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OCTOBER PHYSICIAN PHOTOGRAPHER
SERGIO ILIC M.D.

Orthopedic Surgery

Dr. Ilic is an orthopedic surgeon who has been in practice in Fresno since 1982. He was active at Valley Medical Center as a member of CCFMG from 1982 to 1989.

He was then in private practice from 1989 to 2015. Dr. Ilic closed his private practice in April 2015 and has worked full time at the Veterans Administration Medical Center (VAMC) since then. He developed a Total Joint Program there. Since August 2015 more than 100 Total joint replacements have been done at VAMC, including knees, hips and shoulders. Many readers will know Dr. Ilic as one who has willingly taken on so many medical staff and organized medicine (eg, Fresno Madera Medical Society) roles.

Dr. Ilic loves to travel. These photos are from his trip to French Polynesia Islands (the Society Islands named by Captain Cook after the British Royal society) this past May. He accompanied his brother-in-law for his 50th wedding anniversary. There are more than 100 French Polynesia islands with a population of 230,000. The most important ones are: Tahiti, which has the capital Papeete with a population of 133,000; Mo'orea; Huahine; and, the most famous Bora Bora). Most of the islands are uninhabited. The islands were made famous by the paintings of Paul Gauguin and the book of James A. Michener. They are volcanic islands and the geography is amazing. The one he liked the most was Mo'orea.

He states that The Polynesian sea is one of the world’s most beautiful things, and snorkeling is a must. The fish are many and their colors are unbelievable. Tourism is the main business. The seaside resorts commonly have palafites (over-water bungalows). Many of these have glass floors.
Last month I had the pleasure of presenting our fiscal year-end summary to Community's Board of Trustees. Our entire community should be proud of the comprehensive healthcare network we’re building. Community Medical Centers provides more than half of all inpatient care in Fresno County; we’re the main safety-net provider for the Valley; and we’re the regional referral center for higher-level services other hospitals can’t provide. At the same time, we’re weathering huge transition and uncertainty in our industry by continuing to increase quality and efficiency in the way we deliver care as an integrated network. Here are some highlights from my report to the Board:

Expanding access to care

We’re responding to a steady rise in patient volumes by smartly expanding our services, adding patient capacity where we can, and improving patient flow. We’re also strategically building for the future.

A number of our key service lines grew impressively in fiscal year 2016, including pediatrics, neurosciences, orthopedics, robotic surgery and cardiology/cath lab procedures – all of which have received state and national accolades for excellence.

Our patient-flow initiatives have become increasingly sophisticated and innovative. CRMC significantly improved the acceptance rate for higher-level-of-care patient transfer requests from other hospitals. Both CRMC and Clovis reduced patients’ average length of stay. And overall turnaround times improved in the ED at Clovis Community.

A drive by either campus confirms our commitment to expansion. The new medical office building (MOB) at Clovis will be completed by November. CRMC’s MOB, which began construction in June, is expected to open in September 2017. Both buildings will house physician practices to support enhanced cancer and pediatric programs, among other services.

Additional expansion work under way: a 10-bed Pediatric Intensive Care Unit (PICU) at CRMC; architectural work on a three-story, 100,000-square-foot cancer center on the Clovis campus; site work on a 1,400-stall parking garage for staff at CRMC; and pre-construction work on new bed towers for CRMC and Clovis.

Advancing clinical quality

Equally important to expanding patient access is advancing clinical quality, improving the patient experience, and optimizing the electronic health record system.

We track our performance on nearly 60 outcome and process measures related to multiple diagnoses and the patient experience, and we display the results publicly on our website. We’ve achieved a 98.5% system-wide performance rate this year, for these clinical quality measures. And our patient satisfaction rate is above state and national averages.

The electronic health record system is being used by nearly 8,000 clinicians and physicians at our hospitals and clinics. It also has been implemented by 270 physicians in their offices and is serving more than 400,000 patients. In fiscal year 2016 alone, we enabled care coordination on behalf of our patients through more than 300,000 electronic records throughout our region and across 46 states.

Caring for our workforce

In order to attract and retain top talent, we must continue to enhance our pay and benefits and provide professional growth and training opportunities. Some examples of progress we’ve made:

- **Growth** – Our workforce is now more than 8,450 strong, including almost 3,000 nurses and more than 1,000 other licensed clinicians.
- **Market adjustments** – About 3,000 employees received an increase in pay as a result of $7 million we invested in market adjustments. We’ll continue to invest in pay increases as the market warrants.
- **Learning opportunities** – We provide about $733,000 in education reimbursement, and we save employees $280,000 annually in tuition discounts for health-related degrees.
- **Employee scholarships** – As of this year, about 60 employee scholarships totaling some $150,000 are available annually to employees seeking nursing and advanced degrees.

Stewarding our resources

Community met its bottom-line target for fiscal 2016. That’s vitally important because as our costs continue to rise we must nevertheless save funds to reinvest in the future. It now costs $3.5 million per day to operate Community Medical Centers, and we must generate a 3 to 5 percent operating margin to reinvest in facilities, new equipment, and our staff.

Factors that contributed to our positive results included:

See CEO Corner on page 4
Initial Appointment to the Medical Staff
effective September 8, 2016
New Medical Staff Members Approved by
the Medical Executive Committee and the Board of Trustees

Farooq Abdulla M.D.
Department: Pediatrics
Specialty: Neonatology

Steve Chang M.D.
Department: Surgery
Specialty: General Surgery

Damian DeFranchesch M.D.
Department: Medicine
Specialty: Critical Care

Donald W. Fields D.O.
Department: Pediatrics
Specialty: Pediatrics

Erica Gastelum M.D.
Department: Pediatrics
Specialty: Pediatrics

Raja Mittapalli M.D.
Department: OB/GYN
Specialty: OB/GYN

Larry Wayne Ridings M.D.
Department: Medicine
Specialty: Tele-Neurology

Brooks Rohlen M.D.
Department: Surgery
Specialty: Anesthesiology

Evgeny Tsimerinov M.D.
Department: Medicine
Specialty: Tele-Neurology

Initial Appointment to the Medical Staff
effective July 14, 2016
New Allied Health Professionals Approved by
the Medical Executive Committee and the Board of Trustees

Wendy Baker N.P.
Department: Medicine
Specialty: Critical Care

Chelsea Lynne Flowe N.P.
Department: Family Medicine
Specialty: Family Medicine

Natasha Baptiste Jno N.P.
Department: Pediatrics
Specialty: Pediatrics

Conrad Lo, P.A.
Department: Surgery
Specialty: Neurosurgery

Lorilee Perry N.P.
Department: Emergency Medicine
Specialty: Emergency Medicine

Brittany Pierce N.P.
Department: Medicine
Specialty: Critical Care

Dennis Redubla N.P.
Department: Medicine
Specialty: Nephrology

(1) Transition of the Fresno Heart & Surgical license to CRMC, which resulted in higher volumes at FHSH and better utilization of resources for our patients.

(2) The best fundraising year in the history of Community Medical Foundation, with over $14.5 million raised for programs, services and facilities.

(3) Our employee Value Analysis Teams’ continued success in identifying ways to improve processes and purchasing, resulting in a savings of nearly $8 million last year and bringing our six-year total savings to more than $41 million.

Further contributing to our success are the increasingly strong collaborations with UCSF Fresno and the Santé physicians. It would be virtually impossible to overstate the value of these relationships to Community and our patients. I can assure you, many hospitals across the country wish they had partner resources like the ones Community enjoys.

I’ve seen amazing change in my decade with Community, and I’m particularly proud of our accomplishments over the past year. While I suspect we’ll experience far more change in the decade ahead, I’m more convinced than ever that our organization has a bright and exciting future as the primary healthcare provider in our region. Thank you for being part of it.
Be Aware of the Signs of Burnout

Submitted by Rick Adams Ph.D.,
CRMC and CCMC Well Being Committee Chairperson

As a psychotherapist it is an axiom of mine that self-awareness and self-monitoring are basic requirements of any efforts to change and improve oneself. Health care professionals are required to perform assessments and evaluations of others, to guide the process of improving the health status of their patients. Physicians are highly trained in techniques needed to perform these assessments and evaluations. In order to perform accurate evaluations the doctor must know the signs and symptoms of the disorders within their specialty.

However, when it comes to self-assessment, physicians are vulnerable to errors caused by being too close to the patient. As we evaluate our own selves, we may dismiss symptoms as trivial and fail to seek the evaluation of a professional who can provide a neutral and unbiased opinion. This applies to physical and emotional symptoms. In the realm of psychotherapy such a biased appraisal of our own emotional/behavioral experiences is typically termed “denial”.

As noted in last month’s issue, the prevalence of physician burnout is increasing. Professional life burnout then intrudes into other areas of life. In this edition of the Well-Being Corner I will review common signs and symptoms of burnout. Evidence of burnout can be seen in the following three areas of functioning:

**Emotional**: thoughts and feelings may include irritability/anger, anxiety, depressed mood, apathy, resentment, inability to focus and concentrate, and mental fatigue.

**Behavioral**: social withdrawal, loss of interest/involvement in activities, bad health habits, increased caffeine consumption, increased alcohol use, and procrastination in addressing tasks and responsibilities.

**Physical**: physical manifestations may include cardiac symptoms, gastrointestinal complaints, neuromuscular problems, sleep disturbance, morning tiredness, change in sexual desire, low energy and weariness.

This is a good list to keep in mind when assessing burnout. Being aware of the signs of burnout is necessary for an individual to monitor themselves for the impact of stress on their personal and professional lives. We must also be alert to that voice inside us which wants to dismiss deteriorating wellness as “just part of being a doctor”. Across the country it is apparent that physicians’ tendency to deflect emotional and behavioral concerns is taking an unfortunate toll on colleagues of every age, gender and specialty.

In the next few months we will explore ideas for managing the stress, which so often creates burnout. We will also discuss resources available to physicians, which can assist in understanding and addressing the signs and symptoms of burnout.

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Attention Medicare FFS Physicians: Medicare Access and CHIP Reauthorization Act (MACRA) Update

By James Michael Cole, Director, Government Reimbursement

Plans for the Quality Payment Program in 2017: Pick Your Pace

CMS received feedback on their April 27 proposal (go to “First Steps” below) for implementing the Quality Payment Program. With the program set to begin on January 1, 2017, CMS wants to share its plans for the timing of reporting for the first year. In recognition of the wide diversity of physician practices, CMS intends for the Quality Payment Program to allow physicians to pick their pace of participation for the first performance period that begins January 1, 2017. During 2017, eligible physicians and other clinicians will have multiple options for participation. Choosing one of these options would ensure you do not receive a negative payment adjustment in 2019 (as you might guess, the most cautious option also offers no potential financial upside). These options, and other supporting details, will be described fully in the final rule expected early November.

**First Option**: Test the Quality Payment Program

**Second Option**: Participate for part of the calendar year

**Third Option**: Participate for the full calendar year

**Fourth Option**: Participate in an Advanced Alternative Payment Model in 2017

To see the full text of this excerpted CMS blog (issued September 8) go to: [https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace](https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace)


It's fall, or so they tell me! Lots of things happening around Informatics, so here's a quick overview of what lies ahead.

e-Prescribing of Controlled Substances is still rolling out across the organization. We have NOT overwhelmed medical staff with enrollments, but those who are using it are loving it. To sign up:

- **October 3-21:**
  Department of Medicine (all subspecialties) and all Hospitalists
- **October 24-November 11:**
  Department of Pediatrics and all others (all facilities)

Each member of the medical staff will need to view an online e-learning module within HLC and present in person to the medical staff office (MSO) to have their identity verified. The HLC will provide further information about the process of EPCS and requirements for Identity Proofing. Don’t forget to bring your completed information sheet with you to MSO – that is your certificate of completion.

**Beacon**, the chemotherapy ordering module, is still on track to go live on November 1. We are continuing to move through review of protocols that will be applicable for CRMC’s AIC and inpatients. No defined go live dates for those yet – stay tuned.

The monthly release plan mentioned last time will likely start in January 2017. This will give us more time to communicate changes to all users so everyone will be well-prepared.

Changes were made in the **release of lab tests to MyChart**, in an effort to continue to engage patients. We’re now immediately releasing outpatient labs, releasing inpatient labs at 72 hours while the patient is still in-house, but releasing everything upon discharge. We’ve also been working with the group of ‘sensitive’ tests to redefine what is included in that group, and to create specific ‘rules’ for adolescents and pediatric patients to protect their privacy. Let me know if you would like more information. Phase 2 will be looking at release of radiology results, and eventually sharing notes with patients.

**UpToDate** will be available to everyone in expanded, remote and mobile fashion with the new year. This should help augment the ‘virtual library’, provide easy access to clinical content references, and will also allow us to provide a CMC medical staff-approved look up for our patients through the MyChart portal. More details will come as we get closer to that launch.

We’ve developed a new process for **placing preop orders in Epic from offices**, which allows order to be placed prior to knowing what facility the patient may go to for the surgery. We’re piloting it with a few PNA physicians, and hope to roll it out widely in late October/early November.

**Code status orders** are being updated to better reflect choices to align with the Physician Orders for Life-Sustaining Treatment (POLST). The go live is planned for November 8 – stay tuned for more info about education on this.

Finally, we are looking for a major **upgrade to Epic** (going through 2015 version right to 2016) late next summer. The look and feel may be slightly different, but most exciting to me (I know… don’t say it!) is the enhancements to functionality that will bring more efficiencies for the care team all around… more info to come in months ahead.

I’m still looking to the glorious fall colors here, and cooler weather there, I said it!
If you’ve ever tried communicating with a teenager via a telephone you’ve probably learned that the phone won’t get answered but a text message will. Text messaging has clearly become the preferred method of communication for many people. Healthcare professionals are also rapidly increasing their use of text messaging as a key part of their workflows. However, due to the inherent lack of security in a standard text message, the government has not allowed text messaging to be used for the transmission of electronic protected health information. Today text messaging of patient identifiable information is only allowed if the text message meets the government criteria of “secured text messaging.”

Any unsecured text message may be considered a HIPAA violation, e.g. text messages with transmitted electronic protected health information (ePHI) may reside on a mobile device indefinitely, where the ePHI can be exposed to unauthorized third parties due to theft, loss, or recycling of the device. Text messages often can be accessed without any level of authentication, meaning that anyone who has access to the mobile phone may have access to all text messages on the device without the need to enter a password.

What are some of the key elements for a text message to be considered a secured text? The solution must have audit log capabilities, must require a password to access, and must encrypt the message in transmission. Apple’s default Text Messaging application does not meet these requirements and should never be used to transmit patient information.

It is Community Medical Centers’ responsibility to effectively manage a text messaging solution that ensures compliance with HIPAA and avoid the potential for unauthorized use or disclosure as well as data breach. Community Medical Centers has a secured text messaging solution, called Tiger Text, immediately available. Tiger Text can be installed on your iPhone or other device easily at no cost. Simply call or email the Corporate Information Systems Help desk (customer support) at 459-6560 for assistance.
Cancer Immunotherapy at a Glance

By Omid S. Tehrani M.D. Ph.D.
Assistant Clinical Professor of Hematology Oncology

After decades of debate about the role of immune system in controlling cancer, and many failures, cancer immunotherapy has become a hot topic in cancer treatment. In 3 issues from July 30-August 1, the New York Times published articles about harnessing the immune system to fight cancer. This is a quick glimpse at this new treatment.

Immunotherapy has been used for years in early stage cancer treatment. Probably, Bacillus Calmette-Guérin (BCG) used in early stage bladder cancer was the first successful cancer immunotherapy. Imiquimod is another local immune system modifier approved for use in basal cell carcinoma. Systemic immunotherapy started with Interleukin-2 and interferon-alfa in renal cell carcinoma and melanoma. However, their application was limited (how about hindered??) by low success rate and severe side effects. Later on, Sipuleucel-T became the first systemic immune cell treatment for metastatic prostate cancer. In this treatment, patients' own T-lymphocytes are extracted and stimulated against prostate cancer proteins and injected back to the patients.

While older methods focused on stimulating the immune system, some researchers came up with another idea. Similar to normal cells, malignant cells avoid cytotoxic T-cells using inhibitory check-point mechanisms. New immunotherapy is based on inhibiting immune system check points. Currently there are two actionable check-points. First one is when the cancer antigens are presented to T cells (CTLA-4 system) and the second is upon interaction between T cells and malignant cells (PDI-PDL1 system). The first approved CTLA-4 inhibitor is Ipilimumab. There are currently three FDA approved anti-PD-L1 antibodies, namely Nivolumab, Pembrolizumab and Atezolizumab, and there are many more to come.

Combined or as single agents, these antibodies are used to treat a variety of cancers including melanoma, lung cancer, kidney cancer, and hodgkin lymphoma. They are also shown to be active against many other cancers. One major advantage of immunotherapy is the favorable toxicity profile. Most of the patients find it easy switching from chemotherapy to immunotherapy. Another benefit is the longer duration of response. However, predicting who will benefit from the immunotherapy has been challenging, and is a major research topic. Research thus far has revealed that on average, between 20-40% of the patients respond to single agent check point inhibitors. Though combining CTLA4 and PDL1 inhibitors may increased response rates in certain cancers.

Another immunotherapy approach is to bring T cells near...
Immunotherapy

Continued from page 8

the cancer cells using antibodies that connect the two together. Blinatumomab is the first in its class approved for Acute Lymphoblastic leukemia that possess such a function. Another new tool in immunotherapy is CAR T cells. These are genetically engineered T cells which express antibodies against abnormal cancer proteins. Although still in clinical trial phase, it has been very effective against acute lymphoblastic leukemia, lymphoma, and may have potential in treating other malignancies.

It is important to note that using anti-cancer antibodies are different from immunotherapy. Multiple antibodies are developed against abnormal cancer proteins, or their growth and survival mechanisms. For example, Bevacizumab prevents new vessel formation in different tumors, Rituximab attacks CD-20 on B cell lymphoma, and Trastuzumab attacks HER2 protein on breast cancers. Many other antibodies are available for cancer treatment. Another strategy is using oncolytic viruses, like Talmigen. It is approved for stage III melanoma.

In general, immunotherapy is tolerated well. Side effects range from local, to general, limited up to severe. Yet, severe side effects occur in minority of cases. In general, the side effects occur because of overactivity of the immune system, or targeting the normal tissues like pituitary, liver, lungs, kidneys, guts, joints, eyes and skin. Patients suffering with active or history of autoimmune diseases should inform their physicians about it.

In many cancers, chemotherapy remains the first line of treatment. Response rate of immunotherapy, even combined immunotherapy, is limited. Beneficially, cancers like germ cell tumors can be cured by chemotherapy. On the other hand, immunotherapy is the first line treatment in BRAF negative metastatic melanoma. Similarly, question has been raised to use upfront immunotherapy for resistant tumors, like lung cancer, or even in early stage diseases. Choosing the best patients with higher chance of response is an area of active research in oncology. Unfortunately, whichever method used, immunotherapy is expensive and some agents have limited availability. Currently, check point inhibitors are the most available and used for cancer immunotherapy treatment and is available in Community Medical Centers.

Editor’s Note: Ours is not a political publication. Yet we increasingly see how Federal policies are of monumental importance to the care of our patients and to the healthcare systems which serve them. Given that we’re on the home stretch of an extraordinary presidential election, we reprint here, after seeking permission, the Editor's Column from September issue of the Journal of the National Comprehensive Cancer Network.

Dr. Tempero is also Director, UCSF Pancreas Center; Leader, Pancreas Cancer Program; Professor of Medicine, Division of Hematology and Oncology, UCSF.

(Citation: J Natl Compr Canc Netw 2016;14:1047)

Hillary and Donald, Our Patients Are Watching

By Margaret Tempero M.D.

The United States of America has never seen anything like it. This presidential race is, well, unusual. And that’s an understatement for sure! I don’t think politics belongs in this column, so I won’t go there (although secretly I want too!). But after listening to the candidates, I began to wonder what our patients are thinking. The candidates emphasize taking down terrorists (I get that), tax reform, fixing whatever is broken (not too many specifics there), protecting and improving the lives of children, and on and on. But I’ve heard very little about healthcare and even less about cancer care.

Historically, of course, the Republicans have wanted to repeal the Affordable Care Act (ACA), but that doesn’t seem likely. Even though it’s not perfect, and many things could be improved, many Americans have benefitted from this legislation. Americans have more affordable choices, can get insurance even if they have pre-existing conditions, and can more easily change plans as their needs change.

But hearing more specifics on healthcare reform in the presidential platforms would be refreshing. At least we would know healthcare was on their radar. Legitimate concerns exist about whether the ACA implementation has affected access to high-quality care. For example, is your plan so narrow that you can’t get the specialized care you need? Or did you get locked into a tiered formulary that calls for higher out-of-pocket costs on certain drugs? We need some way to monitor this so we can understand how the changes have affected our patients. That’s the only way we will know what to fix.

And what about MACRA (Medicare Access & CHIP Reauthorization Act of 2015)? It’s not fully implemented yet, but it’s coming. It promises reimbursement reform, quality improvement and measurement, and public transparency. This all sounds good, but the devil is in the details, right? Reimbursement reform, if not done well, could further cripple community practices. Lately, we’ve seen one experiment after another coming from CMS. Can we please get some results first, and then put order into this
Editorial

Continued from page 9

process so we really know how these changes affect our ability to deliver the care our patients deserve?

The quality care part of MACRA is particularly concerning. We will all need to fill out a lot of reports to demonstrate our ability to provide high-quality care. It's going to cost a lot, so we should do it right. But how do we know we have the right metrics? How do we know whatever we measure will improve decision-making? And who will pay for this?

Of course, neither the ACA nor MACRA addresses the problems of the high cost of drugs (can’t someone fix this?), the need for more resources for federal agencies that fund biomedical research, and the limitations placed on physician and patient communication by HIPAA and by existing electronic health records systems that can’t interface with each other.

As the presidential debates proceed, I hope some of these issues will get some air time. And I hope America has the good sense to elect a President willing to work on a bipartisan approach to healthcare reform. You need to help, too. Start by voting!

The Cancer Moonshot

By Uma Swamy M.D.

Oncology Care Providers
Community Medical Centers
Department of Radiation Oncology

Ever since Apollo 11 touched down on the moon, “moonshot” initiatives have been proposed to address perceived insurmountable problems. One such example is the recent Moonshot Initiative for Cancer. This billion dollar pledge* has now been launched by VP Joe Biden with the guidance of an elite multidisciplinary blue ribbon panel. This is not the first time a “war on cancer” has been waged with great fanfare. President Nixon pledged a similar goal in 1971. Over the last 40 years, $90 billion spent on research and treatment has led to increased life expectancy and a reported 23% decrease in cancer mortality (1991-2012). We have certainly gotten better at fighting cancer but curing all cancer continues to elude us.

Cancer is inherently complex, given its myriad evolving gene mutations, the influence of each individual’s macro and microenvironments, and the basic principle that the single largest risk factor for getting cancer is age. All this makes finding a cancer cure a true moonshot. I have often thought back to my undergraduate cancer biology professor’s statement, “If you live long enough, you will get cancer,” and wondered if finding the cure for cancer is as mythical a task as finding the fountain of youth. So even in patients where we have successfully cured the cancer, thus in effect increasing their lifespan, the patient is then exposed to additional risk of developing another cancer either from the treatments itself or by the mere fact their cells are getting a chance to become older, thus more prone to acquiring mutations that converts them to cancer.

My mother was diagnosed with triple-receptor-negative breast cancer 20 years ago. Without surgery and chemotherapy, she would not be alive today. Recent advances in immunotherapy promise further decrease in mortality. While this moonshot may not result in a cure for all cancer, this should lead to significant scientific innovations which will further propel learning and improve outcomes, much like the 40 years of ongoing discoveries linked to our historic lunar missions.

As important as treatments and cure are in the cancer galaxy, prevention is equally important. As a public health researcher so eloquently put it, “many more lives can be saved by doing the boring stuff, like getting people to stop smoking, eat healthfully, exercise and put on sunscreen. And we need to prepare policies that deal with a future where more, not fewer, people have cancer.” The Moonshot panel recently published its 10-point initiative (see next article) wherein the importance of cancer prevention is appropriately mentioned. Humans have long proven to be creative and resilient. If history is to be believed, we will witness impressive progress from this initiative – even with its relatively small allocated budget – toward understanding and combatting this moonshot-worthy disease; one which is sure to touch each of us in one way or another.

* $1.1B has been pledged for the opioid epidemic which killed 14,000 people in 2014 compared to over 500,000 deaths from cancer. $1.1B was just allocated for Zika Virus which has thus far a reported incidence of 2964 cases in the US. By contrast there are 1.6 million cases of cancer in the US annually and the Apollo 11 moon mission had a budget of $166.5B. While all these are noble causes, it leaves one wondering what can we realistically expect from just a billion dollars for cancer.
Editor’s Note: CMC Radiation Oncologist Dr. Swamy just introduced the topic of America’s Cancer Moonshot by providing both professional and personal context (and some needed financial context). As she noted, a Blue Ribbon Panel has just issued its Report with “a set of consequential recommendations for accelerating cancer research to achieve the ambitious goal of making a decade’s worth of cancer research progress in five years and to bring the most promising science and clinical developments to cancer patients in the near term.” Note: Print readers can easily find the report on line—its title page is above.

We recommend the report to interested readers (whether you are a medical professional or one of our administrative readers) – both for the steps it recommends and for its honest cataloguing of “policy issues that were beyond the scope of the BRP but will need to be addressed for many of the recommendations to move forward.”

Here’s the lead-in from its Executive Summary:

In his final State of the Union address, in January 2016, President Barack Obama tasked Vice President Joe Biden with heading up a new national effort to “end cancer as we know it.” The mission of the White House Cancer Moonshot is to make a decade’s worth of progress in preventing, diagnosing, and treating cancer in five years, ultimately striving to end cancer as we know it. Under the Vice President’s leadership, a full set of recommendations for leveraging federal investments, private sector effort, patient initiatives, and more will be announced later this fall. To provide the scientific specificity for this ambitious goal, a Blue Ribbon Panel (BRP) – consisting of cancer researchers, oncologists, patient advocates, and representatives from the private sector and government agencies – was assembled to advise the National Cancer Advisory Board on the exceptional scientific opportunities that could be accelerated through this initiative.

The BRP established seven working groups to assess the state of the science in specific areas and identify major research opportunities that could uniquely benefit from the support of the Cancer Moonshot and that could lead to significant advances in our understanding of cancer and how to intervene in its initiation and progression. Like the BRP, the working groups had broad representation across the cancer community, and included researchers with subject-matter expertise as well as advocates and government and private sector representatives. The working groups concentrated on opportunities in seven areas:

- Clinical Trials
- Enhanced Data Sharing
- Cancer Immunology
- Implementation Science
- Pediatric Cancer
- Precision Prevention and Early Detection
- Tumor Evolution and Progression
DON’T MISS THE OPPORTUNITY TO ATTEND THE 2017 WINTER CME SYMPOSIUM IN SCOTTSDALE, ARIZONA

12th ANNUAL
WINTER CME SYMPOSIUM
PURSUIT OF EXCELLENCE

The Symposium will be held at the luxurious Fairmont Scottsdale Princess that provides world-class hospitality in the Valley of the Sun.

Wednesday, February 22 – Saturday, February 25, 2017
GOLF TOURNAMENT - Friday, February 24th

Join the golf tournament that will take place on Arizona’s dazzling TPC Golf Course at the Fairmont Scottsdale Princess, home of the PGA Waste Management Phoenix Open. Hosted by Santé Health Foundation and Community Medical Centers.

HIGHLIGHTS INCLUDE:

Benjamin Carson, MD
World-Renowned Pediatric Neurosurgeon, Inspirational Speaker, New York Times Best-Selling Author, Syndicated Columnist and former Candidate for President of the United States

Dike Drummond, MD
Mayo trained Family Practice Physician with a unique combination of ground level experience in medicine, coaching and personal and business development. As CEO of TheHappyMD.com, Dr. Drummond has come full circle from career ending burnout to become a leading executive coach to burned out physicians and physician leaders.

ZDoggMD
(Zubin Damania, MD)
ZDoggMD is a physician, off-white rapper, and the founder of Turntable Health. A hospitalist at Stanford for almost 10 years, Dr. Z is an internationally renowned healthcare speaker and man of mild-to-moderate mystery.
Attacking Parkinson’s Disease Where it Lives

Submitted by Erin Kennedy
CMC Senior Communications Strategist

Editor’s Note: There are many stories about physicians who have joined CMC and brought new knowledge and new advances to their colleagues and our patients. This is one more of them, featuring a specialty that is in particularly great demand – Neurology.

In 2007 medical researchers looking at Fresno, Tulare and Kings Counties found an increased risk for Parkinson’s disease for those who lived and worked in agricultural areas sprayed with pesticides and especially for those on well water.

The Central Valley has the highest rates of Parkinson’s disease in California with Kings County being among the worst at 10 times higher than the rest of California.

But until recently those with Parkinson’s had to leave the Valley to find experts in deep brain stimulation – a treatment that has allowed many patients to continue active lives.

For the past 10 years, Leatrice “Doddy” Blevins, 77, has had to travel several hours away from her Clovis home to get her deep brain stimulation device adjusted regularly.

In August, Blevins had her first appointment with a neurologist recently recruited by UCSF to practice at Community Regional Medical Center, Dr. Cong Z. Zhao. Blevins’ daughter Jill Aiello says the transformation with this treatment has been nearly miraculous: “The DBS took mom back to where she was 15 years before when her disease started in 1991. She could drive again. She could go shopping by herself.”

Putting All the Pieces Together to Bring Expert Neuroscience Care Closer to Home

Submitted by Erin Kennedy
CMC Senior Communications Strategist

Patients who once traveled to the Bay Area or Los Angeles for brain and spine specialists have found that expertise at Community Regional Medical Center. Over the past six years Community has committed the resources to quadruple the number neurosurgeons from 3 to 13 and open a 20-bed neuro intensive care unit – the only one in the region. Community has also increased surgical staff by 80% and added four more operating suites to support a surge in patients, many of them transferred from other hospitals for a higher level of care.

Community Regional now sees 1,200 stroke patients a year, about 15 of them each month transferred from other hospitals. It’s among 300 hospitals nationwide with the technology and neurosurgeons able to do large clot retrievals from the brain when the clot-busting drug t-Pa doesn’t work. Using a catheter snaked through a blood vessel in the groin and guided up into the brain, neurosurgeons at Community Regional use a wire mesh grabber to remove a clot blocking blood flow. The same technique can also be used to shore up a leaking blood vessel or an aneurysm in the brain by installing a tiny stent, as they did for Dot Powell, a retired Fresno Unified elementary school principal.

Dot Powell, 69, is back to doing nearly everything, including biking, after bleeding in her brain put her in Community Regional’s neuro intensive care for 11 days this summer. Her husband Larry Powell, the former Fresno County Superintendent of Schools, was amazed at the care and experts he found close to their Fresno home: “It was so slick and everything was

See Neuroscience Care on page 15
$1.1 billion in Zika Funding Approved by Congress

Abstracted from California Medical Association’s CMA News (10/3/16)

Funding for public health efforts against the Zika virus was finally approved by Congress with the passage of a stopgap measure to avoid a federal government shutdown. The spending measure includes $1.1 billion to fight the virus, capping a fierce months-long debate over the money that dismayed public health experts. The White House first requested $1.9 billion in funds to fight Zika in the spring. But Republicans initially resisted the request, before finally putting forward their own $1.1 billion Zika funding bill in July. The Republicans’ bill failed to pass this summer due to a rider that would have prevented funding of Planned Parenthood. With more than 3,358 Zika cases in the U.S. (mostly from people who acquired the virus abroad) and another 19,777 cases in U.S. territories, the money will go towards areas like vaccine research and mosquito control.

“It has been clear over the past several months that the U.S. has needed additional resources to combat the Zika virus,” said Andrew W. Gurman, M.D., president of the American Medical Association (AMA). The American Medical Association is pleased that Congress has taken action to provide the resources necessary to help contain the virus and limit any further impact on Americans,”

Although most people infected with Zika have no symptoms, Zika infection during pregnancy can cause microcephaly and other severe defects in the developing fetus.

The Aedes mosquitoes that carry the disease are not native to California, however they have been detected in 12 California counties in recent years. To date there has been no local mosquito-borne transmission of Zika virus in California.

A team of experts across several disciplines at the California Department of Public Health (CDPH) is working closely with local public health departments, vector control agencies and the medical community to ensure that California is responding aggressively and appropriately to the emerging threat of Zika virus. As of September 23, CDPH has confirmed 302 travel-associated Zika virus infections in 29 California counties. A total of 36 infections have been confirmed in pregnant women. CDPH has also confirmed that two infants with Zika-related microcephaly have been born in California to women who had Zika virus infections during pregnancy after spending time in a country where the virus is endemic.

Editor’s Note: All US blood donations are also now being screened for donor Zika infection by an investigational nucleic acid test (NAT). Locally, the Central California Blood Center is sending its donor samples to a laboratory in Phoenix. There are currently only several locations in the US offering this testing. If your patients ask, reassure them that Zika is now being tested.

Neuroscience Care

Continued from page 14

done so well in that neuro ICU. There was no need for us to go to Stanford or someplace else for great care.”

Community Regional become one of the first 17 hospitals in nation to open a hybrid operating suite with biplane technology in 2014 so surgical teams can go from a minimally-invasive procedure to a full open cranial or spine surgery within minutes. And a second hybrid operating room is planned for 2017 to increase that capacity. Nearly half of all the brain cancer surgeries in a 7-county region are performed at Community Regional.

And to make sure even those in more rural parts of the Valley are close to expert neuro care, Community’s team of neurosurgeons travels to a Tulare County hospital regularly to perform minor neuro surgeries. And Community provides education to emergency department staffs and physicians in surrounding counties on critical neuro care.
Trick or Treat: Halloween Safety Tips

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

October's here and that means its time to break out the pumpkins and hair dye! As you can see Halloween is a BIG deal at our house. Halloween should be a fun time for all children. However, there is a chance that younger children and teens can succumb to dangerous exposures amid the festive chaos. Here are safety tips from our poison control centers for enjoying this year’s festivities with your favorite little ghosts and goblins. Please share with the young parents and youth you see in your practice.

Costumes

• Wear flame-retardant costumes that are roomy enough to allow a child to dress warmly but not too big that children may trip or brush against a flame.
• Choose light colored costumes or use reflective tape to make children more visible.
• Consider using makeup instead of a mask to allow unobstructed vision. All masks, wigs and beards should fit securely, allowing for full vision.
• Face paints or makeup should be made of nontoxic material. Wash with soap and water if an allergic reaction develops.
• Make sure accessories, such as swords, are made of soft or flexible material.

Trick-or-treating in your Neighborhood

• Feed children BEFORE trick-or-treating and give them some candy from home while trick-or-treating to avoid the temptation to eat from their bags. Use smaller trick-or-treat bags to decrease the urge to get more candy. Carry a flashlight or glow sticks, wear reflective clothing or tape, and watch for cars.
• Stay in familiar, well-lit areas and try to finish before dark.
• An adult should accompany young children, and visits should be limited to familiar well-lit homes.
• Avoid barking dogs or other upset animals.
• If you are on door duty, consider giving non-edible treats such as stickers, pencil sharpeners, small toys, magnets, mini-erasers, shiny coins or a Polaroid of the trick-or-treaters.

Enjoying Treats Safely at Home

• An adult should check all treats before they are eaten. Explain why this is important to children.
• Only eat treats in original, unopened wrappers. Throw away candy if wrappers are faded, have holes or tears, or if the candy has been unwrapped.
• Some treats, especially chocolate, can be poisonous to pets.
• Consider giving non-edible treats such as stickers, pencil sharpeners, pencils, and magnets.

Glow Sticks

Glow sticks and necklaces are popular to help illuminate at night during Halloween. The active ingredient, dibutyl phthalate, in small amounts is fortunately very safe. The sticks and necklaces occasionally break or children chew them open. If the contents get on the skin, it can cause irritation and dermatitis. If the contents come into contact with the eyes it can cause severe irritation and cause the eyes to water. Oral ingestion of the contents can cause nausea and a burning sensation in the mouth and throat.

See Tox Tidbits on page 17
Tox Tidbits

Continued from page 16

Dry Ice and Fog Machines
When dry ice is swallowed, oral burns (actually tissue destruction from freezing) may occur. Immediate dilution is recommended. Having dry ice in punch is not a problem as long as the ice itself is not swallowed. Direct contact with the skin can also cause tissue damage – wash skin immediately with water. Fog machines use liquids that can contain toxic alcohols such as methanol and ethylene glycol – very dangerous even in small sips to young children. If exposure occurs call the poison center at 800-222-1222.

Makeup
Look for non-toxic designations when choosing Halloween makeup. Other products may contain emollient laxatives, talc or hydrocarbons, which can cause problems. If any makeup is swallowed, treatment depends on amount ingested, ingredients and symptoms. Call Poison Control (800-222-1222) for questions about the product and how to get immediate and appropriate help.

Cough and Cold Medications
And lastly – the change in seasons brings out the sniffles in just about everyone sooner or later. During cough and cold season, therefore, medications may be more available in the home than at other times of the year. Even though cough and cold medications are not recommended for routine treatment of URI symptoms in young children, children are nonetheless attracted to products that are flavored to taste good or resemble candy or beverages. Cough and cold medication may contain antihistamines, decongestants, and cough suppressants. When used incorrectly, they may cause agitation or drowsiness. In large doses they may have effects on blood pressure and heart rhythm.

It is recommended to keep all medications in a locked cupboard, and return them to safe storage immediately after use. Always check with other adults to prevent-double dosing of medications given to children. Be sure to turn on lights at night to ensure that the right medication and the right dose is given, no matter the age of the patient.

Stay safe this fall and Happy Halloween!

New Pharmacy Residency at Clovis Community Medical Center

Submitted by Bryan Carlson, PharmD
Pharmacy Residency Coordinator/Clinical Coordinator at CCMC

Please welcome to the CMC family Shao-Ju Chang PharmD and Cheree Sosin PharmD our inaugural class of residents in the new CCMC Post Graduate Year 1 Pharmacy Residency. We are happy to announce the beginning of a pharmacy residency at Clovis Community to complement the long standing program at Community Regional Medical Center and to welcome our new residents. They will be rotating through many areas of the hospital including acute care, ICU, emergency and the Women’s and Children’s Pavilion. They would love to be of service to the medical staff as medication experts. Please let them know what they can do to help out in the care of our patients here at Clovis Community.

“In a chronically leaking boat, energy devoted to changing vessels is likely to be more productive than energy devoted to patching leaks.”

– Warren Buffett, investor
In August, 2016 CMC hosted a continuing education class for the CMC Out-Patient Rehabilitation departments in a treatment technique known as Instrument Assisted Soft Tissue Massage, IASTM. The technique, and more specifically, the Graston Technique (GT), was introduced to our clinic 18 months ago by a local trained instructor, which generated interest among the staff. According to the Graston website, CMC Physical and Occupational Therapists are currently the only Graston providers of IASTM within a 40 mile radius and are leaders in the field for applying this type of skilled therapeutic intervention. Public interest is growing in this technique and we are proud to provide this service.

IASTM has been part of our clinical practice for many years, but the Graston Technique allows for more thorough evaluation and graded treatment sessions. The GT utilizes carefully designed instruments to assist in diagnosing the location of soft tissue and connective tissue dysfunction and isolating the treatment of the lesion. The objectives of the treatment include facilitation of connective tissue healing, introduction of a controlled micro trauma and inflammation process, release of functional soft tissue restrictions, edema reduction and pain management. GT can be used at any stage of tissue healing. Patient participation and verbal feedback is continual.

Evidence based research supports the use of GT and there are current randomized controlled trials. The scientific principles for soft tissue mobilization are well defined according to Wolf’s Law and Davis’ Law which state that soft tissue and connective tissue remodel themselves under an imposed demand. The Graston Technique provides the ideal environment for this tissue remodeling to occur. We at CCMC are in the process of writing a grant for continued research using IASTM, specifically GT, in conjunction with standard of care treatment, to measure the effectiveness of GT in enhancing shoulder ROM.

Patients who would benefit from GT are literally anyone with musculoskeletal dysfunction. Clinical indications include tendinopathies, fascial syndromes, ligamentous pain syndromes, soft tissue adhesions and entrapment syndromes. Absolute contraindications would include active infection, open wounds, uncontrolled HTN, unstable fractures, osteomyelitis and myositis ossificans.

As PT’s, we consider GT to be an evidence based method of IASTM that is combined with rehabilitative exercise to improve musculoskeletal function. The GT has never been intended as a stand-alone treatment, but as an adjunct technique. GT is always followed by exercise and stretching for maximum soft tissue healing. We currently have used GT to enhance ROM, decrease pain, and improve muscle function and strength. Observed benefits of GT are a reduction in treatment time, improved patient tolerance and a quicker response to treatment by the patient.

We have had several patients come to the clinic specifically for the GT. They have benefited from the combined rehabilitative treatments, which include GT. One patient states, “I am a breast cancer survivor sent to Clovis Community Physical Therapy to be treated for lymphedema. Within 3 weeks the swelling in my arm was gone but remained in my hand until the Graston Technique was used. I was amazed at the results, noticing a reduction in swelling the following day. During my third treatment, I could not only see the improvement but could feel the improvement by how smooth the fibers underneath the skin had become.”

We in the Rehabilitation departments at CCMC and CORC would be happy to answer any questions you might have about the Graston Technique and would be willing to provide this treatment for your patients with musculoskeletal diagnoses.

“When you have that window of opportunity called a crisis, move as quickly as you can, get as much done as you can. There’s a momentum for change that’s very compelling.”

– Anne Mulcahy, corporate leader

Editor’s Note: This can be overdone as a strategy for facilitating change – look for other avenues, too.
We Are Working for a Healthier Planet

Submitted by Connie Young, RN, CMC Sustainability Coordinator

What do the Fresno Madera Medical Society (FMMS), the California Medical Society (CMA), the Health Officers Association of California, and the American Lung Association all have in common? They and many other health organizations have issued statements about the threat that climate change poses to human health, and the need for health care providers and other leaders to address this problem. The corporate-wide team committed to helping Community Medical Centers become a greener organization is continuing to learn ways we can contribute to a healthier planet for all of us. Several months ago, Fresno physician Dr. Don Gaede, spoke to our Sustainability Value Analysis Team (S-VAT) about climate change. He explained how rising temperatures increase concentrations of ozone that can harm people with asthma, emphysema and heart disease. Warmer temperatures worsen drought conditions and dry out our forests, contributing to wildfires that add smoke to our already polluted air. Even otherwise healthy people like young athletes and outdoor laborers are at greater risk of heat-related illnesses like heat exhaustion and heat stroke.

Having authored both the FMMS’s and CMA’s Climate Change Resolutions, Dr. Gaede explained that they advocate for educating patients and the medical community about the potential adverse health effects of global climate change. They encourage health care institutions to review and improve their carbon footprints, including their supply chains, and to prepare for climate impacts. Finally they recommend communicating with local, state, and national legislators to request that they take action to adapt to and mitigate the effects of climate change.

While Community Medical Centers hasn’t issued a similar statement, we have made a commitment towards being sustainable by buying greener products, recycling what we can and reusing items when it benefits patient care. I’m proud that Community Medical Centers has joined Healthier Hospitals and is participating in several of its challenges.

And we are the first hospital network in California to join the federal Department of Energy’s Workplace Charging Challenge by providing free car charging stations for employees and doctors at all of our hospitals. Community is the third Valley employer and among 600 workplaces nationwide to encourage cleaner commuting by helping employees extend the commuting range of their zero emissions vehicles. Encouraging cleaner driving is something that’s crucial to a place where you can often see and taste the dirty air and where we see the effects on people who show up in our emergency rooms in respiratory distress.

In addition, the S-VAT, many departments and individual employees are taking actions to reduce waste and emissions and to conserve resources. Interested employees may contact Rhonda Hightower to join the Green Champions email list for updates on S-VAT initiatives and to exchange ideas. Together, we’re promoting the health of the community by addressing climate change and moving towards a healthier future.

To learn more about this topic and find out who else is speaking out about climate change, go to: www.lung.org/our-initiatives/healthy-air/outdoor/climate-change/declaration-on-climate-change.html
for woman and infant, with benefits that improve safety and promote short- and long-term maternal and infant health.

The rate of induction in the United States (23.4% of all births) has more than doubled since 1990. The increase is not thought to be attributable to a similar rise in medical conditions in pregnancy that warrant induction of labor.

Researchers have demonstrated that induction of labor for any reason increases the risk for a number of complications for women and infants. Induced labor results in more postpartum hemorrhage than spontaneous labor, which increases the risk for blood transfusion, hysterectomy, placenta implantation abnormalities in future pregnancies, a longer hospital stay, and more hospital re-admissions. Induction of labor is also associated with a significantly higher risk of cesarean birth. For infants, a number of negative health effects are associated with induction, including increased fetal stress and respiratory illness.

Research on the risk-to-benefit ratio of elective augmentation of labor is limited. However, many of the risks associated with elective induction may extend to augmentation. In a recent systematic review, the authors found that women with slow progress in the first stage of spontaneous labor who underwent augmentation with exogenous oxytocin, compared with women who did not receive oxytocin, had similar rates of cesarean. Such results call into question a primary rationale for labor augmentation, which is the reduction of cesarean surgery.

In addition to the serious health problems associated with non-medically indicated induction of labor, hospitals, insurers, providers and women must consider a number of financial implications associated with the practice. In the United States, the average cost of an uncomplicated cesarean birth is 68% higher than the cost of an uncomplicated vaginal birth. Further, women who deliver vaginally have shorter hospital stays, fewer hospital readmissions, faster recoveries and fewer infections than those who have cesareans.

Don’t prescribe opioid pain medication in pregnancy without discussing and fully weighing the risks to the woman and her fetus.

In utero exposure to opioids can lead to risks for the infant, including neonatal abstinence syndrome (NAS) and/or developmental deficits affecting behavior and cognition.

Pregnant women’s use of opioids dramatically increased from 1.19 per 1000 hospital births in 2000 to 5.63 per 1000 hospital births in 2009. Prescription opioids are among the most effective medications for the treatment of pain. However, regular or long-term use of opioids can create physical dependence and in some cases, addiction. Women who are prescribed, or continue to use, opioids during pregnancy may not understand the risks to themselves or their babies.

Pregnant women and their fetuses are an inherently vulnerable population and opioid dependence increases their vulnerability. Women using opioids during pregnancy were shown to have higher rates of depression, anxiety and chronic medical conditions as well as increased risks for preterm labor, poor fetal growth and stillbirth.

Women who used opioids during pregnancy were four times as likely to have a prolonged hospital stay compared to nonusers and incurred significantly more per-hospitalization cost.

Neonatal abstinence syndrome (NAS) occurs in newborns that are exposed to substances, typically opioids, while in their mothers’ wombs. In utero exposure to these substances can cause a newborn to experience withdrawal symptoms after birth. Symptoms of NAS vary depending on the type and amount of the substance that the mother used, how the mother and fetus metabolize the drug and how long the mother used the drug. Symptoms of NAS range from blotchy skin and sneezing, to respiratory complications, low birth weight, prematurity, feeding difficulties, extreme irritability and seizures.
Don’t separate mothers and their newborns at birth unless medically necessary. Instead, help the mother to place her newborn in skin-to-skin contact immediately after birth and encourage her to keep her newborn in her room during hospitalization after the birth.

Keeping mothers and newborns together promotes maternal-infant attachment, early and sustained breastfeeding and physiologic stability. Early initiation of skin-to-skin care and breastfeeding promotes optimal outcomes and can significantly reduce morbidity for healthy term and preterm or vulnerable newborns. Breastfeeding is the ideal form of infant nutrition and should be the societal norm. Given the numerous health benefits for infant and mother and the health care cost savings associated with breastfeeding, breastfeeding has become a global public health initiative that can improve the overall health of nations. Ideally, infants should be exclusively breastfed for the first six months of life; after the first six months, appropriate complementary foods should be introduced, and the infant should continue to breastfeed for 1–2 years, or longer as desired. Worldwide, the lives of an estimated 1.5 million children less than the age of five would be saved annually if all children were fed according to this standard.

Don’t administer “prn” (i.e., as needed) sedative, antipsychotic or hypnotic medications to prevent and/or treat delirium without first assessing for, removing and treating the underlying causes of delirium and using nonpharmacologic delirium prevention and treatment approaches.

The most important step in treating delirium is identifying, removing and treating the underlying cause(s) of delirium. Delirium is often a direct physiological consequence of another medical condition, substance intoxication or withdrawal, exposure to a toxin, or is due to multiple etiologies. Clinicians should therefore perform a detailed history and physical exam, order appropriate laboratory/diagnostic tests, conduct a thorough medication review, and discontinue any potentially deliriogenic medications. Because numerous medications or medication classes are associated with the development of delirium (e.g., benzodiazepines, anticholinergics, diphenhydramine, sedative-hypnotics), their administration on a prn basis should be avoided if possible. Moreover, due to the potential for harm and lack of sufficient evidence supporting the safety and efficacy of antipsychotics for the prevention and treatment of delirium, these medications should be administered only at the lowest effective dose, for the shortest amount of time, in patients who are severely agitated and/or at risk for harming themselves and/or others. In terms of delirium prevention, it is recommended health systems should implement multicomponent, nonpharmacologic interventions that are delivered consistently throughout hospitalization by the interdisciplinary team.

Don’t assume a diagnosis of dementia in an older adult who presents with an altered mental status and/or symptoms of confusion without assessing for delirium or delirium superimposed on dementia using a brief, sensitive, validated assessment tool.

Delirium is common in older adults, especially in the hospital setting, yet delirium is frequently unrecognized and not documented by nursing or medical staff. Delirium occurs in as much as 50% of older adults in the hospital and delirium superimposed on dementia occurs in as high as 90% of hospitalized older adults. Delirium is associated with very poor clinical outcomes, including prolonged length of stay, high costs and lower quality of life for older adults when not detected early. Delirium is treatable and often reversible and dementia is not, so mislabeling older adults with dementia may miss a life threatening underlying condition causing the delirium such as an infection, medication side effect or subdural hematoma. Delirium is extremely costly to the health care system and to society with estimates ranging from $143 to $152 billion annually. Nurses and physicians often fail to recognize delirium. Only 12–35% of delirium cases are detected in routine care, with hypoactive delirium and delirium superimposed on dementia most likely to be missed.
Please see below for a list of Order Sets that were released into production between 08/30/2016 to 09/13/2016. 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>1308</td>
<td>Adult Discharge Shell Z</td>
<td>Change Request. Update to include referral to CEC CHF teaching follow up at Fresno Heart and Surgical Hospital.</td>
</tr>
<tr>
<td>45</td>
<td>Adult SSS Anesthesia Level 2</td>
<td>Change Request. Update pain medication section to be able to allow physicians to save selections.</td>
</tr>
<tr>
<td>1637</td>
<td>ALSA Cardiac Evaluation</td>
<td>Change Request. Updated nursing orders, labs, diagnostic procedures, intravenous fluid orders, and medications.</td>
</tr>
<tr>
<td>1540</td>
<td>ALSA Cardiovascular Surgery Discharge Orders</td>
<td>Change Request. Updated to include referral to CEC follow up at Fresno Heart and Surgical Hospital.</td>
</tr>
<tr>
<td>1500</td>
<td>Antepartum Testing Outpatient</td>
<td>Biennial Review. Minor modifications and clarity on language for non-stress test monitoring.</td>
</tr>
<tr>
<td>1331</td>
<td>Emergent Heparin &amp; Low Molecular Weight Heparin Reversal</td>
<td>Biennial Review Modifications to mirror new heparin nomogram instructions for PTTs greater than 120.</td>
</tr>
<tr>
<td>43</td>
<td>Post Anesthesia PACU</td>
<td>Change Request. Standardize meperidine dosing (including maximum dose) for shivering management.</td>
</tr>
<tr>
<td>1372</td>
<td>Post-Op Anorectal Perineal Short Stay Discharge</td>
<td>Biennial Review. Minor modification to antibiotic language and consult ordering.</td>
</tr>
<tr>
<td>1409</td>
<td>Post-Op Orthopedic Upper Extremity Surgery Discharge</td>
<td>Change Request. Name change of order set, stream line order set, and appropriate and necessary orders for type of surgery.</td>
</tr>
<tr>
<td>256</td>
<td>Pre-Admit Surgery/ Procedure Z</td>
<td>Change Request. Improve workflow efficiency. Labs need to be STAT to support timely draw/result, modify order set restrictor so all orders will be available to providers at the ambulatory care clinics entering orders.</td>
</tr>
<tr>
<td>520</td>
<td>Pre-Op Interventional Radiology (Patient in hospital)</td>
<td>Biennial Review. Clinical lab section modified to reflect appropriate labs for interventional radiology procedures.</td>
</tr>
<tr>
<td>572</td>
<td>SQ Insulin</td>
<td>Change Request. Update timing of blood glucose draws and nutritional scales. Minor modification to hypoglycemia management per diabetes guidelines.</td>
</tr>
<tr>
<td>24</td>
<td>Transfusion Orders</td>
<td>Change Request: Edit to Epic only, to have Tranexamic acid pre-checked and exception code removed.</td>
</tr>
<tr>
<td>1383</td>
<td>Ventricular Assist Device Implant</td>
<td>Change Request. Standardize and improve the communication to nursing at bedside. Orders multifunctional and can be used for both initial implant or VAD re-admissions.</td>
</tr>
</tbody>
</table>

“Failure is only the opportunity more intelligently to begin again.”

– Henry Ford, industrialist
UCSF Fresno Department of Psychiatry Presents:

Title: “Antipsychotic Prescribing Trends in Children and Teens”
Date: Thursday, October 13, 2016
Speakers: Dr. Andrew Goddard
Time: 4:00 pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Room 116
CME: 1 CME

Title: “On Death and Dying: Aid In Dying In Patients With Active Psychiatric Illness”
Date: Thursday, October 27, 2016
Speakers: Drs. Anjani Amladi and Shawn Hersevoort
Time: 4:00 pm
Place: UCSF Fresno Center, 155 N. Fresno Street, Room 116
CME: 1 CME

CRMC Perinatal M & M

Title: “Delaying Cord Clamping”
Date: Wednesday, October 19, 2016
Speaker: Drs. David Aguilar, John C. Partridge and Melissa Rosenstein
Time: 12:30 pm-1:30 pm
Place: UCSF Fresno Center, 155 N. Fresno St., Fresno, CA 93701, Rm 136
CME: 1 CME

SAVE THE DATE

Clovis Community presents:

Title: “Update In Breast Care-Symposium for Primary Healthcare Professionals”
Date: Saturday, November 5, 2016
Speakers: TBD
Time: 8:00 am-12:30 pm (breakfast and lunch provided)
Place: UCSF Fresno Center, 155 N. Fresno St., Fresno, CA 93701
RSVP: www.ClovisCommunity.org/breastcare2016 or Contact Jessica Lipsius at: 559-324-4002 or jlipsius@communitymedical.org
CME: 4.5 CME

California Central Valley Coalition for Compassionate Care Presents:

Title: “End of Life Options-Healthcare Professionals Symposium”
Date: Monday, November 7, 2016
Speakers: Patrick Macmillan, MD, Matthew Whitaker, Lynn Burnett, MD, Cynthia Farley and Christina Swift
Time: 8:00 am-12:00 pm (continental breakfast and lunch provided)
Place: UCSF Fresno Center, 155 N. Fresno St., Fresno, CA 93701
RSVP: Register online: ENDOFLIFEOPTIONS.EVENTBRITE.COM
Cost: $35
CME: 4 CME Applied for

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

SERGIO ILIC M.D.
See page 2 for details
Patient’s Own Insulin Pumps
Policy, Procedure, Order Set and Tools

Go Live: Tuesday, October 4, 2016

In order to meet the needs of our community’s growing population of individuals with their own insulin infusion pumps, Community Medical Centers (CMC) has developed policies, procedures and tools to support the inpatient management of this patient population.

The Policy and Procedure, Adult Continuous Subcutaneous Insulin Infusion, states:

“Generally, at CMC, continuation of insulin pump therapy during acute illness is NOT recommended. Instead the insulin pump regimen should be transitioned immediately to a basal plus prandial subcutaneous insulin regimen upon hospital admission.”

Nevertheless, it is recognized that, on occasion, it may be decided to continue therapy with a patient’s own insulin pump.

Please note that, if continued, mechanical operation of the insulin pump is the responsibility of the patient, with assessment and documentation by the nursing staff. If, at any time, the healthcare team has concerns about a patient’s ability to operate their pump in a collaborative fashion, the physician should consider transitioning the patient to an alternative insulin regimen.
To assist healthcare providers in the glucose management of insulin pump patients, the following tools have been developed:

1. **Adult Continuous Subcutaneous Insulin Infusion Policy** to guide the process
2. **Patient Competency Assessment Tool** to be used by nursing staff to assess patient’s ability and knowledge to manage their own insulin pump
3. **Patient Agreement Form** for nursing to inform the patient about their responsibilities to manage the pump in collaboration with nursing staff.
4. **Physician’s Order Set (Adult Insulin Pump Self-Management Order Set)** to guide medication prescribing and monitoring associated with either:
   a. Conversion from the insulin pump to an intermittent subcutaneous insulin regimen – OR -
   b. Continuation of the insulin pump.

Prescribers are encouraged to collaborate with a provider with pump expertise (e.g. patient’s outpatient endocrinologist) to develop insulin pump management plans.
Perinatal M & M Presents:
"Delayed Cord Clamping"

Wednesday, October 19, 2016 from 12:30pm – 1:30pm

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

Principal Discussants
Neonatology: Dr. David Aguilar
Neonatology: Dr. John C. Partridge (UCSF Benioff Children's Hospital)
Perinatologist: Dr. Melissa Rosenstein (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 delayed cord clamping.
2) Gain insight into cord clamping, 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 Directors Dr. K. Rajani; Dr. Aguilar and Program Planner Bernadette Neve have no relevant commercial relationships to disclose. This is an activity offered by Community Medical Centers, a CMA-accredited provider. Records of attendance are based on sign-in registration and are maintained only for Community Medical Centers staff members who are credentialed as an MD, DO, CNM, NP, or PA.

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

Community Medical Centers designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.
UPDATE IN BREAST CARE
SYMPOSIUM FOR PRIMARY HEALTHCARE PROFESSIONALS

DATE:
Saturday, November 5, 2016
7:00 am — 8:00 am Registration
8:00 am — 12:30 pm Symposium
Breakfast & Lunch will be provided

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

ATTENDEES WILL:

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

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

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

• Review case studies of patients with positive findings (cancer) and gain a better understanding of the ethical decision making process physician’s use when diagnosing and treating breast disease and apply this knowledge in practice.

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

CME: 4.5

TO RSVP, PLEASE CLICK ON:

FOR MORE INFORMATION:
Jessica Lipsius at:
(559) 324-4002
jlipsius@communitymedical.org
### COURSE ACTIVITIES INCLUDE:

<table>
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<tr>
<th>SPEAKERS</th>
<th>PHYSICIAN TITLES</th>
<th>PRESENTATION TITLES</th>
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<tbody>
<tr>
<td>Deanna Attai, MD</td>
<td>Assistant Clinical Professor of Surgery at the David Geffen School of Medicine at the University of California, Los Angeles; Past-President of the American Society of Breast Surgeons</td>
<td>Life After Breast Cancer Treatment: How to Help Your Patients Thrive</td>
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<tr>
<td>Judy Champaign, MD</td>
<td>Breast Imaging Radiologist, CMI Radiology Group, Fresno, CA</td>
<td>Breast Imaging</td>
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<tr>
<td>Dawn DeLozier, PHD</td>
<td>Medical Geneticist, Clovis Community Medical Center, Clovis, CA</td>
<td>Evolution of Genetic Testing for Hereditary Cancers</td>
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<tr>
<td>Vassi Gardikas, MD, FACS</td>
<td>Breast Surgeon, Valley Surgical Specialists, Fresno, CA</td>
<td>Benign Diseases of the Breast</td>
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<tr>
<td>Andrea Stebel, MD</td>
<td>Breast Oncologist at California Oncology of Central Valley, Fresno CA</td>
<td>Update in Breast Cancer Care</td>
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<tr>
<td>Deborah Gumina, MD, FACS</td>
<td>Breast Surgeon, Valley Surgical Specialists, Fresno, CA</td>
<td>Case Study – Panel Discussion</td>
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### Disclosure

Activity Director Deborah Gumina, MD has no Commercial Disclosures to make. Speaker Andrea Stebel, MD would like to disclose that she has a financial interest/arrangement or affiliation with the following corporation or other organization that sell or develop products or drugs for medical use: Celgene – Speakers Bureau. Speakers Deanna Attai, MD, Judy Champaign, MD, Dawn DeLozier, PhD, and Vassi Gardikas MD, have no Commercial Disclosures to make. Moderator Uma Swamy, MD has no Commercial Disclosures to make. Planner Jessica Lipsius has no Commercial Disclosures to make.
Participants will

1. Increase understanding of California’s End of Life Options Act and will be able to add this competency to one’s practice.

2. Increase knowledge of all facets of the Palliative Care Continuum and become familiar with contemporary strategies of palliative care, geared towards improving patient care/outcomes.

3. Engage in palliative care and advanced care planning conversations and use this knowledge to more effectively communicate availability of these treatment options to patients, improving satisfaction and care.

PATRICK MACMILLAN MD, FACP
CHIEF, HOSPICE & PALLIATIVE CARE, UCSF FRESNO
Dr. Macmillan received his medical degree from Ross University School of Medicine and completed a combined Internal Medicine and Psychiatry residency at East Tennessee State University. He is board certified in hospice and palliative medicine, with six years experience as a medical director for a home hospice agency.

MATTHEW WHITAKER
CALIFORNIA AND OREGON STATE DIRECTOR, COMPASSION & CHOICES
An advocate of person centered care, Matt is an expert resource on end of life choices to numerous legislative committees. He is a board certified music therapist with clinical experience in long term acute care and geriatrics, and has a passion for improving end of life care through empowerment and education.
October 2016

October 6
No Grand Rounds – PRITE Exam

October 13
“Antipsychotic Prescribing Trends in Children & Teens”
Andrew Goddard, MD
Professor of Psychiatry
Chief, UCSF Fresno Psychiatry Residency Program

October 20
M&M Presentation

October 27
“On Death and Dying: Aid In Dying In Patients With Active Psychiatric Illness”
Anjani Amladi, MD, Presenter
Shawn Hersevoort, MD, Discussant
UCSF Fresno Psychiatry Residency Program

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<th>MONDAY</th>
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<td>Ortho Surg./Foot/Ankle/Hand SPOC</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
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<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>HPB Planning Conf. CRMC-Sequoia West Conf Rm</td>
<td>Surgical Grand Rounds CRMC- Sequoia West Conf. Rm</td>
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<td>8:00 - 9:00 am</td>
<td>Medicine Grand Rounds UCSF Auditorium</td>
<td>Cardiac Cath &amp; Intervention Cath Lab (7 West)</td>
<td>Emergency Medicine UCSF Rm 136</td>
<td>Surgery Clinical Case Rev. CRMC-Sequoia West Conf. Rm</td>
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<td>Neurovascular Conference CRMC-TCCB3 Conf. Rm</td>
<td>Brain Tumor/Cyberknife Conf. CRMC- Sequoia West Conf. Rm</td>
<td>Critical Care/Trauma CRMC- Sequoia East Conf Rm</td>
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<td>CRMC Robotic Steering Committee</td>
<td>TCCB Surgery Conference Room</td>
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<td>CCMC Cardiology</td>
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<td>CRMC Medicine</td>
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<td>CRMC Facility Executive Committee</td>
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<td>Pediatrics Surgery Meeting</td>
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<tr>
<td>9:00am</td>
<td>Formulary Subcommittee</td>
<td>CRMC Sequoia West Room</td>
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<td>6:00pm</td>
<td>FHSR Surgical Advisory</td>
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<td>Pharmacy &amp; Therapeutics</td>
<td>CRMC Sequoia West Room</td>
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<td>6:00pm</td>
<td>FHSR Quality Patient Safety</td>
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