospitals continue to have higher use of platelets, plasma and cryoprecipitate than the mean of other hospitals (for same care). Remember this data excludes outlier unusual large volume cases that can skew data sets.

Palliative Care

Continued from page 21

not advocating for her. In my culture we extend great deference to our elders. Perhaps I could have spoken up to those making decisions for her in all good faith, and maybe she could have avoided all the procedures which were ultimately futile and not consistent with her goals. It is certainly the patient’s right to defer medical decision making to the family. However, I do believe we should always provide an opportunity for self-determination to the patient in a sensitive way. I always remind family members that the patient would be the person actually undergoing the proposed treatment – not the family, not the physicians. That being the case, our shared goal of providing the best care would likely be best served by seeking the patient’s direct input.

I believe exposure to other beliefs and customs makes us more sensitive to the needs of our patients and families. In Palliative Care, we treat the patient and family as a unit. I’d suggest to all my colleagues that you ask families about any fears and concerns regarding engaging the patient in decision making. In that conversation they can be reassured that you will tread delicately around those issues with the patient. The best plan of care is one that reflects the patient’s values and desires, values patient autonomy, and is supported by the family.

Choosing Wisely

Research Report: Why Physicians Want These Lists

Editor’s Note: Choosing Wisely is something the physician community itself initiated. Choosing Wisely was initiated in response to expressed strong need for such information. We will continue to publish the actual lists but thought our readers would benefit this issue from seeing the results of a physician poll which makes clear the wisdom of the Choosing Wisely initiative.

In early 2014, the ABIM Foundation, with funding from the Robert Wood Johnson Foundation, commissioned a survey conducted by PerryUndem Research/Communication to explore physician attitudes regarding the overuse of medical services in the United States.

The research found that nearly three out of four U.S. physicians say the frequency with which doctors order unnecessary medical tests and procedures is a serious problem for America’s health care system – but just as many say that the average physician orders unnecessary medical tests and procedures at least once a week.

The survey also found that more than half of physicians think they are in the best position to address the problem and have ultimate responsibility for making sure patients avoid unnecessary care. Yet at the same time, more than half the physicians surveyed say they’d give an insistent patient a medical test they knew to be unnecessary.

Additional survey findings include:

• 73 percent of physicians say the frequency of unnecessary tests and procedures is a very or somewhat serious problem.
• 66 percent of physicians feel they have a great deal of responsibility to make sure their patients avoid unnecessary tests and procedures.
• 53 percent of physicians say that even if they know a medical test is unnecessary, they order it if a patient insists.
• 58 percent of physicians say they are in the best position to address the problem, with the government as a distant second (15%).
• 72 percent of physicians say the average medical doctor prescribes an unnecessary test or procedure at least once a week.
• 47 percent of physicians say their patients ask for an unnecessary test or procedure at least once a week.
• 70 percent of physicians say that after they speak with a patient about why a test or procedure is unnecessary, the patient often avoids it.

Learn more about the results in the summary research report. Full topline results and information on the methodology are also available.
The current edition of “Your Community at Work,” the Community Medical Centers corporate social responsibility report, is an update on the joint partnership with Adventist Health Central Valley Network for managed Medi-Cal patients. The June edition announces Anthem Blue Cross’ endorsement of the health plan and outlines benefits to everyone in the Valley. Only 52% of physicians in the Valley are able to accept new Medi-Cal patients so having access to Adventist clinics in rural areas should eventually relieve pressure on local emergency rooms and provide better follow up care after hospitalizations for those managed Medi-Cal patients.

“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, 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.

http://www.communitymedical.org/Community-at-Work

Print readers: Go to Communitymedical.org > Community Involvement (on the top tab) > Your Community at Work (on the right side menu in the page)
Please see the below list of Order Sets that were released into production between 04/26/2016 to 05/10/2016. If you identify a problem with one of the order sets please follow the procedure for corrective action or contact a member of the Clinical Content Team.

<table>
<thead>
<tr>
<th>Epic PRL#</th>
<th>Order Set Name</th>
<th>Description of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1583</td>
<td>COPD Module Z</td>
<td>Change Request: Updated antibiotics, respiratory orders</td>
</tr>
<tr>
<td>1399</td>
<td>CRRT NO anticoagulation</td>
<td>Change Request: Adding prisma bags, changing name of order set</td>
</tr>
<tr>
<td>1537</td>
<td>CRRT No Citrate Anticoagulation Daily</td>
<td>Change Request: Adding prisma bags, changing name of order set</td>
</tr>
<tr>
<td>33</td>
<td>CRRT with Citrate Anticoagulation Solutions</td>
<td>Change Request: Removing prisma bags, changing name of order set</td>
</tr>
<tr>
<td>1338</td>
<td>Epoprostenol (FLOLAN) Infusion</td>
<td>Change Request: Updated to allow for continuation vs. new start infusions</td>
</tr>
<tr>
<td>572</td>
<td>Insulin Orders for Non-Pregnant Adult</td>
<td>Change Request: Update tube feeding and TPN diet section</td>
</tr>
<tr>
<td>1702</td>
<td>Iron Dextran (INFED) CEC (FHSH)</td>
<td>New Order Set</td>
</tr>
<tr>
<td>1346</td>
<td>NICU Admit</td>
<td>Change Request: Updated routine lab default time</td>
</tr>
<tr>
<td>U919</td>
<td>NICU Transportation Orders</td>
<td>Biennial review: Updated to reflect that it is used on paper only</td>
</tr>
<tr>
<td>1080/1416</td>
<td>Pre Cath Lab Procedural</td>
<td>Epic change only: “Loop Recorder, implant/explant” order update in Epic to match existing paper version.</td>
</tr>
<tr>
<td>1375</td>
<td>Pre-Op Cardiotoracic Surgery</td>
<td>Epic Change: Updated labs in Epic to mirror blueprint</td>
</tr>
<tr>
<td>1433</td>
<td>Prostatectomy-Radical-Postoperative (Robotic) Z</td>
<td>New Order Set</td>
</tr>
<tr>
<td>1337</td>
<td>Treprostinil (Remodulin) Infusion</td>
<td>Change Request: Updated to better distinguish continuation vs. new start</td>
</tr>
<tr>
<td>227</td>
<td>Universal CRRT Prismaflex-Citrate</td>
<td>Change Request: Removing prisma bags, changing name of order set, pre-check critical solutions</td>
</tr>
<tr>
<td>1358</td>
<td>Universal Oxytocin Augmentation Supplemental Orders</td>
<td>Change Request: Updated titration orders</td>
</tr>
<tr>
<td>1323</td>
<td>Warfarin (Coumadin) Reversal Orders</td>
<td>Biennial Review: Full review and updated according to current guidelines and CMC practices</td>
</tr>
</tbody>
</table>

The following order sets were retired

<table>
<thead>
<tr>
<th>Epic PRL#</th>
<th>Order Set Name</th>
<th>Reason for Retirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1605</td>
<td>CHIP Diuretic Sliding Scale</td>
<td>Biennial Review: Zero usage in past year</td>
</tr>
</tbody>
</table>
UCSF Fresno Department of Pediatrics Presents

Title: “Autism Treatment: Who Needs It and How to Get It”
Date: Monday, June 6, 2016 6:00pm-8:30pm
Tuesday, June 7, 2016 12:30pm-1:30pm (program will be repeated)
Speakers: Renee C. Wachtel M.D. and Karen Fessel Ph.D.
Place: June 6: California Autism Center, 1630 E Shaw Ave, Suite 190, Fresno, CA
June 7: UCSF Fresno Center, 155 N. Fresno St., Fresno, CA 93701, Rm 136
RSVP: June 6: 559-475-7860
June 7: 559-499-6569
CME: 1 CME Applied for

UCSF Fresno, CMC and CSU-Fresno Present

Title: “Recognizing Elder Abuse; Keeping our Elders Safe, It Takes a Community”
Date: Wednesday, June 15, 2016
Speaker: Diana Homeier M.D.
Time: Box lunch served at 11:30am
Program at 12:00pm-2:00pm
Place: UCSF Fresno Center Auditorium, 155 N. Fresno Street, Fresno, CA 93701
CME: 2 CME

Supported through the Walter A. Rohlfing, Geriatric Lectureship.
Dr. Rohlfing was a long time CMC physician.

CRMC Perinatal M & M

Title: “Neonatal Herpes”
Date: Wednesday, June 15, 2016
Speakers: Philip Cheng M.D., Colin Partridge M.D., Kirsten Salmeen M.D.
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

UCSF Fresno Psychiatry Department

Title: “Mental Health Burnout: Perspectives on Meaninglessness”
Date: Thursday, June 16, 2016
Speaker: Michael Thao M.D.
Time: 4:00pm-5:00pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 116
CME: 1 CME

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

CME HIGHLIGHTS

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Speakers: Renee C. Wachtel M.D. and Karen Fessel Ph.D.
Place: June 6: California Autism Center, 1630 E Shaw Ave, Suite 190, Fresno, CA
June 7: UCSF Fresno Center, 155 N. Fresno St., Fresno, CA 93701, Rm 136
RSVP: June 6: 559-475-7860
June 7: 559-499-6569
CME: 1 CME

UCSF Fresno, CMC and CSU-Fresno Present

Title: “Recognizing Elder Abuse; Keeping our Elders Safe, It Takes a Community”
Date: Wednesday, June 15, 2016
Speaker: Diana Homeier M.D.
Time: Box lunch served at 11:30am
Program at 12:00pm-2:00pm
Place: UCSF Fresno Center Auditorium, 155 N. Fresno Street, Fresno, CA 93701
CME: 2 CME

Supported through the Walter A. Rohlfing, Geriatric Lectureship.
Dr. Rohlfing was a long time CMC physician.

CRMC Perinatal M & M

Title: “Neonatal Herpes”
Date: Wednesday, June 15, 2016
Speakers: Philip Cheng M.D., Colin Partridge M.D., Kirsten Salmeen M.D.
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

UCSF Fresno Psychiatry Department

Title: “Mental Health Burnout: Perspectives on Meaninglessness”
Date: Thursday, June 16, 2016
Speaker: Michael Thao M.D.
Time: 4:00pm-5:00pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 116
CME: 1 CME

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

CME HIGHLIGHTS

UCSF Fresno Department of Pediatrics Presents

Title: “Autism Treatment: Who Needs It and How to Get It”
Date: Monday, June 6, 2016 6:00pm-8:30pm
Tuesday, June 7, 2016 12:30pm-1:30pm (program will be repeated)
Speakers: Renee C. Wachtel M.D. and Karen Fessel Ph.D.
Place: June 6: California Autism Center, 1630 E Shaw Ave, Suite 190, Fresno, CA
June 7: UCSF Fresno Center, 155 N. Fresno St., Fresno, CA 93701, Rm 136
RSVP: June 6: 559-475-7860
June 7: 559-499-6569
CME: 1 CME

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Contact: Bernadette Neve, 559-459-7059
CME: 1 CME

UCSF Fresno Psychiatry Department

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Place: UCSF Fresno Center, 155 N. Fresno Street, Fresno, CA 93701, Room 116
CME: 1 CME

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

CME Dinner Lecture

Title: “Update In Thoracic Surgery”
Date: Thursday, June 23, 2016
Speaker: Dr. Binh N. Trinh
Time: 6:30pm- 8:30pm
Place: Vintage Press, 216 N. Willis Ave., Visalia, CA
RSVP: Ric Morales (559) 459-6211 or Rmorales3@communitymedical.org
CME: 1 CME

CME Dinner Lecture

Title: “Update On Pediatric Gastroesophageal Reflux”
Date: Thursday, June 30, 2016
Speaker: Dr. Michael Haight
Time: 6:30pm- 8:30pm
Place: Bella Luna Bistro, 350 W. Main St., Merced, CA
RSVP: Ric Morales (559) 459-6211 or Rmorales3@communitymedical.org
CME: 1 CME

Save the Date

Title: “Cataract Update”
Date: Wednesday, July 20, 2016
Time: 6:00pm-8:00pm
Place: H. Marcus Radin Conference Center- The Palm Room
Contact: Jessica Lipsius at: 559-324-4002 or ilipsius@communitymedical.org
CME: 2.0 CME Applied for

Title: “Update In Breast Care”
Date: Saturday, November 5, 2016
Time: Registration 7:00am-8:00am
Symposium 8:00am-12:30pm
Place: H. Marcus Radin Conference Center- The Palm Room
Contact: Jessica Lipsius at: 559-324-4002 or ilipsius@communitymedical.org
CME: 4.5 CME Applied for
This Snowy Egret just stole a fish from a Coot (Woodward Park)

Bufflehead launching (Lost Lake)

Black-necked Stilt (Merced NWR)

Red-tailed Hawk (Woodward Park)

Female Western Tanager
Frog doing weight-lifting exercise with Great Egret

American Avocets (Merced NWR)

Sunrise over Merced NWR

Anna’s Hummingbird (Clovis)
Bald Eagle (San Joaquin River Center)

Acorn Woodpecker (Woodward Park)  Belted Kingfisher diving (San Joaquin River Center)  White-tailed Kite (Merced NWR)

JUNE PHYSICIAN PHOTOGRAPHER: HUA PHAM M.D.
See page 2 for details
Bella Luna Bistro
350 W. Main St. Merced, CA

June 2, 2016
Thursday: 6:30 pm – 8:30 pm

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

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.

CME 1.0

Dinner will be provided (Vegetarian options available)

Pediatricians, Family Practice Physicians, Nurse Practitioners and Physician Assistants.

Email: Steve Esqueda - Physician Relations
Sesqueda@communitymedical.org or Cell Ph. (559) 231-3962

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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 Steve Esqueda have no disclosures to make.
For Pediatric Primary Care Providers

Present

Autism Treatment:
Who Needs It & How to Get It
Led by: Dr Renee Wachtel, Developmental Pediatrician
Karen Fessel, Dr PH, Executive Director of the MHAIP

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

1. Identify and apply in practice, the diagnostic criteria for autism spectrum disorder (ASD) as described in Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).
2. Gain knowledge of and understand the referral process to available resources within the health plans and community which diagnose and treat children with ASDs, thus improving patient care.
3. Gain knowledge of appropriate laboratory measures as recommended by clinical practice guidelines, which determine the possible etiology of ASD in a child and utilize this knowledge in practice.

When: Monday June 6, 6:00 – 8:30 PM
Where: California Autism Center, 1630 East Shaw, Suite 190, Fresno
Please RSVP: 559-475-7860 or http://evite.me/8cnQ6CBR41 Dinner will be served

Sponsored in part by a grant from

Program speakers Dr. Wachtel and Karen Fessel have no disclosures, Program Planners Serena Yang, MD, Linda Copeland, MD and Trena Dixon have no disclosures.

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Led by: Dr Renee Wachtel, Developmental Pediatrician
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3. Gain knowledge of appropriate laboratory measures as recommended by clinical practice guidelines, which determine the possible etiology of ASD in a child and utilize this knowledge in practice.

When: Tuesday June 7, 12:30 - 1:30 PM
Where: UCSF Fresno Building, Rm 136
Please RSVP: 559-499-6569 or http://evite.me/EuWmkZUP7z
Lunch will be served

Sponsored in part by a grant from

Program speakers Dr. Wachtel and Karen Fessel have no disclosures, Program Planners Serena Yang, MD, Linda Copeland, MD and Trena Dixon have no disclosures.

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Perinatal M & M Presents:

"Neonatal Herpes"

Wednesday, June 15, 2016 from 12:30pm – 1:30pm

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

Case Presentation
Neonatology: Dr. Philip Cheng

Principal Discussants
Neonatology: Dr. Colin Partridge (UCSF Benioff Children's Hospital)
Maternal Fetal Medicine Specialist: Dr. Kirsten Salmeen (UCSF Benioff Children's Hospital)

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

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

1) Apply to practice, current clinical evidence and guidelines relating to neonatal herpes.
2) Gain insight into fetal herpes, 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.
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

Supported through the Walter A. Rohlfing, Geriatric Lectureship. Dr. Rohlfing was a long time CMC physician.

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-2pm: 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.
Inpatient Diabetes Management

Speaker:
Soe Naing, M.D. – Diabetes Associate Clinical Professor, UCSF

Date:
Wednesday, June 22, 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 and improve competency in developing basal insulin regiments and does calculation.
- Will improve the inpatient diabetes management skill and outcomes of the glycemic control of the inpatients.
- Learn, better understand and incorporate into patient care the knowledge of ordering insulin by using the new subcutaneous insulin order sets.

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

CME: 1.0

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

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Disclosures: Speaker, Soe Naing, MD has no disclosures to make. Planners, Ric Morales and Jessica Lipsius has no Commercial Disclosures to make.
CME Dinner Lecture
Update In Thoracic Surgery

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

DATE/TIME:
June 23, 2016
Thursday – 6:30 pm – 8:30 pm

SPEAKER:
Binh N. Trinh, M.D.
UCSF | Thoracic Surgery

JOIN US TO:
1. Identify and apply in practice the latest diagnostic and treatment strategies for thoracic tumors, thus achieving better outcomes.

2. Become aware of treatment options for thoracic tumors and use that knowledge to more effectively communicate availability of these treatment options to patients, improving satisfaction and care.

ADDITIONAL INFORMATION:
CME 1.0
Dinner will be provided (Vegetarian options available)

TARGET AUDIENCE:
Primary Care Physicians, Family Practice, Internal Medicine, Emergency Medicine, Oncologists, Pulmonologists, Nurse Practitioners and Physician’s Assistants.

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

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

Disclosures: Speaker: Binh N. Trinh, M.D. and event planner Ric Morales have no disclosures to make.
CME Dinner Lecture

Update on Pediatric Gastroesophageal Reflux

SPEAKER: Michael Haight, M.D.
Pediatric Gastroenterologist
UCSF │ University Pediatrics Pulmonologist

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

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

CME 1.0
Dinner provided (Vegetarian options available)

ATTENDEES WILL:

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

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

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

RSVP: Ric Morales at Phone: (559) 459-6211 or email: Rmorales3@communitymedical.org

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

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

www.CommunityRegional.org
TARGET AUDIENCE:
All Physicians and Allied Health Professionals

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

CME: 4.5 Applied for
Invitation to follow
# Department of Surgery
## Trauma Critical Care Conference
### Thursday 12p.m-1p.m

**June 2016**

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Location</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/02/16</td>
<td>The History &amp; Science Behind the Surgical Care Improvement Project (SCIP)</td>
<td>Seq. East</td>
<td>Rachel Caiafa, MD</td>
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<tr>
<td>06/09/16</td>
<td>Combined ED/Surgery Conference</td>
<td>Seq. East</td>
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<tr>
<td>06/16/16</td>
<td>TBD</td>
<td>Seq. East</td>
<td>Shaina Schaetzel, MD</td>
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<tr>
<td>06/23/16</td>
<td>TBD</td>
<td>Seq. East</td>
<td>John Koo, MD</td>
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<tr>
<td>06/30/16</td>
<td>No Conference</td>
<td>Seq. East</td>
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</tbody>
</table>

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

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

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

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The Department of Orthopaedic Surgery Presents:
ORTHOPAEDIC GRAND ROUNDS

June 3, 2016  M & M Conference
Timothy Galan, MD / Gustavo Garcia, MD / Arbi Nazarian, MD

June 10, 2016  NO CONFERENCE

June 17, 2016  NO CONFERENCE

June 24, 2016  Topic: TBD
Faculty: TBD

7:00 a.m. – 8:00 a.m.
UCSF Fresno Auditorium

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

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

- Understand the indications and contraindications of orthopaedic care and to improve the quality and safety of patient care depending on the topic and series for that day.
- Gain insight into Orthopaedic Medical Science knowledge and use that knowledge in one’s practice.
- Use new orthopaedic techniques and procedures to improve patient outcome in a safe and satisfactory manner.

Timothy Galan, MD, Gustavo Garcia, MD, and Arbi Nazarian, MD; Program Chief Dr. Eric Lindvall, Program Director Dr. Armen Martirosian, Planner Jenny McHenry, Lorena Davis and Lisa Husak have no relevant commercial relationships to disclose.

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June 2016

June 2
No Grand Rounds – Resident Open Meeting

June 9
No Grand Rounds – Housestaff Graduation

June 16
“Mental Health Burnout: Perspectives on Meaninglessness”
Michael Thao, MD
VACCHCS
Associate Clinical Professor
Department of Psychiatry

June 23
No Grand Rounds – Psychiatry Dinner

June 30
No Grand Rounds

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The Department of Surgery
SURGICAL GRAND ROUNDS

June 2016

June 3, 2016   Mostly Dead: A Brief Review of Cardiopulmonary Resuscitation
Dr. Jordan Lilienstein

June 10, 2016   CANCELLED

June 17, 2016   TBA

June 24, 2016   Professionalism
Dr. Mary Wolfe

7:30 a.m. – 8:30 a.m.
CRMC Sequoia West

Target Audience: CMC Faculty, community physicians, house officers, mid-level providers, nurses and others potentially involved with patient care.

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

- Demonstrate a commitment to carry out professional responsibilities while adhering to ethical principles
- Achieve increased competency and performance using newly integrated surgical techniques
- Improve the performance and competency of the faculty in teaching and increase the knowledge of resident trainees

Drs. and Program Planner Denise Goodman have no relevant financial disclosures.

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<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
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<tbody>
<tr>
<td>1</td>
<td>Ortho Surg-Adult Recon GR- Ortho Surgery Conf. Rm</td>
<td>7:30 - 8:30 am</td>
<td>Chest Conference</td>
<td>7:00 - 8:00 am</td>
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<tr>
<td>2</td>
<td>Neuroscience Pt. Case Present. NORC Conf. Rm</td>
<td>7:30 - 8:30 am</td>
<td>HPB Planning Conf. CRMC-Sequoia West Conf Rm</td>
<td>7:30 - 8:30 am</td>
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<td>3</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>8:00 - 12:00 pm</td>
<td>Emergency Medicine UCSF Rm 136</td>
<td>8:00 - 9:00 am</td>
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<td>4</td>
<td>Cardiac Cath &amp; Intervention CRMC-Cath Lab</td>
<td>12:00 - 1:00 pm</td>
<td>Critical Care/Trauma CRMC-Sequoia East Conf Rm</td>
<td>8:30 - 9:30 am</td>
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<td>5</td>
<td>Brain Tumor/Cyberknife Conf. CRMC-Sequoia West Conf. Rm</td>
<td>12:00 - 1:00 pm</td>
<td>OB GYN Residency GR UCSF Rm 116</td>
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<td>6</td>
<td>Ortho Surg-Foot/Ankle Hand</td>
<td>7:00 - 8:00 am</td>
<td>Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm</td>
<td>7:00 - 8:00 am</td>
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<td>7</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm</td>
<td>7:00 - 8:00 am</td>
<td>Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm</td>
<td>8:30 - 9:30 am</td>
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<tr>
<td>8</td>
<td>Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>7:30 - 8:30 am</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>8:30 - 12:30 pm</td>
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<td>9</td>
<td>Cardiac Cath &amp; Intervention CRMC-Cath Lab</td>
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<td>10</td>
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<td>15</td>
<td>Cardiology Grand Rounds CRMC-Sequoia West Conf Rm</td>
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<tr>
<td>16</td>
<td>Cardiology Grand Rounds CRMC-Sequoia West Conf Rm</td>
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<td>Cardiology Grand Rounds CRMC-Sequoia West Conf Rm</td>
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Continuing Medical Education June 2016

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This credit may also be applied to the CMA Certification in Continuing Medical Education. Email: lsmith@communitymedical.org Phone: 559-459-1777 F: 559-459-1999
<table>
<thead>
<tr>
<th>MON</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
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<tr>
<td>6:30 - 7:15 am</td>
<td>Ortho Surg. - Foot/Ankle/Hand SPOC</td>
<td>7:00 - 8:00 am</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>Chest Conference UCSF # 116</td>
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<td>Ortho Surgery Conf. Rm.</td>
<td>7:30 - 8:30 am</td>
<td>CRMC-Sequoia West Conf. Rm</td>
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<td>8:00 - 9:00 am Medicine Grand Rounds UCSF Fresno Auditorium</td>
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12:00 – 1:00 pm Neuroscience Grand Rounds UCSF Rm 137

12:00 – 1:30 pm QPSC-CCMC CCMC Palm Room
## COMMUNITY MEDICAL CENTER
### Medical Staff Committee Meetings
#### June 2016

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<tr>
<th>Monday</th>
<th>Tuesday</th>
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<td>12:30pm Infection Control Committee CRMC Sequoia East Room</td>
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<td>5:30pm CRMC Robotic Steering Committee CRMC TCCB3 Conference Room</td>
<td>7:00am CCMC Cardiology CCMC Outpatient Conference Room</td>
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<td>6:00pm CRMC Facility Executive Committee CRMC Sequoia West Room</td>
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<td>12:00pm Peds/Neo CFPRC CRMC 4 West NICU Conference Room</td>
<td>12:30pm CRMC Pediatrics CRMC Sequoia West Room</td>
<td>4:45pm CRMC Quality Council CCMC Outpatient Conference Room</td>
<td>7:30am FSHS Quality Patient Bariatric FSHS Riverpark Conference B</td>
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<td>12:00pm CIPD CRMC Sequoia East Room</td>
<td>12:30pm CCMC Ob-Gyn/Pediatrics CCMC Outpatient Conference Room</td>
<td>2:00pm CCMC Quality Patient Safety UCSF Auditorium</td>
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<td>12:30pm Credentials Committee CRMC Lab Conference Room</td>
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<td>12:30pm CCMC Medicine/Family Medicine/ Psychiatry/Psychology/Physical Med and Rehab Committee CCMC Outpatient Conference Room</td>
<td>12:00pm CCMC Formulary Subcommittee CRMC Sequoia East Room</td>
<td>2:00pm FSHS Quality Practice Heart Committee FSHS Riverpark Conference Room B</td>
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<td>2:00pm CRMC Utilization Review CRMC Sequoia East Room</td>
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As of 5/24/16