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JANUARY PHYSICIAN PHOTOGRAPHER
DIANNE M. LIMA, CRMC, Laboratory
Point of Care Department

I love taking photographs! Whether in day-to-day celebrations of life, or travel excursion and exploration of different cultures, flora, fauna, and food, I am fascinated by different angles and compositions. I frequently strive to capture the not-so-common view. Sometimes I succeed by photographing the reflection of a skyscraper on a window, or the image of statues that appear in motion in a park. Sometimes, however, I simply get caught up in the beauty and majesty of a location, and can’t help but photograph the same image that millions before me have captured. And, therein, lies the beauty of photography: the ability to transcend time and space to allow us to once again re-live the memories of that moment, or to ignite a desire to create new ones. If I can do this with any of my photographs, I consider it a success. May you enjoy these photographs as much as I enjoyed taking them. Cheers!

Dianne M. Lima C.L.S., M.T. (ASCP), POCT-S (ACC) is a Clinical Laboratory Scientist with CRMC Laboratory’s Point of Care Testing Department, and has 30+ years of cumulative Clinical Laboratory experience. This is her first year with CRMC. Her role within POCT includes training patient care staff and Clinical Educators on bedside laboratory testing, trouble-shooting instrumentation, auditing certification records, and reviewing lab results performed at the bedside. She believes that her role within POCT provides her a unique platform to serve as an (unofficial) ambassador of the Laboratory, and an approachable resource on the myriad State and Federal regulations, as well as the accrediting bodies governing Laboratory testing, and POCT specifically.

Physician Editor: David L. Slater M.D., F.C.A.P.
Managing Editor: Laurie Smith
Manager, Physician Education and Communication

Deadline to submit articles for the March 2017 issue of Physicians’ Edition is Friday, February 17.
The 2016 Election and Implications for CMC

With the campaign season behind us, the questions have shifted to just what the election results will mean for healthcare, for hospitals, and for Community Medical Centers. It is far too early to know exactly how campaign promises or ballot initiatives will play out. But we will be carefully tracking these three areas: changes to the Affordable Care Act, prospective changes in reimbursement, and shifts in the regulatory environment.

At the Federal level

The biggest news of this election was the election of Donald Trump as the 45th President. President-Elect Trump campaigned on a promise to “repeal and replace” the Affordable Care Act (ACA). Republican majorities in both the Senate and the House ensure that the ACA will be a top agenda item when Congress returns to work in January. However, among Republicans, there is some divergence in just how to make changes in the ACA – some advocating for a complete repeal, others favoring incremental changes over time. We are monitoring the potential impacts of these and other federal actions on the State health insurance exchanges, such as Covered California, as well impacts on future Medicare and Medicaid funding.

Editor’s Note: The federal-level changes to ACA and all aspects of the vast federal landscape related to US health care, are in flux and evolving rapidly. An excellent source for thorough, impartial, and up-to-date health care reporting is Kaiser Health News.

At the State level

The most significant California ballot initiative was Proposition 52, the Medi-Cal Hospital Fee Program. This initiative, sponsored by the California Hospital Association, passed with nearly 70% of the vote. Proposition 52 will help ensure that existing supplemental funding for Medi-Cal hospital services, care for uninsured patients, and children’s health coverage will continue indefinitely and that the funds won’t be diverted for other State programs. Proposition 52 was important for CMC because it safeguards a significant source of revenue to support our work as a safety-net provider.

Two other propositions – Proposition 55 (Tax Extension to Fund Education and Healthcare) and 56 (Cigarette Tax to Fund Healthcare, Tobacco Use Prevention, Research, and Law Enforcement) – both will provide additional revenue to the state for Medi-Cal programs and may have an indirect benefit to CMC in the future, but that is not clear at this time.

Proposition 64 – legalizing recreational use of marijuana – is also getting a great deal of attention. While this proposition has passed in California, it is important to remember marijuana is still a controlled substance under Federal law. Our current policies regarding drug and alcohol use are still in effect. You can expect further communication from Human Resources in the coming weeks on this issue.

Editor’s Note: State healthcare news and potential changes are also highly in flux. An excellent California-focused source of reliable information is the California Healthcare Foundation’s California Healthline e-newsletter – highly recommended to all California healthcare professionals.

As we monitor the events unfolding at every level of government, there are many things that remain unchanged for Community Medical Centers.

At our core, we remain committed to serving all patients in this region, including those who are underserved or uninsured. Despite the challenges that come our way, we will respond to changes in funding, insurance programs, legislation, and more just as we have always done – thanks to the work of our staff, physician partners, Board of Trustees, and volunteers – with clear strategy, strong community relations, and effective implementation of new requirements.

VP Lynne Ashbeck, who heads our public affairs office, has assembled a public policy team that will track, provide feedback, and swiftly respond to policy, legislative and regulatory changes of potential impact to CMC. Over the next several weeks and months, we will reconnect with our elected officials and remind them of the important work you do every day to make ours the best health system in central California.
Initial Appointment to the Medical Staff
effective January 12, 2017

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

Muhammad Alam M.D.
Department: Medicine
Specialty: Hematology-Oncology

Chenwi Ambe M.D.
Department: Surgery
Specialty: General Surgery

Leslie Crebassa M.D.
Department: Emergency Medicine
Specialty: Emergency Medicine

Walter Forred M.D.
Department: Family Medicine
Specialty: Family Medicine

Timothy Foster M.D.
Department: Medicine
Specialty: Pediatric Neurology

Nitasha Klar M.D.
Department: Radiology
Specialty: Diagnostic Radiology

Evelyn Maddela M.D.
Department: Pediatrics
Specialty: Pediatrics

James Pick M.D.
Department: DOCS
Specialty: Psychiatry

Shreyas Saligram M.D.
Department: Medicine
Specialty: Gastroenterology

Muhammad Salim M.D.
Department: Medicine
Specialty: Pediatric Neurology

Initial Appointment to the Medical Staff
effective January 12, 2017

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

Abel Garcia C.R.N.A.
Department: Surgery
Specialty: Anesthesiology

Charles Hurd P.A.
Department: Surgery
Specialty: General Surgery

Jehnette Lopez N.P.
Department: Surgery
Specialty: Neurosurgery

Vicki Lynn Pease N.P.
Department: Pediatrics
Specialty: Pediatrics

Janice Pitman N.P.
Department: Pediatrics
Specialty: Pediatrics

Thuy Nhu Tran C.C.P.
Department: Surgery
Specialty: Clinical Perfusionist

“If you don’t know what truly motivates you, you really don’t know what will satisfy you.”

– Tanya Tarr,
Media Consultant and Forbes columnist
I just saw the latest edition of the Fresno Madera Medical Society’s magazine and was so thrilled to see that four of the five physicians recognized with Lifetime Achievement awards were affiliated with Community Medical Centers. These are amazing pioneers in local medicine, who lead the way in mentoring other doctors and in service to our community. And they chose to care for our patients at our facilities – which says a lot about them and about Community.

I want to offer my kudos to the medical society’s 2016 Lifetime Achievement Award winners: Dr. Robert Libke, Dr. Andre Minuth, Dr. Christopher Perkins, and the late Dr. Alex Moir, who all have Community and UCSF affiliations, and Dr. Morton Rosenstein, who retired as chief of obstetrics and gynecology at St. Agnes Medical Center. I know all but Dr. Moir and consider each of them “rock stars” in their profession and friends of mine. These pillars of medicine more than deserve accolades and honors for the huge difference they’ve made in the Valley.

While many of us know the achievements of our Community doctors, I learned a few things that I’d love to share.

I knew Dr. Robert Libke was the first infectious disease specialist in central California and that he’s the chief of infectious disease for UCSF Fresno, mentoring the next generation of infectious disease doctors. But, I didn’t know that he’s trained more than 600 medical residents, that he literally wrote the medical textbook chapters on Valley Fever and that his peers call him “Mr. Infectious Disease” because he was the one rounding at all the area hospitals in the early days and he served as infection control officer at several hospitals at once. Other doctors say he’s the one they turn to when they can’t figure out a difficult diagnosis.

Dr. Andre Minuth, a member of my Rotary, was the first nephrologist in central California and he’s the chief of nephrology for UCSF Fresno’s internal medicine faculty. At 80-something, he still staffs the UCSF Fresno renal clinic two days a week sharing his knowledge with residents practicing in the Deran Koligian Ambulatory Care Center. He’s a true pioneer in the region, establishing the first outpatient dialysis clinic in Fresno, starting home dialysis here at a time when that was considered radical and even serving as a dialysis doctor on cruise ships so people who had advanced kidney disease could enjoy a vacation. How selfless!

Most people know Dr. Minuth from his activities in local and state politics, including his run for congress. He’s passionate about getting local doctors involved in the California Medical Association and in making sure local political candidates pay attention the their doctor constituency and understand how they can make a difference in healthcare for patients and doctors. We hope he never retires in his advocacy for the Valley!

Dr. Alex Moir was chief of family and community at UCSF Fresno before his death at age 53 in December 2015, and he also served as chief of medicine at the Selma District Hospital. Dr. Moir, who died in a skiing accident while on vacation in Canada with his family, left a big impression on those who trained with him and practiced medicine with him. They say he epitomized the traditional small town doctor who knew everybody by name where ever he went out in town and who took an active interest in making his small town a better place to live.

I think UCSF’s Dr. Michael Peterson really summarized the impact Dr. Moir had in a wonderful way: “All of us remember the physicians who taught us. We all take a little piece of them into our careers and so the fact that Dr. Moir really set the kind of tone and example that he did, for many decades to come the healthcare that happens in this Valley is going to be tied directly to the model that he provided for his trainees and the people he worked with.”

Dr. Christopher Perkins, whom I’ve known since first started his practice in 1987, is not only a top a medical oncologist with California Oncology of the Central Valley, he’s the founder of the Art of Life Cancer Foundation. He treats many of Community’s cancer patients. He was the medical society’s Special Project award winner for the project he started in 2007 to help people affected by cancer connect with local artists and heal through creative visual expression. Art of Life, which started with 30 cancer survivors from Perkins’ practice, has been expanded to include any cancer patient or survivor, no matter what stage of cancer and no matter where they were treated. So far, more than 500 patients have teamed up with local artists to share their cancer journey. And in 2015, the Art of Life Cancer Foundation broke ground on a 3-acre healing garden in Fresno’s Woodward Park. I’ve had the privilege of viewing some of the works of art created through this wonderful program and all have touched me deeply.

Again, kudos to these wonderful physicians. I am so proud to work with them at Community!
Editor's Note: It used to be that “Cognitive Overload” was an academic subject applicable to a subset of particularly high-complexity and unforgiving tasks and situations. All these electronic device-years and distraction-inducing-stuff and their social fall-out later, Cognitive Overload is an almost assumed part of modern life, as if it must be factored in, instead of guarded against or reversed in our lives.

But this Editorial in the Fall Alpha Omega Alpha Pharos, written by Editor Richard L. Byyny M.D., an Internist and Educator, counsels otherwise. Cognitive Overload is a threat to our professional and personal lives and to our well-being. The good news is that it can be combatted and resisted. If you’ve checked your phone while reading the above few lines, you need this article…. (Reproduced with permission)

We are in an age of information overload. The Internet, e-mails, apps, spam, tweets, social media, texting, Facebook, Instagram, memes, news feeds, online videos, updates, and myriad other forms of information have significantly increased the information directed at us, as well as those in which we request to participate.

We have come to regard this overload of information, and brain drain, as the norm. We accept this inundation as communication, learning, practice, performance, social and professional interaction, and decision-making, without ever considering our well being, productivity, and sanity.

A 2012 survey found that average workers spend 28% of their time managing e-mail,¹ and a British study found we check our phones on average 221 times a day, or about every 4.3 minutes.² A Stanford University School of Medicine team found that nearly one in eight Americans exhibit problematic Internet use.³

In 2009, 50 billion e-mails were sent each day. In 2010, that number rose to 294 billion e-mails per day.

Social norms have introduced a presumed requirement to participate, and collaborate, in every message we receive. In contrast to the continuous growth in technology and information, our human capabilities are limited. Our neurons don’t increase in numbers, nor do they respond more quickly to this overdose of information. Our memory does not increase in capacity. We do not learn or think faster, and this mismatch creates, contributes to, and causes information, participation, and collaboration overload. The effort required to keep track of, and participate in, what is going on professionally, with family and friends, and in the world requires an ever-increasing amount of attention and time.

We are continuously distracted from important priorities—thinking, learning, reflecting, decision-making. The presentation of information has become an insidious influence in the loss of our intellectual independence. We are bombarded with jibber-jabber, rumor, and opinions that are often biased with inaccurate or false information.

In the days of Walter Cronkite, there were only a few sources of information, and each had important filters—journalistic reviews, peer reviews in journals, and fact checkers—that reviewed the information and verified its accuracy before it was presented publicly. With today’s 24/7 communication environment, it’s about posting it on the Internet first, and fact checking later.

Information is often presented by self-claimed experts, colleagues, and a multitude of journalistic-like outlets. Many media specialists, bloggers, podcasters, and others have no professional training or background in journalism, professionally-mandated ethics, or communication.

We should wonder if what we are reading or hearing is valid and substantiated. Many so-called experts are more interested in serving their own egos, and enhancing their reputations than actually providing valuable information and knowledge. Unfortunately, based on their biases, they presume that they know what we should know, and think they know better than we know for ourselves.

From a social perspective, this is compounded by a herd mentality that can characterize and influence the story and information over time. As a society, we have come to let people we don’t know, and who are not always qualified, to decide what we need to know and when we need to know it. This creates an unintended consequence of impeding knowledge and learning.

Increasingly, more people are becoming addicted to the...
plethora of information on the Internet, which can result in compulsive pursuits without any thought process. There is unsolicited information, task-relevant information, well-known information, vaguely known information, and information based on belief and opinion. It takes an inordinate amount of time and attention to participate in the preponderance of available sources of information.

Information must be filtered and considered in the context of the user—not the disseminator. It should be filtered for substance, significance, reliability, and completeness. Our critical thinking should make us wary to completely trust what we read on the Internet. As Gerhard Fischer wrote, “We should focus on our need for the right information, at the right time, in the right place, in the right way, to the right person.”

Information overload is compounded by the accompanying participation overload, which consumes time, attention, and brain power. It creates a poverty of attention.

Cognitive overload

Cognitive load is the amount of mental effort being utilized in working memory at any given time. Human memory is limited in its capacity to effectively utilize and learn from cognitive input. Cognitive psychologists and scientists often categorize memory into three primary subsystems—sensory, working, and long-term memory.

Sensory memory perceives, and briefly retains, visual and auditory information. Sensory information is stored long enough to be transferred and utilized in short-term memory allowing for the retention of impressions of sensory information, after the original stimulus has been processed.

Working memory is constrained by a small storage capacity. It is vital to learning, and performing tasks. Working memory retrieves relevant knowledge possessed and stored by the learner in long-term memory. It organizes the new with the existing information to facilitate efficient storage of the new information in a modified schema.

In a seminal paper in 1956, George Miller, Princeton University, demonstrated that most individuals can only hold seven +/- two units of information in working memory at any given time, and can organize, compare, and contrast no more than two to four elements at any given time. That means working memory is very limited in capacity, which creates an inherent constraint on our ability to process and store information in long-term memory.

Long-term memory has nearly unlimited storage. Retrieving information is constrained by use rather than limits on capacity.

In order for information to be used and applied it must be stored in long-term memory and be recalled and applied when necessary. Memory retains and stores information learned into file drawers or schemas of accessible learned information. We retrieve the information using retrieval cues to open the right drawers, and transfer that information into working memory. The long-term schemas give rise to expertise.

Cognitive load has also been categorized as intrinsic load, which depends on number and complexity of information elements, and the interaction of the elements in the learner’s knowledge—the load associated with the task.

Extraneous load is not essential to the task, but induced by design of the task, and how information is presented in the environment. It includes thoughts about non-emergent and unimportant work items—social media, transient digital information, etc.

Germane load is devoted to the processing, construction and automation of schemas in working memory so they can be integrated into existing knowledge and long-term memory, and retrieved and used for problem solving and decision-making.

Dr. Jerome Kassirer (AΩ Α, Jacobs School of Medicine and Biomedical Sciences at the University of Buffalo, 1956) found that, “to develop expertise in problem-solving and decision-making, it is not enough to learn how to find information. We also need to remember the information and know how to use it.” Cognitive learning theory is based on understanding and diverting cognitive processing power toward germane cognitive load.

We have a harder time learning new things when our brains are distracted. This is also complicated when inaccurate information is stored for retrieval into working memory, resulting in faulty reasoning and decision making ability.

Multi-tasking is not all it’s cracked up to be

Information overload is also related to multi-tasking. Many people take great pride in being a multi-tasker, and see multi-tasking as an accomplished skill. However, evidence indicates that multi-tasking does not improve work, decision-making, or productivity, but it does contribute to cognitive overload and its associated consequences.

The average young adult moves between media platforms 27 times per hour, which can lower IQ by as much as 15

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points. As a contrast, studies that have shown an eight percent decrease in IQ for regular marijuana smokers who used heavily from adolescence onward.

Multi-tasking adversely affects emotional intelligence, and cognitive functions. We know that the brain cannot pay attention and process more than one thing at a time, but multi-tasking requires rapid and repeated switching of attention from one thing to another, and back again. This results in ignoring important information, faulty or incorrect reasoning, and slower completion of tasks that are done less well than if done one at a time with a thoughtful approach.

Multi-tasking creates decreased attention span, a state of inaction, and negatively impacts the ability to make smart decisions. It adversely affects work performance, and the time to get the task done, thereby limiting innovation, ingenuity, and creative thinking. It has been shown that it takes an average of 25 minutes to return to a work task after an e-mail interruption, and workers who completed the same tasks in parallel took 30% longer and made twice as many errors as those who completed tasks sequentially.

We are also increasingly burdened by just-in-case learning rather than just-in-time learning. Studies on heavy media multi-taskers compared to light media multi-taskers found that heavy media multi-taskers have a reduced ability to filter out interference from irrelevant information, and they are more likely to pay attention to a large scope of information rather than focusing on any particular piece of information. Heavy multi-taskers are less selective in filtering information and tasks they should attend to, and accomplish, in a defined time period. They are more likely to interpret all information as equal, or nearly equal, in importance. In addition, it is harder to learn and remember new important information when frequently distracted by many activities.

Chronic multi-tasking is rapidly becoming nearly ubiquitous, creating challenges and adversely affecting human cognition, thinking, and learning.

New disorders

Neuroscientists and psychologists have identified new maladaptive behaviors including Internet Addiction Disorder (IAD), Problematic Internet Use (PIU), and Addiction Deficit Disorder (ADD). The layperson may know this as Information Fatigue Syndrome, but it can, and often does, evolve into a full-blown disorder.

Although the definitions and criteria lack standardization, and are not yet recognized in DSM-5 as psychological disorders, they do seem to be part of a continuum of technology addiction. Due to the prevalence, and potential adverse effects and outcomes, it appears to be analogous to other compulsive use disorders.

Officially named disorder, or not, excessive involvement and use of information technology and social media can have serious effects, affect memory, and influence everyday life. It is still unknown how much use and involvement is too much to cause adverse emotional, functional, and health outcomes.

What can, and should, we do about this new and increasing phenomenon? Let’s start with increasing awareness of the problematic side of information and cognitive overload.

As physicians, teachers, educators, and writers, we strive to contribute to others’ learning about new things, including unintended adverse consequences. As physicians, it is our job to understand and influence harmful behaviors, and support positive change. We have patients who can benefit from changing their perceptions, attitudes and regimen with regard to Internet and social media use. We have family, friends, colleagues, and are a member of organizations where our awareness and knowledge can be of benefit to those suffering from information and cognitive overload.

In 1967, Peter Drucker noted in “The Effective Executive” that effectiveness in accomplishing tasks requires a focus of attention on one problem at a time, and devotion of the time needed to complete the task. Our profession, we have developed task and time management approaches and strategies, but often by habit rather than thoughtful planning. We also know that some approaches work better than others.

We need to respond and adapt to behavioral changes, and modify our thinking and behaviors. We can do things differently, make changes, better manage our time, and reduce interruption and unanticipated distractions.

Developing a time management protocol requires a modest investment and focus for one week to analyze current time use. By keeping an hourly time log for a typical week, with all hours and activities logged, including sleep and non-work-related activities recorded, we can determine how, when, where, and why we spend our time. At the end of the assessment week, time should be subclassified into categories, e.g. medicine, education, meetings, idle/wasted, family, etc. This helps determine changes that can be initiated to better manage time.

The next step is to set personal goals categorized by...
interest, necessity, work, education, health, etc. This will develop an awareness of requirements, electives, unnecessary activities, and others, to create a plan to make effective changes.

After personal goals comes daily goals, also categorized by what can be achieved each day, then prioritized. Goals that are achieved are checked off. Strategies to achieve goals and eliminate time-wasting activities will become apparent, and the ability to take control through choices will become achievable.

Time is our greatest asset and must be used wisely. Parkinson’s Law states that there is a human tendency to spend effort and time on more insignificant tasks that are perceived as important rather than on those of true importance. For example, Dr. Pete Reynolds, one of my mentors and professors, felt compelled to keep up his continuing education, but found difficulty in pursuing his education because of constant interruptions. When on rounds, he had a notebook in which he would record questions that he or others couldn’t answer when asked. Every Thursday night, his family knew that he would be away studying, and not home for dinner. He would go to the county medical association library, because he wouldn’t know anyone there who might disrupt his attention and concentration. He would research the questions he had written down in his notebook. Upon leaving, he would tear up the list of notes, and start over for the next week. He was the smartest and best informed of any of my teachers, mentors, and colleagues.

As another example, when I started my first job as a faculty clinician, I had an open door policy in my nonclinical office. I was repeatedly interrupted by almost anyone for almost anything, and couldn’t complete tasks, study and write. I obtained a study carrel in the university library, and scheduled time on my calendar to be away for a half day each week. I didn’t carry a beeper during those times, and wouldn’t have carried my cellphone if I had one. No interruptions, and my productivity soared. I found that the problems that were waiting for my return had usually been solved without my input.

Time management strategies include setting short and long-term goals; setting priorities for responsibilities; planning and organizing activities; and minimizing activities that waste time. It is more about behaviors than time; and matching time with priorities and goals. Time management takes time to learn, practice, and master.

**Effective time management is one of the most important competencies for physicians. We must learn to say no in a professional and justifiable way. We must learn to delegate, and minimize interruptions and distractions. We should schedule time on our calendars – professional and private – for our predetermined priorities and important tasks.**

Stephen Covey’s “7 Habits of Highly Effective People” provides Covey’s Time Management Grid (see illustration). The grid is used to manage information and responsibilities into classifications: urgent; non-urgent; important; and not important. Quadrant I is urgent and important for the immediate and imperative deadlines. Quadrant II is non-urgent and important for long-term strategizing, priorities, tasks and responsibilities that require time and attention. Quadrant III is urgent and not important. It represents unimportant time pressured distractions, but someone wants it now or soon creating an illusion of importance and a stress response mentally with an adrenergic/dopaminergic reaction (many information and cognitive distractions fall into this quadrant). Quadrant IV is not urgent and not important for activities that have little or no value, but are often used for taking a break or distraction from other important activities.

Most activities fall into Quadrants I and III, while Quadrant II is most important because one must work with attention and allocated time to accomplish the task. The lesson here is to quit spending time and attention on unimportant tasks and activities, and do the important things first.

**Improving our well-being**

Information and cognitive overload lead to a loss of control over much of our professional and personal lives. This creates undo stress and unimportant distractions, which See Cognitive Overload on page 10
Congitive Overload

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may adversely affect our work and lives and contribute to professional dissatisfaction and burn out. A thoughtful understanding of this problem, and implementing effective approaches and strategies can help to regain control of many, if not most, responsibilities, work, and other activities.

We are exposed to too much unimportant information that leads to cognitive overload. We are depleting our brainpower with babble, drivel, foolishness, gibberish, and balderdash. The expectation that we will participate and respond to copious unimportant sources of information is unreasonable and impracticable. We must become experts at managing our time, expectations, and the influx of information that we seek out, and in turn, seeks us out. If we recognize and understand this new intrinsic element of the modern era, we can adapt, make behavioral changes, regain control, and improve our professional roles, personal and professional lives, and our overall well-being.

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5. Miller GA. The Magical Number Seven, Plus or Minus Two: Some Limits on Our Capacity for Processing Information. The Psychological Review.1956;63: 81-97.

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

By James Michael Cole, Director, Government Reimbursement

CMS has released an ACO Track 1+ Fact Sheet detailing the model and answering questions for its implementation beginning in 2018. This more limited ACO model will test a payment design that incorporates more limited downside risk than exists in the several more “ambitious” tracks of the Medicare Shared Savings Program. The Model is designed to encourage more practices, especially small practices, to advance to performance-based risk, and also allows hospitals, including small rural hospitals, to participate.


CMS announces new APM participants

On January 18, 2017, CMS announced new participants in four of its Advance Payment Models (APMs) for the 2017 performance year. The announcement included 59,000 clinicians participating in the Medicare Shared Savings Program (Shared Savings Program), Next Generation Accountable Care Organization (ACO) Model, Comprehensive End-Stage Renal Disease (ESRD) Care Model (CEC) and Comprehensive Primary Care Plus (CPC+) Model.


• For Comprehensive ESRD Care Model: www.innovation.cms.gov/Files/fact-sheet/cec-fs.pdf

Our radiation oncology group at Community Medical Centers now offers Tumor Treating Fields (TTF) in addition to surgery, radiation therapy and chemotherapy for recurrent and newly diagnosed glioblastoma multiforme, one of the most serious brain malignancies and one with much poorer 5-year survival rates. Glioblastoma accounts for approximately 60% of the malignant brain tumor patients seen at Community Regional Medical Center. A new tool in the fight against glioblastoma is crucial.

My colleagues, Brent Kane M.D. and Uma Swamy M.D. and I are now certified through Novocure to provide Optune, the TTF device for our patients. This new approach applies an alternating electric field to the brain tumor to disrupt cell division. A set of four electrodes, placed on the scalp create the alternating electric fields determined by the physician and physicist. Clinical support is offered to patients around the clock. More information can be found at https://www.optune.com.

Alternating low intensity electric fields have been found to disrupt both mitosis and cytokinesis in the rapidly dividing tumor cells in the laboratory setting for some time. However, more recently the randomized trial EF-14, published in JAMA, revealed increased survival and decreased tumor progression in newly diagnosed glioblastoma. In the recurrent setting, this approach has is equivalent to medical therapy with improved quality of life.

I am excited to be leading the effort to offer this great option to increase both survival and hope for this devastating brain tumor. We are dedicated to delivering the highest level of evidence-based care to the Central Valley.
When I arrived at UCSF-Fresno in 2005, one of my goals was to enhance CME for providers in Fresno and the surrounding communities. My obvious initial target was in cardiovascular diseases. In 2006, I established, “Cardiology in the Valley”, a half day Saturday meeting each May. Cardiology in the Valley is now in its 12th year, as of the upcoming 2017 Symposium. Its audience is always varied and includes practicing cardiologists, cardiology fellows, general internists, family physicians, NPs, medical students/residents and other cardiology staff.

Initially, outside speakers were needed to supplement our own faculty lectures. However, as our cardiology faculty has grown and its talents have diversified, outside speakers lately have generally not been required, as our faculty now has expertise in nearly all areas of cardiology. The topics are always varied and the lectures are up to date with important information for all who attend. Over the years, the attendance has grown to presently over 100/year.

This year, Cardiology in the Valley will be held on Saturday, May 13. Topics featured include management issues in congestive heart failure and cardiac arrhythmias. There is no charge to attend this meeting. Registration includes both a breakfast, an interactive lunch, and 5 CME credits.

Two years ago, colleagues and I decided to introduce a second meeting, “Medical Update in the Valley”. This annual conference is for the practicing generalist provider. It includes lectures in multiple disciplines of practical importance to the audience. This meeting is one and a half days. Our 3rd annual meeting will be held this year on Friday evening, March 3 and Saturday, March 4 at the UCSF-Fresno building. With the help of Dr Vipul Jain, my co-director, and with the support of Community Regional Medical Center, we expect another high quality, insightful meeting which promises to be well worth the effort to attend.

The Friday evening meeting is followed by a reception and the Saturday meeting includes both breakfast and an interactive lunch. There will be plenty of time for questions from the audience. Ten CME credits are available and the tuition is only $200 and $75 for either medical students, residents or fellows.

To register for either meeting, please contact Monica Sozinho at 559-499-6421. A brochure can be obtained for the March meeting upon request. Brochures will also be available at Medical Staff Services at CRMC.
We’re barely into the new year, and healthcare is already in a bit of a shakeup. We have new leadership, both for the country and our medical staff – what will they bring?

As mentioned in my last column, IT and Informatics are hard at work identifying enhancements within the Epic upgrade that will make things better for everyone (although the patient comes first!), and allow us to close the gaps on functions and workflows we hadn’t enabled yet. All of this means lots of work for everyone, and working side by side with operations and Medical Staff leadership to hone the list, identify the impacts for everyone in the healthcare delivery team, and ensure we are making GOOD choices.

I’m asking each and every person within the CMC community, including the medical staff, to personally take on this leadership challenge… to lead by example in doing the right things, though they may not be easy or very popular; and to encourage others in your sphere of influence (yes, we all have one) just to take a chance on the essential journey toward efficiency, cost effectiveness, and always, superior quality of care.

My door is always open – let’s talk about the difficulties you’re having getting your work done efficiently in the electronic record. Let’s talk about how we can provide you with refresher training around pain points. Maybe the very thing you’re struggling with is something that has always been there, but you just needed a reminder. Let’s talk about how we can get better, cleaner information into our record so we can bring information out of that source of truth to know how we’re really doing. And finally, let’s talk about moving information across the continuum more fluidly so you have what you need at your fingertips, wherever you are.

Many of you are asking for more mobility… a team has been diving into the whole issue of working in a mobile fashion with expansion of Haiku and Canto for iphones and ipads respectively. We’re looking at bringing a number of helpful tools to your fingertips through the Apps@CMC umbrella on YOUR own device, including secure texting, Amion, GE connect for fetal monitoring, Haiku, and Dragon. We’re working on identifying additional medical calculators we can serve up as well… tell us what else you’d like.

I’m still up for the effort, whatever that is… are you?

“When you have full belief in yourself and the need to make things happen, that’s the powerful force behind being successful.”

– Julia Landauer, American NASCAR champion racer
An Epidemic of White Death: A Canary in the Coal Mine?

An Alarming National Trend Wreaks Havoc in California’s Central Valley

Editor’s Note: CMC Medical staff and other readers of this newsletter share a deep concern about the fragility of health care access for many if not most residents of our Valley communities. Whether primary care or specialist, for most providers in the Central Valley, this issue plays out every day of our professional lives, and many of us have instantly recallable examples of what is described below.

There is currently much in the clinical and economic medical press regarding potential major changes to the Affordable Care Act, many of which would imperil California’s MediCal expansion and subsidies for other Exchange insurance products. Some of what one reads at the moment is speculative, but some is soundly based on quality data and careful observation. One example of the latter is a recently published “Morality Brief” based on data from The California Endowment’s Building Healthy Communities initiative.

We present here The California Endowment’s Press Release announcing its recently released data followed by the Fact Sheet with major findings. The Fresno Bee did a fine article on the report, which is available online.

Fresno, Calif. (Jan. 18, 2017) – According to preliminary data from an ongoing new health study, reducing access to health care or weakening the health care safety net could have severe consequences for the Central San Joaquin Valley of California. This is a region that already suffers from high unemployment, deep poverty and skyrocketing drug use… and surprisingly, the white population may be uniquely vulnerable in this region.

Working in partnership with The California Endowment, the Center on Society and Health at Virginia Commonwealth University, reports an unprecedented surge in the death rate for middle-aged whites living in this region (Kern, Fresno, Tulare, and Kings counties). Over the past 20 years across California, death rates among Black, Hispanic, and Asian adults ages 40-64 years have fallen by 16-20 percent. Among California Whites, however, they have decreased by only 5 percent. In this same 20-year period in this four-county region of the Southern San Joaquin Valley, white death rates have actually increased by 11 percent!

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This ongoing study comes in the wake of national reports that show a worrying decline in life expectancy in the U.S. “Many Americans are really struggling to find opportunity in this new economy. In some regions of the country, a lot of people are losing hope, and turning to alcohol, drugs, and even suicide,” said Dr. Tony Iton, Senior Vice President with The California Endowment. “In the wake of these findings, this is the worst possible time to reduce access to health care or any health care safety net programs. Rather than dismantling our already fragile social compact, we need to be strengthening it so that all people have a meaningful shot at opportunity and good health.”

The new death rate data suggests that Whites in Kern and Tulare counties would be particularly vulnerable to reductions in health care access, but all rural communities in the Central Valley would suffer greatly, where Medi-Cal now serves close to half of all residents. Not surprisingly, Medi-Cal’s expansion was the heaviest in the state’s rural counties, where most of the low-income residents live. Specifically, Tulare County had the state’s highest level of Medi-Cal enrollment.

In addition to the weak economy that strangles the above counties, Steven Woolf, one of the lead authors of the report, cites other factors for the increase in death rate among whites.

“Household incomes have been stagnant and poverty rates have been climbing in these counties over a period of many years,” he said. “Stress, anxiety and depression are taking their toll on this population. The economy is literally costing lives.”

The California Endowment continues to support grassroots community efforts to improve health outcomes through its 10-year, $1 billion place-based initiative called Building Healthy Communities (BHC). Three of the 14 BHC sites are located in the San Joaquin Valley.

“We believe California is stronger when we stand as one and work together to reweave our tattered social compact. Access to high quality affordable healthcare is a crucial cornerstone of that social compact,” Iton said. “For too many Californians, the odds are that our zip codes are more important than our genetic codes when it comes to our health. We think it is time to change those odds.”

For additional information, feel free to contact: Paula Braveman M.D., M.P.H., professor, UCSF School of Medicine, 415-476-6839, Paula.braveman@ucsf.edu

Mark R. Cullen M.D., professor of medicine (general internal medicine), of biomedical data science, of health research and policy (epidemiology) and senior fellow at the Stanford Institute for Economic Policy Research; 650-721-6209; mrccullen@stanford.edu
An alarming national trend wreaks havoc in California’s South Central Valley

**Introduction**

Target Counties are among the poorest in the state, if not the nation: Fresno, Kern, Kings, and Tulare.

This is not the time to dismantle the health care safety net anywhere – particularly in an area and for a population that desperately needs it. This preliminary data from an ongoing statewide study targets four counties in California’s Central San Joaquin Valley: Fresno, Kern, Kings, and Tulare. Residents in these areas are considered the poorest in the state. Any change in safety net services such as health coverage will have devastating and potentially life threatening effects not only in California, which is ground zero based on the findings, but in other rural parts of the country. All residents need to know the facts and that our social compact is being torn apart.

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**All Deaths in California State vs the Central Valley: Fresno, Kern, Kings, and Tulare**

The overall white death rate for ages 40-64 was 512 per 100,000 from 2010-2014.

During that same period, in the four California counties from the study (shown in red), the overall white death rate was almost 40% higher.

That difference, and the rapid rate of increase among middle aged whites, is stunning health experts.

512 deaths / 100,000 people
White death rate for ages 40 – 64 from 2010 – 2014

708 deaths / 100,000 people (almost 40% higher)
White death rate for ages 40 – 64 in Fresno, Kings, Kern and Tulare from 2010 – 2014

Learn more at [www.buildinghealthycommunities.org](http://www.buildinghealthycommunities.org) #ChangeTheOdds

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About **The California Endowment** – The California Endowment, a private, statewide health foundation, was established in 1996 to expand access to, quality health care for underserved individuals and communities, and to promote fundamental affordable improvements in the health status of all Californians. The Endowment challenges the conventional wisdom that medical settings and individual choices are solely responsible for people’s health. At its core, The Endowment believes that health happens in neighborhoods, schools, and with prevention. For more information, visit The California Endowment’s homepage at [www.calendow.org](http://www.calendow.org).

About **BHC** – Building Healthy Communities (BHC) is a 10 year, $1 billion comprehensive community initiative launched by The California Endowment in 2010 to advance statewide policy, change the narrative, and transform 14 of California’s communities most devastated by health inequities into places where all people have an opportunity to thrive.

See **Red Alert** on page 16
Red Alert

In the two southernmost counties of the Valley, Kern and Tulare, where the poverty rate in 2015 was 22% and 28% respectively, the rising death rates are alarming.

Death rates from stress-related conditions have climbed faster in the Southern Central Valley than they have statewide. Here are some examples:

- In Fresno County, the rate at which middle-aged white adults (ages 40-64 years) are dying from accidental drug poisoning has increased by 212% since the 1990s; and in Kern County it has increased 164% over the same period.
- In Tulare County, the death rate from viral hepatitis has increased by 167% since the 1990s.
- White women are being most affected. In Kern County, the rate at which young white men (ages 25-34 years) are dying from accidental drug overdoses has increased by 248% since the 1990s. Among women, the death rate appears to be rising faster.
- In Kern County, suicides by hanging, strangulation and suffocation among middle-aged whites have increased by 133% since the 1990s.

We cannot blame these deaths simply on the opioid epidemic. These are deaths of despair.
Legionnaires’ disease (LD) is an emerging infectious disease first discovered following an outbreak of severe pneumonia at the 1976 American Legion Convention in Philadelphia. It has become increasingly common in this country, with a demonstrated 286% increase in reported cases per 100,000 population from 2000 to 2014. Eighteen cases of LD were reported to the Fresno County Department of Public Health (FCDPH) in calendar years 2015 and 2016, and four of these were associated with healthcare facilities.

Over the last several months, there is seldom a week that goes by without a call over the Centers for Disease Control and Prevention’s (CDC) national epidemiological network for cases of LD that may be related to specific venues (usually hotels or healthcare facilities).

The CDC attributes these increases in LD to an older U.S. population, increased numbers of at-risk individuals, aging plumbing infrastructure, and increased recognition of, and testing for, the disease. However, there are those who mention climate change as a contributing factor also.

Legionnaires’ disease is a severe form of pneumonia caused by any one of several species of bacteria known as Legionella when water contaminated with the bacteria is aerosolized and inhaled or, less commonly, aspirated. Legionnaires’ disease begins as many other community or hospital acquired pneumonias do, with cough, fever, and shortness of breath. It can also cause headache, neurological symptoms and gastrointestinal symptoms. Symptoms begin 2-10 days after exposure. The illness has a 10% fatality rate and is not transmitted from person to person. Less commonly, the organism can cause a mild flu-like illness that resolves in 2-5 days, and is known as Pontiac Fever.

Individuals at highest risk for infection and death include those with renal or hepatic failure, diabetes, chronic lung disease, smoking history, immune disorders, and age 50 or above.

Legionella species are ubiquitous in nature, especially in aquatic environments, and can survive in extremely varied water conditions, including treated water systems. Proliferation of the bacteria is dependent upon symbiotic relationships with other microbes, especially those found in biofilms, making relatively stagnant areas within complex water systems of some facilities subject to colonization.

While infection with LD is commonly connected to facilities with these complex water systems, many have no such connection, and may be from exposures at locations closer to and including, your home. Fixtures such as shower heads, faucet aerators, humidifiers, nebulizers, whirlpool baths, hot tubs, misters (including those found in the produce sections of food stores), and decorative fountains have all been implicated.

When a case of LD is reported to FCDPH a communicable disease specialist is assigned to obtain information regarding possible exposure while travelling or while an inpatient or outpatient at any healthcare facility. While these travel-associated and healthcare-associated cases of LD are becoming more common, even more frequent are sporadic cases which cannot be associated with travel venues or healthcare facilities, and must be assumed to have been contracted in or near the home.

If a healthcare facility is implicated as a source to Legionella infection, FCDPH communicable disease and environmental health staff work closely with the involved facility, the California Department of Public Health’s Healthcare Associated Infections Branch and the California Department of Public Health’s Licensing and Certification Branch to isolate the possible source(s) of the organism. This work involves medical record and laboratory review of patients in whom LD may have been missed, careful consideration of LD in patients subsequently presenting with pneumonia, and a full environmental assessment of the facility for likely sources of the organism. This is followed by appropriate sampling and testing for the organism. Should Legionella bacteria be found in samples of water or fixtures, facilities are required to implement a plan for remediation which usually involves hyperchlorination or super-heated flushing. Following remediation, retesting is required until the organism is no longer detectable. A schedule of periodic follow up samplings and testing is then prescribed for a period of time.

During this investigation strict control measures are implemented to prevent further infection. These include:

- Ensuring that sterile water is used in all respiratory devices and procedures
- Avoiding the use of ice from facility ice machines
- Avoiding the use of facility tap water for drinking
- Avoiding patient showers unless point of use filters are in place
- Shutting down spas, cooling towers, misters, and decorative fountains

See Legionnaire’s on page 18
Because there are healthcare facilities in Fresno County that have been implicated as sources of infection of LD, and because sporadic cases seem to be on the rise, local providers were notified on October 19, 2016 to have a high suspicion for the infection, and healthcare facilities were subsequently advised to develop water management programs.

Editor’s Note: CMC Laboratories offer rapid testing for urine Legionella antigen. Urinary antigen testing is rapid, sensitive, specific, and not costly, but is only useful for the diagnosis of L. pneumophila type 1 infection (which accounts for 90 percent of community acquired Legionella infections in the United States). It may remain positive for months after active infection. In patients suspected of having Legionella infection, it is recommended that both culture of an appropriate respiratory specimen and urinary antigen testing be obtained. Legionella culture of respiratory specimens is a send-out test for the CMC Laboratories.

The Environment of Care Committee is pleased to appoint Charlotte Davis as the Hospital Safety Officer for Community Regional Medical Center. Charlotte has been chosen for the is position due to her experience in both hospital facilities management and also environment of care analysis and project management. The Hospital Safety Officer’s job is to coordinate the development, implementation, and monitoring of the safety management program and activities throughout the facility. The Hospital Safety Officer (HSO) is granted the authority to intervene whenever conditions immediately threaten life or health or threaten damage to equipment or buildings.

Charlotte’s duties as HSO shall include, but are not limited to:
- Coordinate the development, implementation, and monitoring of the safety management program and related activities throughout the hospital and associated patient care and staff facilities on campus.
- Coordinate comprehensive, proactive risk assessments that evaluate the potential adverse impact of building, grounds, equipment, occupants, and internal physical systems related to the safety and health of patients, staff, and other people coming to the hospital’s facilities
- Co-Chair the Environment of Care Committee, submit summary report of activities, findings, recommendations, and actions of the Environment of Care Committee to the Leadership Council, at least on a quarterly basis
- Coordinate the ongoing, hospital-wide collection of information about deficiencies, problems, failures, and user errors related to managing the environment of care
- Participate in hazard surveillance rounds and incident reporting on a regular basis.
- Participate in the development and implementation of safety policies and procedures.
- Participate in the environment of care education program for new employees, and in the continuing education program for all employees.
- Participate in the review of changes in law, regulation and standards of safety, and perform other activities essential to implement these changes.

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Legionnaire’s

Continued from page 17

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The intersection of what we are required to do, what we intuitively know because we all live and work here, and what Community Medical Centers as a health system is committed to do through our mission to improve community health, lies Community's Community Health Needs Assessment (CHNA) report.

The CHNA process is governed by both existing California law enacted in 1994 (SB 697) and further refined by the Affordable Care Act guidelines in 2010, both aimed to ensure that not-for-profit hospitals plan for, implement and measure their impact on community health.

Conducted every other year in partnership with the 14 other hospitals in our four-county region, the CHNA is intended to identify the leading health needs facing our community and to guide non-profit hospitals in deploying their community benefits wisely and sufficiently. Through a process that includes primary and secondary data collection, community focus groups, and stakeholder interviews, priority health needs are identified. Hospitals then use that data, along with their own internal resources, to craft action plans to impact those needs.

The context for this work

[We live in a]…“demographic region of peaks and valleys… [we have]… among the nation’s highest rates of unemployment, poverty, disability, tobacco use, and chronic health issues such as diabetes. It ranks near the bottom for income, educational attainment, and percentage of people with health insurance.” (Health Leaders, October 2015)

This description sounds awfully familiar to those of us who work every day in this community, caring for our most vulnerable populations. But it might… or might not… surprise you to learn that this quote was actually in reference to the Appalachian region of the Eastern US, with which we out here on the West Coast share more in common than we might like to admit.

So where do we begin, in order to impact these weighty issues?

The process is a combination of aligning our existing work as a health system AND identifying new opportunities to impact a community health need, either as a health system or in collaboration with our community partners.

Our Community Health Needs Assessment:
Facts, Intuition, and a Roadmap for Work To Be Done

Submitted by Lynne Ashbeck, M.A., M.S., R.D., Vice President,
CMC’s Community Health, Population Health and Community Engagement

The five priority community health needs identified in this latest CHNA include:

- Access to care
- Asthma (breathing problems)
- Diabetes
- Mental health
- Obesity

Health priorities identified in the 2016 CHNA

There are no surprises on this list. Data supporting these priorities are compelling and these are areas that Community Medical Centers and all of our provider and community partners work on every day. Our challenge is to remain focused on each of those priorities, align with others to leverage our resources, and develop shared metrics to actually measure improvement. All of these efforts are underway, both within our health system and across our community at large.

From an emerging pilot project around housing and health to pediatric asthma programs, behavioral health collaborations, chronic disease care services, community education and patient-centered medical homes, amazing work is occurring here and across our community every day. There are no doubt hundreds of additional examples of how our hospital, our physician partners and our staff impact these community needs every day. I would love to hear from you to learn more and will write about some of them in future issues of this newsletter.

Over the past two decades, no other hospital organization in the San Joaquin Valley has invested more to ensure access to all patients of this growing region than Community Medical Centers. Thank you for the contributions you each make to the health of this place we call home.

For more information, Lynne Ashbeck, M.A., M.S., R.D., Vice President, CMC's Community Health, Population Health and Community Engagement, lashbeck@communitymedical.org.

If you missed the link above, and for our print readers, a copy of the complete 2016 CHNA is available on CMC's website: https://www.communitymedical.org/Community-Involvement/Community-Benefit
Editor’s Note: The USPSTF continues to be very busy. Last month we featured its recommendations for statin use for primary prevention. This issue we present a less controversial topic, in that the recommendations below largely reaffirm – on the basis of newer evidence – their 2009 recommendations regarding this important advance in perinatal public health.

Interested readers are directed to the entire free-access Recommendation Statement in Jan 10, 2017 JAMA.

An accompanying JAMA editorial addressed the following question of whether a diet inclusive of the many folate-fortified foods we enjoy today is sufficient for neural tube defect (NTD) prevention. It comes down on the side of supplementation:

“…Should the USPSTF recommendation be rejected because fortified food is already providing sufficient folic acid to prevent NTDs? No. Too little is known about how folic acid prevents NTDs. For example, it is not known whether the tissue stores of folate in the developing embryo or the availability of folate in the serum during the all-important few days of neural tube closure is most important. Habitual use of folic acid supplements is a more reliable method of ensuring adequate levels than diet. In theory, a woman might not consume sufficient enriched cereal grains during the critical period of approximately 1 week when the neural tube is closing. Exactly when folate must be available also is not known. In addition, some popular diets, such as low-carbohydrate or gluten-free, may reduce exposure to grains, limiting folic acid intake.

The USPSTF recommendation that all women of childbearing age take folic acid supplements is a prudent one. Ideally, it will educate all women who are planning or capable of pregnancy to follow this recommendation and thereby reduce the risk of these severe birth defects in their infants.”

Print readers can find both of these free-access items by searching something like JAMA 2017 Folic Acid Supplementation.
History of present illness

By Liat Bird; Illustrations by Laura Aitken

I know that sounds crazy, and maybe I am, but I just don’t want to. Nothing sounds good. Not even strawberry ice cream mixed with strawberry Boost, my go-to meal since chemo.

I’m losing weight.

My family is worried.

My family. I know they want me to eat. I think they know that I’m trying. I would eat for them, if I could. I just can’t. And now, I’m sitting in the oncology clinic, again, having the conversation about chemotherapy, again. I’ll listen.

My daughter mentions that I haven’t eaten in four days, that I just say I’m not hungry and move on with my day. This is true. I’m not hungry, and the days go on, don’t they?

The oncologist’s face scrunches into a worried frown. He asks me why I’m not eating. Why do they keep asking? I just don’t want to. Nothing sounds good.

He asks me if I feel depressed. The small part of me that is still alive laughs at that. Depressed? Me? With stage IV lung cancer and the most miserable three months of my life behind me? With more miserable months ahead hooked up to an IV pumping in chemicals that make my skin feel like it’s melting off my body, make me nauseous, make me tired? Wouldn’t that make anyone welcome death, like an old friend?

I can’t think like that. My family. They need me. My children. My husband. I can’t fail them.

I just don’t want to eat.

My daughter explains that I would force down food maybe once a day, but that stopped four days ago. I couldn’t force it anymore. Not even when my husband looked at me with those hurting eyes. Not even when my daughter was crying in the kitchen when she thought I couldn’t hear. I can’t force it anymore.

I tell the doctor that I don’t want to eat. Nothing sounds good.

His face stays frozen in that concerned pose. I know he wants to talk about chemotherapy again. I was supposed to start today. But now I can’t. Because of the dehydration. And the weight loss. I’m ruining his plan. He sighs. He says something about going to the hospital. I don’t see why. My daughter’s face brightens, so I say I’ll go.

In the hospital, I get changed into a gown. They put a needle in my arm. They set me up in bed. The nurse is very nice. It’s a cancer floor. They know how to deal with people like me.

See Palliative Care on page 22
Palliative Care

Continued from page 21

The doctors come in. They ask all the same questions. I tell them, again, I just don’t want to eat. I can’t force it anymore. Everyone leaves. My daughter says goodbye.

A girl in a short white coat comes in. She looks nervous. She sits down. She asks what is going on.

I thought she was going to ask me about the food again. I answer that I just don’t want to eat. She says she heard that from the others. She repeats her question: What’s going on? She just looks at me. Cocks her head like a dog does when it’s listening. Says nothing.

She told me later it was because she was so nervous. She’s a student, and she didn’t know what to do or say. She was scared, so she did the only thing she could think of, which was to wait and listen. Now that I think of it, I could hear her heart beating from across the room.

She sits, looks at me expectantly, and lets the silence fill us up. We let my death be with us. It feels gentle, and the part of me that is still alive stirs. It says, I can’t force it anymore. It says it’s not about the food, it’s about the fight.

She nods, and my living part grows, exploding upward, rushing to the surface and bursting out of my face as I say aloud the things I’m scared to feel.

I say that I never wanted to fight this, to spend my last months in misery. I have had such a wonderful life, with my husband of 40 years, and my two beautiful daughters. I have done all I ever wanted right at home, in Waltham. I have made Halloween costumes, and baked cookies, and fought with my rebellious teens and my exasperating husband, and made up with them, and lived my simple beautiful fulfilled life.

Suddenly, I am saying out loud that I do not want more chemotherapy; that I am ready to die. My living part, rooted within me and now blooming across my cheeks, demands to be sustained until my heart stops beating. This is not living I say. It is worse than dying. It is something else, and I do not want it.

She still says nothing. I come back to myself and remember why I started chemotherapy in the first place.

I remember sitting in my doctor’s office after having pneumonia for months and months. It would get better with antibiotics, but then it would come back once the pills ran out. My daughter, the preschool teacher, felt bad because she thought she gave it to me from her kids at school. She was sick before me, then I was sick. She got better but I didn’t.

The X-rays kept coming back with things on them. I was still smoking cigarettes then; a decades-long habit doesn’t disappear just because you’re having trouble breathing. Then I started sweating heavily at night, and losing weight. With the recurrent lung infections, my doctor said something about “post-obstructive pneumonia.” Then there was a scan of my lungs, and then another one of my whole body, and then, all of a sudden, there I was with my doctor and she was saying cancer. Then I couldn’t hear anything at all.

Of course, my two daughters and my husband came with me to the first oncology appointment. I wasn’t feeling too bad, just drenching sweats at night, and that annoying cough that wouldn’t go away. The oncologist starting talking about chemotherapy, and I thought why, it’s everywhere: in my lungs, and my bones, and my liver, and I don’t want to suffer. Before the words could get out, my daughters and husband were nodding along, comforted by the you-never-knows, and the she-could-have-five-more-years, and the we’ve-come-a-long-ways. When they looked at me, brimming with hope, it was spilling out of their eyes and into their laps in a shower of golden groundless optimism – I couldn’t say no.

I started chemotherapy, and went from night sweats and coughing to nausea, vomiting, skin rashes, pain in my arms and legs, hair loss that hurt, and fatigue so bone-deep and wearying that getting out of bed became a Sisyphean task – just one more struggle in the wasteland of my life.

The scans came back with still more cancer, and I wanted to scream, but the shimmering insubstantial hope kept pouring out of my oncologist, and out of my desperate, eager, wounded family so much that I felt like it was choking me in a beautiful boundless flood.

So, when the oncologist said we should try again, I said “yes,” rather than stem that tide of belief.

I have lived my life for my family, and I would live my death for them too, if that was what they wanted.

But now…I just don’t want to eat anymore. I can’t force it.

I’m crying. The girl strokes my hand, says that I am so strong, she cannot imagine how a person can be that strong. She tentatively asks me if I know about a thing called hospice. I do not. She says she worked in one for a summer and it was the patients there, like me, who inspired her to go to medical school.

She tells me about it. About comfort, and acceptance,
and symptom control.

My living piece – pausing in its task of implanting roots within me – tells me that this is what we need, or we’ll go back to the not-living-not-dying place where not even strawberry ice cream with strawberry Boost tastes good.

I ask her to call the hospice doctors.

It all happens so fast. My living part busily curling up past my ears in green growing tendrils as things move forward. A doctor comes and talks to me, and then we all meet – my oncologist, my family, and this doctor who runs the meeting.

I say all the things I wanted to say months ago when the chemo started. I cry, and my family cries. Then, the most wonderful thing happens. They tell me that it’s hard to let go, but they don’t want me to hurt. I know they all can see my living piece, the part that came from them, and our years together. The realest thing. Budding above my eyes and around my forehead, waiting.

The ethereal flood of boundless optimism stops flowing out of them, stops crushing me. Instead, small searching vines of warmth, love, acceptance, support, everything, grow from them, down their legs, up my arms, right into my beating heart. My living part bursts into full bloom.

My husband’s hurt is still there in his eyes, but then he takes my hand gently and says he will stand with me now, just like he did 40 years ago at the altar when we promised each other in sickness and health, til death do us part.

He says I have always taken care of him, and he asks me to let him take care of me, just this one time. I say of course. Of course.

We’re all so sad, but it’s peaceful too. Somehow comforting, real, honest, right.

I’m finally happy, now that I’m out of the not-living not-dying place. The flowers of my life are around me, sustaining me. I’m happy now that I can be alive, right up until I die.

When the girl comes to say goodbye (because I can go home now, now that I’m alive again) we hug. I think for a moment, and then ask her to share a strawberry ice cream mixed with strawberry Boost with me.

It tastes wonderful again.

Ms. Bird is in the Class of 2016 at Boston University School of Medicine. Her essay won Second Place in the 2016 Helen H. Glaser Student Essay Competition.

Don’t Guess. Be Sure About Poisonous Plants!

Every day worried parents call the California Poison Control System because their small child has touched or eaten a plant. Many plants are safe to have in the home and in the garden. But, it’s important to know that some might be dangerous. It is also important to know the names of your plants, so the poison control experts can answer your questions.

The California Poison Control System can help. Highly trained Poison Control health professionals can help you 24-hours-a-day every day of the year. We are happy to answer your questions. We are FAST, FREE & CONFIDENTIAL.

February 2017: Daffodils, Narcissus

When eaten, Daffodils can cause nausea, vomiting or diarrhea. The most toxic part of this plant is the bulb. With skin exposure, Daffodils can cause symptoms ranging from redness, itching, rash to even painful blisters. Although these symptoms may cause illness, they are usually not life threatening. Call Poison Control to help guide you to proper medical care.

Medicines

Medicines cause most of the serious poisonings in children. The most common situations include:
• Accidental overdoses of over-the-counter pain relievers like acetaminophen, ibuprofen, or aspirin.
• Giving the wrong amount of a prescribed medicine.
• Home remedies from other countries such as Mexico, China, or India can have toxic metals like lead and iron in them.
Avoid Queries for clarification by specifically describing the circumstances surrounding potential complications. Enhanced documentation of potential complications = assigning codes that reflect true complications.

Patient Safety Indicators (PSI) are a set of indicators providing information on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth.

Potentially Preventable Complications (PPC) identify in-hospital complications among secondary diagnoses that occur after admission.

PSIs & PPCs are publicly reported & provide an overview of hospital-level quality vs. potentially preventable hospital-related events associated with harmful outcomes for patients. Facilities are ranked based on the patient safety environment.

It is essential to document the following details:
- Inherent/expected based on the intensity of the surgery or actually a complication?
- Present on Admission?

More to come...

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

Editor’s Note: The question with the ongoing Choosing Wisely Project, is: what positive effects is it having among providers and patients? Is it perceived as advocating “rationing”? OR is it perceived and being used in the positive ways it is intended? These lists (we will get back to them next issue, with local expert commentary) are compiled after evidence review by expert physicians working through professional organizations – there is no agenda of rationing-of-needed tests or care.

So with that in mind let’s look at some of the most notable ways Choosing Wisely was used in 2016. As we said in our last issue, Community’s medical staff leaders and medical directors should be familiar with the lists pertinent to their disciplines, and make use of them. As you will read, other places are doing so…

The Year in Choosing Wisely: Top 5 from 2016

Choosing Wisely continued to expand in 2016 with new initiatives and lists and the ongoing work of many partners and grantees helping advance conversations about reducing overuse in health care. Let’s take a moment to look back:

Introducing Champions

The Choosing Wisely Champions program launched in March 2016 to recognize clinicians who are leading efforts to reduce overuse and waste in medicine. Champions are selected by participating societies and include clinicians or teams of clinicians whose work in their respective specialties advances the goals of the campaign. Ten societies have announced more than 40 champions, whose work includes, for example, more than a thousand drug adjustments for patients, decreased inpatient blood product usage by 46 percent over three years, and inspiring state legislation requiring that all children undergo vision screening prior to starting kindergarten.

Collaborations to Improve Outcomes

Choosing Wisely grantees are a little more than halfway through their projects to reduce the overuse of at least three tests or treatments – including inappropriate prescribing of antibiotics to adults – in their respective communities. Many are identifying new ways to collaborate to reach new populations and overcome barriers that have traditionally inhibited efforts to make and sustain measurable progress in reducing unnecessary care.

For example, the United Auto Workers Retiree Medical Benefits Trust is educating its 720,000 members in Michigan and beyond about Choosing Wisely. To address the opioid epidemic See Choosing Wisely on page 25.
Choosing Wisely

Continued from page 24

affecting Bangor, Maine Quality Counts provided Choosing Wisely opioid resources created by Consumer Reports to the community. The Los Angeles County Department of Health Services (DHS), the nation’s largest “safety net” health system serving vulnerable populations, is working with UCLA/LA County to create a survey to better understand patients’ awareness and attitudes and is designing culturally sensitive patient education materials.

Learn more about these innovations as the grantees tell their stories in their own words. Read about several interventions that have helped grantees reduce inappropriate antibiotics prescribing.

Sharing Wallet Cards with #ChoosingWisely Wednesday

Every Wednesday, Consumer Reports posts pictures on social media of health care consumers, patients and stakeholders holding up the “5 Questions Wallet Card” that aims to help patients know the right questions to ask their clinicians. The goal of this effort is to educate clinicians and patients about Choosing Wisely and encourage them to engage in conversations about what care is necessary. To date, Consumer Reports has sent out approximately 80,000 of the free wallet cards and has received requests for thousands more. Consumer Reports says many have shared their wallet cards with family and friends as well as through medical settings, public libraries, senior centers, churches and even convenience stores. Learn more about #ChoosingWisely Wednesdays and how to request your wallet cards.

New additions: Lists, partners and international efforts

In 2016 the American Dental Association became the first dental organization to publish a Choosing Wisely list, and the American Society of Health-System Pharmacists became the first pharmacy organization to join the campaign.

In addition, several specialty societies released new lists or added new recommendations to their existing list, including: American Society of Breast Surgeons, Society of Surgical Oncology, Society for Maternal-Fetal Medicine, HIV Medicine Association, Obstetric and Neonatal Nurses, and the American Society for Clinical Pathology.

The list of countries that have introduced Choosing Wisely efforts has grown to 18. As the campaign continues to go global, Wales, the UK and Brazil each launched their own Choosing Wisely initiatives in 2016.

Implementations reported in 2016

Johns Hopkins School of Medicine: Chest X-rays fell by 28 percent, with no impact on the ordering of urgent scans, in the intensive care unit (ICU) by removing chest X-rays from the daily morning ordering set, holding discussions during grand rounds, and creating pocket card and workstation reminders.

Department of Medicine at the University of Vermont Medical Center: High-value care projects that relied on a combination of physician education, best practice advisories within EHRs, or redesigned order sets have led to a 72 percent reduction in labs for patients with end-stage renal disease, a 90 percent reduction in DXA scans for patients younger than 65 with low risk for osteoporosis and a 71 percent decrease in portable chest X-rays in intubated patients.

American College of Radiology’s Radiology Support, Communication and Alignment Network (R-SCAN): Baylor Medical College completed the first project through the new R-SCAN platform by using educational materials to reduce inappropriate orders for CT scans for PE clinical indication by half. Radiologists and internists can receive maintenance of certification (MOC) credit for collaborating on these projects.
CME HIGHLIGHTS
FEBRUARY 2017

UCSF Fresno Department of Psychiatry Presents:
Title: “Get Movin’ with Memantine: Targeting Cognition and Negative Symptoms”
Date: Thursday, February 9, 2017
Speakers: Drs. Cranford and Hierholzer
Time: 4:00 p.m.
Place: UCSF Fresno Center, 155 N. Fresno Street, Room 116
CME: 1 CME

CRMC Perinatal M & M
Title: “Use of Steroids in Late Pre-Term Infants”
Date: Wednesday, February 15, 2017
Speaker: Drs. Uong, Mokrian, Downer and Ladella
Time: 12:00 p.m.-1:30 p.m.
Place: UCSF Fresno Center, 155 N. Fresno St., Fresno, CA 93701, Rm 136
CME: 1 CME

CRMC Neuroscience Grand Rounds
Title: “MRI-Guided Surgery for Parkinson’s Disease: DBS and Gene Therapy”
Date: Thursday, February 23, 2017
Speaker: Paul Larson M.D.
Time: 12:00 p.m.-1:00 p.m.
Place: UCSF Fresno Center, 155 N. Fresno St., Fresno, CA 93701, Rm 137
CME: 1 CME

UCSF Fresno presents:
Title: “2nd Annual Air Pollution and Climate Change Symposium”
Date: Saturday, April 8, 2017
Speakers: Various
Time: 8:00 a.m.-12:30 p.m.
Place: UCSF Fresno Auditorium
RSVP: 559-499-6421 or msozinho@fresno.ucsf.edu
Fee: Yes
CME: 3.45

Clovis Community presents:
Title: “Anorectal Disorders”
Date: Tuesday, February 21, 2017
Speakers: Phuong Hguyen, MD
Time: 12:30 p.m.-1:30 p.m. (lunch provided)
Place: H Marcus Radin Conference Center, The Palm Room
RSVP: 559-324-4002 or lipsius@communitymedical.org
CME: 1.0

SAVE THE DATE
Title: “Current Trends In Healthcare For Women In the Central Valley”
Date: Saturday, March 11, 2017
Speakers: TBA
Time: 7:30 a.m.-8:30 a.m. Registration
8:30 a.m.-12:30 p.m. Symposium (breakfast and lunch provided)
Place: H Marcus Radin Conference Center
RSVP: 559-324-4002 or jlipsius@communitymedical.org
CME: 4.0 Applied for

Title: “Novel Biologic Therapies In The Management Of Treatment Resistant Asthma”
Date: Tuesday, March 21, 2017
Speakers: Praveen Buddiga M.D.
Time: 12:00 p.m.-1:30 p.m. (lunch provided)
Place: H Marcus Radin Conference Center, The Palm Room
RSVP: 559-324-4002 or jlipsius@communitymedical.org
CME: 1.0

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

Sisters of Notre Dame
LePuy, France

Chateau de Chenonceau, France

et de l’eau
Geneva, Switzerland

FEBRUARY PHYSICIAN PHOTOGRAPHER
NEWSLETTER ARTICLE & FLYER SUBMISSION DATES-- 2017

• FRIDAY, JANUARY 20  (For February Newsletter)

• FRIDAY, FEBRUARY 17 (For March Newsletter)

• FRIDAY, MARCH 17  (For April Newsletter)

• FRIDAY, APRIL 21   (For May Newsletter)

• FRIDAY, MAY 19    (For June Newsletter)

• FRIDAY, JUNE 16   (For July/August Combined Newsletter)

• FRIDAY, JULY 21   (For August Time-Specific Packet)

• FRIDAY, AUGUST 18 (For September Newsletter)

• FRIDAY, SEPTEMBER 15 (For October Newsletter)

• FRIDAY, OCTOBER 20 (For November/December Combined Newsletter)

• FRIDAY, NOVEMBER 17  (For December Time-Specific Packet)

• FRIDAY, DECEMBER 15 (For January 2018 Newsletter)
Perinatal M & M Presents:

Use of Steroids in Late Pre-Term Infants

Wednesday, February 15, 2017 from 12:30pm – 1:30pm
UCSF – Fresno, Room: 136
155 N. Fresno Street, Fresno, CA 93701

Case Presentation
Obstetrics: Dr. Helen Uong
Neonatology: Dr. Shahriar Mokrian

Principal Discussants
Neonatology: Dr. Shahriar Mokrian
Obstetrics: Dr. Chris Downer
Perinatology: Subhashini Ladella M.D., FACOG

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 use of steroids in late pre-term Infants.
2) Gain insight into use of steroids in late pre-term Infants, 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; Dr. D. 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.
H. MARCUS RADIN
CONFERENCE CENTER
presents:

ANORECTAL DISORDERS

DATE:
Tuesday, February 21, 2017
12:30 pm - 1:30 pm
Lunch will be provided

LOCATION:
H. Marcus Radin Conference Center
The Palm Room

ATTENDEES WILL:
1. Gain a better understanding of how to correctly diagnose common anorectal disorders to improve patient outcomes.
2. In order to improve patient safety, learners will gain a better understanding of how to manage patients with common anorectal disorders and apply this knowledge in practice.
3. Improve patient outcomes by learning how to identify when a patient should be referred to a colon and rectal surgeon to improve patient safety.

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

CME: 1.0

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

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

Disclosures: Speaker, Phuong Nguyen, MD has no Commercial Disclosures to make. Activities Director, Michael Gen, MD would like to disclose that he has a financial interest/arrangement or affiliation with the following corporation or other organization that sell or develop products or drugs for medical use: Regeneron – Current or Pending Grant/Research and Speaker’s Bureau, Amgen – Current or Pending Grant/Research and Speaker’s Bureau, Sanofi – Current or Pending Grant/Research and Speaker’s Bureau and – AstraZeneca – Speaker’s Bureau. Planner, Jessica Lipsius has no Commercial Disclosures to make.
The Neuroscience Program at Community Regional Medical Center cordially invites you to attend the

**Neuroscience Grand Rounds**

“MRI-Guided Surgery for Parkinson’s Disease: DBS and Gene Therapy”

Lecture with Audience Participation

**Guest Speaker: Paul Larson, MD**
Associate Clinical Professor and Vice Chair of Neurological Surgery, Department of Neurological Surgery
UCSF

**DATE/TIME**

Thursday, February 23, 2017 – 12:00-1:00 PM

**LOCATION**

UCSF Fresno – Room 137

**TARGET AUDIENCE**

All CMC Medical Staff Physicians including UCSF Fresno House Staff Physicians, Clinical Staff & Allied Health Care

**OBJECTIVES**

- Attendings will be able to describe the advantages of MRI-guided DBS surgery and be able to use this knowledge in patient care.
- Attendings will better understand and use in patient care the risks of MRI-guided surgery to traditional stereotactic surgery.
- Attendings will be able to describe the shortcomings of prior gene therapy trials for Parkinson’s disease and use this knowledge in patient care.

1.0 AMA PRA Category 1 Credit(s)™

**INFORMATION**

For information, contact:
Natasha Saleem, Administrative Assistant – UCSF Fresno Neurology
(559) 459-6394 | nsaleem@fresno.ucsf.edu

**DISCLOSURES**

Presenter Paul Larson has the following disclosures: Voyager Therapeutics and MRI Interventions – current/pending grant/research support. Planner: Natasha Saleem has no Commercial Disclosures to make. Program Director, Shahrzad Akhtar, MD, has no Commercial Disclosures to make.

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This credit may also be applied to the CMA Certification in Continuing Medical Education.
UCSF Fresno Department of Internal Medicine Presents:

**3rd Annual Medical Update in the Valley**

**March 3 - 4, 2017**

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

A two-day conference for general internists, family practitioners, primary care physicians, nurse practitioners, physician assistants and other clinicians who work in the primary care field

**Course Director:**
John A. Ambrose, MD, FACC

**Course Co-Director:**
Vipul Jain, MD, MS

**CME:** 10 (applied for)

**Registration Fee:** $200
Medical Students, Residents and Fellows Fee: $75

<table>
<thead>
<tr>
<th>Friday, March 3</th>
<th>4pm-6pm</th>
<th>Saturday, March 4</th>
<th>8am-5:15pm</th>
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</thead>
<tbody>
<tr>
<td>Screening &amp; Management of Colon Cancer</td>
<td>Devang N. Prajapati, MD, FRCP, (C )</td>
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<tr>
<td>Breast Cancer – Screening &amp; Management Update</td>
<td>Uzair Chaudhary, MD</td>
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<td>STD’s</td>
<td>Naiel N. Nassar, MD, FACP</td>
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<td>Aortic Valve Disease</td>
<td>Ryan Berg, MD, FACC</td>
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<tr>
<td>Essentials of Anti-Coagulation / Antithrombotic Management</td>
<td>Ralph Wessel, MD, FACC</td>
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<td>Polymyalgia Rheumatica and Giant Cell Arteritis</td>
<td>Candice Reyes Yuvienco, MD, RhMSUS</td>
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<td>Advances in Clinical Genetics: What Primary Care Providers Need to know</td>
<td>Maries Joseph, MD, FACC, FAAP</td>
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<tr>
<td>Hand Injuries</td>
<td>Nathan A. Hoekzema, MD</td>
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<tr>
<td>Geriatric Pearls</td>
<td>Alan Kelton, MD</td>
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<td>Diabetes: Update 2017</td>
<td>Soe Naing, MD, MRCP(UK), FACE</td>
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<tr>
<td>Bariatric / Metabolic Surgery - An Update for Primary Care</td>
<td>Kelvin D. Higa, MD, FACS, FASMBS</td>
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<tr>
<td>Seizures: Primary Care Perspective</td>
<td>Arash Afshinnik, MD</td>
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<tr>
<td>Approach to Plural Effusion</td>
<td>Jose Joseph Vempilly, MBBS, MD, MRCP(UK), FCCP</td>
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<tr>
<td>Pulmonary Rehabilitation in COPD &amp; Chronic Lung Diseases</td>
<td>Karl Van Gundy, MD, FACP</td>
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<td>Smoking: Cardio - Pulmonary Effects &amp; Cessation</td>
<td>John A. Ambrose, MD, FACC/ Vipul Jain, MD, MS</td>
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**SAVE THE DATE**

**Welcoming reception is Friday, March 3, 6pm-8pm in the UCSF Fresno atrium**

If you have questions regarding the conference or wish to be added to the conference email list, contact Monica Sozinho at msozinho@fresno.ucsf.edu or 559-499-6421
Current Trends in Healthcare for Women in the Central Valley Symposium

DATE:
Saturday, March 11, 2017
Registration  7:30 am – 8:30 am
Symposium  8:30 am – 12:30 pm
Breakfast & Lunch will be provided

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

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

RSVP:
Jessica Lipsius at:
(559) 324-4002
jlipsius@communitymedical.org
Novel Biologic Therapies in the Management of Treatment Resistant Asthma

DATE:
Tuesday, March 21, 2017
12:30 pm - 1:30 pm
Lunch will be provided

LOCATION:
H. Marcus Radin Conference Center
The Palm Room

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

RSVP:
Jessica Lipsius at:
(559) 324-4002
jlipsius@communitymedical.org
CONFERENCE LOCATION & PARKING
The Air Pollution & Climate Change Symposium will be held at the UCSF Fresno Center for Medical Education and Research, 155 North Fresno Street, Fresno, CA 93701. UCSF Fresno is located on the campus of Community Regional Medical Center (corner of Divisadero and Fresno Street).

Free and secure parking (labeled as PERMIT PARKING) is available off Illinois Street off the East Medical Plaza Parking Garage (validation will be provided).

CONTACT
Monica Sozinho
Events Coordinator for Development Relations & Internal Medicine
UCSF Fresno Department of Internal Medicine
Call: 559-499-6421
E-mail: msozinho@fresno.ucsf.edu

AIR POLLUTION & CLIMATE CHANGE SYMPOSIUM
You are invited to participate in the second annual Air Pollution & Climate Change Symposium at UCSF Fresno. Organized by the Department of Internal Medicine at UCSF Fresno, the conference will present the following themes: state of air in the Central Valley of California, air pollution and its effects on obstructive airway diseases. Followed by climate change and its effect on air pollution and medium and longer term solutions to combat climate change and air pollution.

In keeping with our mission to have a meaningful impact on the direction of medicine in California’s Central Valley, the goal of our conference is to provide current clinical updates in air pollution and climate change to physicians, surgeons, mid-level providers, and nurses in our region, between Los Angeles and San Francisco.

COURSE OBJECTIVES
At the conclusion of this activity, participants will be able to:
• Will understand how agriculture related air pollution causes breathing difficulties and other health effects in patients
• Will be able to identify the effects air pollution has on incidence of chronic, ischemic heart disease and cerebro-vascular accidents and apply to patient care
• Learn about recent advances made in the Central Valley to mitigate air pollution and its effects in patient care
• In order to improve patient outcomes you will understand emerging health threats caused by air pollution and climate change
• Will be able to apply different solutions to mitigate air pollution and climate change on human health into one’s practice.

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 4.0 AMA PRA Category 1 Credits™. Attendees 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.
## 2017 Air Pollution & Climate Change Symposium: Schedule of Topics & Speakers

### Saturday, April 8, 2017

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>7:00am-8:00am</td>
<td>Check-In &amp; Coffee</td>
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<tr>
<td>8:00am-8:10am</td>
<td>Opening Remarks &amp; Program Overview</td>
<td>Michael Peterson, MD</td>
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<td>UCSF Associate Dean at UCSF Fresno</td>
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<td>Chief of Medicine at UCSF Fresno</td>
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<td>UCSF Professor of Clinical Medicine at UCSF Fresno</td>
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<tr>
<td>8:10am-8:40am</td>
<td>Overview</td>
<td>Jose Joseph Vempilly, MBBS, MD, MRCP (UK), FCCP</td>
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<td>UCSF Professor of Clinical Medicine</td>
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<td>Director Asthma Education Program</td>
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<td>Director of Respiratory Care, UCSF Fresno</td>
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<tr>
<td>8:40am-9:10am</td>
<td>What's in SB 350 and AB1550 to Combat Air Pollution and Climate Change</td>
<td>Alex Sherriffs, MD</td>
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<td>UCSF HS Clinical Professor at UCSF Fresno</td>
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<tr>
<td>9:10am-9:40am</td>
<td>Air Pollution and Systemic Diseases</td>
<td>Daya Upadhyay, MD</td>
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<td>UCSF Associate Professor of Clinical Medicine</td>
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<td>Medical Director of Lung Nodule Program</td>
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<td>Director of Translational Research, UCSF Fresno</td>
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<tr>
<td>9:40am-10:20am</td>
<td>Air Pollution and Health Disparity</td>
<td>John Balmes, MD</td>
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<td>UCSF Professor of Medicine</td>
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<tr>
<td>10:10am-10:30am</td>
<td>Brunch</td>
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### Registration

The registration fee is $50. Registration is on a first-come, first-served basis. Early registration is recommended, as seating is limited to 200. Registration fee includes conference participation and meals.

Register online at: [www.fresno.ucsf.edu/conferences/air2017](http://www.fresno.ucsf.edu/conferences/air2017)

### Disclosures

Presenters: Michael W. Peterson, MD, Jose Joseph Vempilly MD, Daya Upadhyay, MD, Alex Sherriffs, MD, John Balmes, MD, Judy Chow, MD, Lingjuan Wang Li, PhD, William Rom, MD and planner Monika Szczesny has no commercial disclosures to make. All potential conflicts of interest will be resolved prior to this event. All faculty with relevant financial relationships will disclose at the time of their presentation.
JOIN THE UNIVERSITY OF CALIFORNIA SAN FRANCISCO - FRESNO DEPARTMENT OF EMERGENCY MEDICINE
at Bass Lake, California - gateway to Yosemite National Park - for the High Sierra Wilderness and Travel Medicine Conference. The conference is designed to meet the needs of those who may encounter life-threatening situations with limited resources. This includes not only emergency physicians, nurses and PAs, but also internists, family practitioners, backcountry rangers, EMS providers, members of the search and rescue community, and outdoor enthusiasts. Through both lecture and hands-on skills workshops, we will explore topics including survival and field treatment of environmental illness, rescue techniques, wound care, and fracture management. This course is proudly presented by the University of California San Francisco- Fresno Wilderness Medicine Program.

Registration for course by phone: (415) 476-5808

CONFERENCE LOCATION: The Pines Resort at Bass Lake, CA
This unique mountain resort – conveniently located just 17 miles from the Southern gate of Yosemite National Park and just 56 miles north from Fresno – offers lakefront lodging and dining with spectacular views of Bass Lake and year round recreational activities. If you plan to stay at The Pines Resort we have negotiated a special rate of $109 per night for a two-queen chalet.

Room Description includes: 700 square-foot, two-story cabin with full kitchen, living area with queen bed sofa sleeper, some with wood burning fireplace (limited availability), private patio with small BBQ, downstairs bedroom with two queen beds and private bath. Includes evaporative cooler/heater, hair dryer and full size iron/board. Maximum occupancy is 6 guests. Non-smoking only.

For a Hotel Reservation call the front desk at 559-642-3121 and request to book under the group name: UCSF Fresno EM with the arrival date of 4-25-17. Please specify you will be booking the two-queen Chalet.

Pet Friendly hotel. Some rooms are pet friendly so let them know when booking that you will need a room with a pet. An additional $75 fee applies when bringing pets.

Contact -Mary Swenson - UCSF Fresno Dept. of Emergency Medicine
155 North Fresno Street, Fresno, CA 93701
Phone: (559) 499-6443
email: mswenson@fresno.ucsf.edu

Accreditation
The University of California, San Francisco School of Medicine (UCSF) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

UCSF designates this live activity for a maximum of 14 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

California EMS continuing education credits are also available.

Course Objectives
Upon completion of the High Sierra Wilderness Medicine Conference, attendees should be able to:
- Apply evidence-based management of medical problems that are unique to the wilderness setting, including environmental exposure, wound care, and lightning;
- Utilize necessary skills for remote medical care such as patient assessment and trauma care, including needle decompression and management of wounds and orthopedic injuries;
- Apply basic principles of survival and rescue, from trip planning to behaviors that are likely to result in a successful rescue.
February 2017

February 2
“The Future of Psychiatry”
Renee Binder, MD
Associate Dean of Academic Affairs
Professor and Director Psychiatry and Law Program
UCSF School of Medicine
Immediate Past President, American Psychiatric Association

February 9
“Get Movin’ with Memantine:
Targeting Cognition and Negative Symptoms”
Kim Cranford, MD, Presenter
Robert Hierholzer, MD, Discussant
UCSF Fresno Psychiatry Residency Program

February 16
“Why Not Weed?”
Robert Hierholzer, MD, Presenter
HS Clinical Professor
UCSF Fresno Medical Education Program

February 23
No Grand Rounds – Resident Open Meeting

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

Community Medical Centers designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.
<table>
<thead>
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<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
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<td>Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm.</td>
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<td>Chest Conference UCSF # 116</td>
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<td>Brain Tumor/Cyberknife Conf. CRMC-Seqoia West Conf. Rm</td>
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<td>Surgery Clinical Case Rev. CRMC- Sequoia West Conf. Rm</td>
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<td>Critical Care/Trauma CRMC- Sequoia East Conf Rm</td>
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<td>CCMC GI Subsection</td>
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<td>CRMC Medicine</td>
<td><strong>CRMC Facility Executive Committee</strong></td>
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<td><strong>CCMC OB-GYN/Pediatrics Committee</strong></td>
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<td><strong>FHSH Well Being Subcommittee</strong></td>
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<td><strong>Quality Council</strong></td>
<td><strong>CRMC Anesthesia Subcommittee</strong></td>
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<td><strong>FHSH Quality Practice Bariatric</strong></td>
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<td>FHSH Riverpark Conf B</td>
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<td><strong>CCMC Multispecialty Peer Review</strong></td>
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<td><strong>Presidents’ Day Holiday</strong></td>
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As of 1/30/17