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JANUARY PHYSICIAN PHOTOGRAPHER
DAVID L. SLATER M.D., F.C.A.P.

CMC Pathologist

Water – enhanced by light and wind – provides an endless source of reflections, patterns and textures. The Sierra’s clean streams have surface ridges and ripples, smooth concave and convex stretches, and lots of floating stuff. Deeper down, wavy algae or prismatic reflections from stones can be enchanting. Falling water has ever-changing 3-dimensional structure and is highly influenced by sun, wind and flow rates. Still water responds to sun and wind and time of day in long-horizon, grand images. The moving sea has a timeless mix of all these properties. Snow and ice move the esthetic dial in different fascinating directions. Water – in all its forms and structure – has always held a primary place in visual art. I’m far from alone in having great affinity for all that water offers our senses and our need for beauty – I think it’s a primal fascination, hard wired into us.
Getting the Flavor

GREETINGS! Two short years ago the medical staff voted me in as president-elect. I feel privileged and I thank you all for the honor you bestowed upon me. As president-elect, I observed and learned immensely about the dynamics of our system and its inherent challenges. I have great respect for the many people who share the responsibilities and commitment, which are vital to shared success at Community.

Change is a constant in life, and 2017 is going to be a year of change. We’ve had changes in our medical staff leadership locally and a change in the nation’s leadership. Undoubtedly, with those changes will come unanticipated challenges. We are blessed with an extremely engaged, versatile and knowledgeable team of Hospital trustees, administrators, and physician leaders – who together have demonstrated the ability and the will to deal effectively with ongoing demands. I thank Dr. Jeffrey Thomas, Dr. Thomas Utecht, medical staff members, and all the CMC staff for a job well done.

My mission as President of the Medical Staff is to facilitate improvement of the health of those we serve – in a caring, convenient, comprehensive, cost-effective and accessible manner. Our facilities should be the best places to teach, learn, administrate, and both deliver and receive healthcare. I am committed to ethics, compliance, patient safety, and the best interests of physicians. I look forward to working closely with my peers and administration.

We have made significant strides, such as advancing additional services in pediatrics and oncology. The Hospital board is aligned to provide the support and infrastructure for these invaluable service lines.

5 Things for my colleagues to do in January:

1. Familiarize yourselves with the significant changes in our by-laws and associated policies and procedures, as they do impact us. You can access them from the Epic Forum home page, under 'Shortcuts/Tools'.
2. Obtain a CMC/Sante/UCSF based e-mail address for effective and secure communication. CMC e-mails are easily set up via the Help Desk.
3. Sign up for EPCS in Epic to prescribe controlled substances.
4. Consider a flu shot if you don’t yet have this season’s green badge.

I believe that as President, I am of the people, elected by the people, and for the people. I will strive to serve to the best of my ability. I will welcome your comments and suggestions, and I wish you all the best for the New Year.
Initial Appointment to the Medical Staff
effective December 8, 2016

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

David Abel M.D.
Department: OB/GYN
Specialty: Maternal Fetal Medicine

Nimeshkumar Ahir M.D.
Department: Medicine
Specialty: Internal Medicine

Anas Elias M.D.
Department: OB/GYN
Specialty: OB/GYN

Kevin Ferguson M.D.
Department: Emergency Medicine
Specialty: Emergency Medicine

Jonathan Grossman M.D.
Department: DOCS
Specialty: Physical Medicine & Rehab

Danilo Jaravata M.D.
Department: Surgery
Specialty: Anesthesiology

Panchali Khanna M.D.
Department: Medicine
Specialty: Endocrinology

Rohit Mahajan M.D.
Department: Medicine
Specialty: Internal Medicine

Andrea Stebel M.D.
Department: Medicine
Specialty: Hematology/Oncology

Constance Stoehr M.D.
Department: Medicine
Specialty: Hematology/Oncology

Initial Appointment to the Medical Staff
effective December 8, 2016

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

Toni Lee Drew C.R.N.A.
Department: Surgery
Specialty: Anesthesiology

Jonathan Reed Gardner C.R.N.A.
Department: Surgery
Specialty: Anesthesiology

Tran Huyen Luong P.A.
Department: Surgery
Specialty: General Surgery

Annette Munoz N.P.
Department: OB/GYN
Specialty: OB/GYN

Sean Peng N.P.
Department: DOCS
Specialty: Psychiatry

Jaspreet Riar P.A.
Department: Medicine
Specialty: Endocrinology

Meribeth Wareham N.P.
Department: Surgery
Specialty: Orthopedic Surgery

“There is no greatness where there is no simplicity, goodness and truth.”

– Leo Tolstoy, writer
Board of Trustees

Effective January 1, 2017, Board of Trustees and Officers for Community Hospitals of Central California, Fresno Community Hospital and Medical Center, Sierra Hospital Foundation and Community Hospital of Central California Foundation are:

Linzie Daniel, Chair
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Ren Imai M.D.
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Farid Assemi, Chair-Elect

Terry Bradley
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Michael Peterson M.D.

H. Michael Synn M.D.
Susan Abundis
Manuel Cunha, Jr.
Ruth Quinto
Chandra Venugopal M.D.

The Board also approved the appointments to Community Hospitals of Central California, Fresno Community Hospital and Medical Center, Sierra Hospital Foundation and Community Hospital of Central California Foundation, of:

Joseph M. Nowicki, Chief Financial Officer
Debbie Moffett, Vice Treasurer
Juanita Hernandez, Vice Secretary

Editor’s note: Holiday cards are full of best wishes for the season and the new year. The image on the front often supports in some way the message inside. This card, crafted by CMC’s photographer extraordinaire Dr. Scott Ahles, wins the prize for its truly laser-sharp link between image and message. Please enjoy and keep this imagery with you in 2017.

The light in this slot canyon shines for only a few minutes each day. May the light in your heart glow brightly throughout the New Year!

Happy Holidays,
Scott Ahles
The most recent Physicians' Well-Being article presented in this newsletter addressed the importance of being knowledgeable regarding the signs of stress and burnout. Gaining awareness of such signs in ourselves is sometimes the difficult part of using that knowledge effectively. There is great value in taking a step back and looking at what we are doing and what we are thinking. A new year is beginning and I think it might be valuable to set aside the negative aspects of being a physician, and take a moment to reflect on the positive experiences that are a part of the professional life of a doctor. Such reflection does not eliminate the negatives but it can put them in perspective and reduce their impact on our sense of what it means to be a physician. There are six rewarding opportunities that come quickly to mind when considering the good things about being a doctor. The first one listed is commonly the most satisfying aspect of being a doctor. The other five are not in any order of significance.

**Patient Care** – It is a consistent finding in research on physician satisfaction that providing care to patients is the most rewarding part of a physician’s day. This is also the feedback I receive when meeting with physicians in my role as Chair of the Well-Being Committee.

**Colleagues** – Many physicians enjoy the camaraderie and association with other physicians. This can be as friends with similar interests, or as colleagues in medical organizations such as medical societies or group practices.

**Community Resource** – Quite a few doctors find it rewarding to be a resource with medical expertise for their local community. This experience can be as a member of a volunteer agency or through assisting in one’s own social circle.

**Mentoring** – For some the process of teaching and guiding the next generation of health care professionals is a valuable part of their self-definition of being a physician. This can be in an informal manner such as mentoring within one’s practice or on a treatment unit of a hospital. It can also be through formal roles in a medical residency program.

**Leadership** – Formal leadership roles provide some physicians with an opportunity to make a difference to the medical profession. Such roles can be found within medical societies, group practices, and hospital medical staffs.

**Research** – Retaining an interest in academic pursuits can find an outlet in participating in medical research which enables the practitioner to contribute to the body of knowledge which is necessary for physicians to do the best they can for their patients and the community.

These six areas of physician life provide opportunities for fulfillment in stewardship of patients, colleagues, students, the community, and the medical profession. It is a humbling thought to see all of the ways in which a physician can have a positive experience and impact on others and themselves.
With this new year, we will have choices... LOTS of choices: from healthcare program reform to new regulations and requirements, from current radiology systems to Radiant, from Epic 2014 to a new and improved Epic 2016. So how will YOU greet these new beginnings?

My goal has always been to improve our clinical technology, making patient care better, easier and more continuous. Some things this past year were a win with providers; others, not so much.

To summarize the year, we've:
• reduced drug and medication alerts
• continued to review, standardize and streamline order sets
• standardized alerts, be they pop-ups, best practice alerts, in-line warnings or chart advisories
• initiated the OnBase patient window to assist with viewing items in the Media Tab
• initiated electronic prescribing of controlled substances
• worked to redeploy secure sign on
• enhanced documentation for staff
• initiated well over 550 change requests, completing over 230 of them thus far
• started and finished a host of other initiatives in conjunction with IT and operations

In the New Year, we have BIG changes coming... but my resolution is that we do a better job of not just informing you, but involving you in decision-making. We will be working through lists of enhancements available in Epic 2016, identifying which make sense for CMC, as well as identifying things we hadn't taken advantage of in earlier versions, which would bring value to our environment for the future.

Additionally, Radiant will be coming live, and several other modules are planned – Case Management and Infection Control. We anticipate the CRMC AIC and inpatient areas to come live with Beacon for chemotherapy, and we will continue to grow the organization’s data awareness and utilization. Finally, we will begin the ‘monthly’ release cycle for changes to the EMR in February, with robust communications and education materials available well in advance of the system changes.

If you are interested in being part of the decision-making team for the upgrade work, please let me know – volunteers are most welcome!

In closing, the 18-month time I’ve been here has flown, and I’m still loving it. I appreciate the opportunity to serve this organization, and to get to know even more members of the medical staff in this next year. Here’s to an action-packed 2017!

“Know what you want to do, hold the thought firmly, and do every day what should be done. Every sunset will see you that much nearer your goal”

– Elbert Hubbard, writer
If you've ever had an MRI, you probably already know that MRI's are often difficult for patients to go through due to noise, claustrophobia, and need to remain still and supine for a prolonged period of time. Sometimes they are required to hold their breath intermittently. Patients frequently require anxiolytics or some degree of sedation to complete the test. Sometimes there are acute pain issues that are exacerbated by the supine position. Of even more concern are patients with cardiopulmonary issues such as CHF, COPD or sleep apnea that can be exacerbated by positioning and/or sedation. Many inpatients undergo MRI to evaluate for stroke. Frequently these patients have some baseline altered mental status and may require sedation, which subsequently affects neuro exam. We have had some unfortunate cases of patients being over-medicated for this procedure in an unsafe fashion. Physicians need to be careful on how they sedate their patients, needing to consider not only types of medications and doses, but also whether or not monitoring is needed.

As for any procedure, the indications, risks and benefits must be considered, especially in patients with potential for cardiopulmonary compromise. Patients frequently get a head CT for altered mental status, to rule out bleed, etc. Often at the end of the radiology report, consideration of MRI to rule out stroke is mentioned as it is more sensitive than CT. However, if clinical suspicion of stroke is low, the risk-benefit analysis may dictate that MRI is not appropriate. If sedation is required for the patient to undergo the study, RN monitoring should be strongly considered, especially in high risk patients.

**Here are some important facts to consider:**

**Per hospital policy**, whether a patient goes to a radiologic test monitored or unmonitored is at the discretion of the physician.

**An RN is required to accompany the patient** if he/she is to be monitored, and there is no monitoring whatsoever without an RN present.

**Monitoring via devices alone is difficult** in MRI scanner – cardiac monitoring displays a lot of artifact. Pulse oximetry can be monitored but requires an RN to be present. If an RN does not go down with the patient, there is no pulse oximetry monitoring. When an MRI is performed, the patient is alone in the MRI room and in the scanner for a prolonged period of time. Communication is via headphones.

**The MRI order templates include** the capability to specify if patient should be monitored or if they may go unmonitored. Be sure to specify the appropriate choice for your patient. If you select monitored, a licensed RN will accompany your patient.

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**QI Quicky:**
**MRI Patient Sedation and Safety**

Submitted by CRMC Multi-Specialty Peer Review Committee

**MRIs, Sedation and Monitoring:**

If you've ever had an MRI, you probably already know that MRI's are often difficult for patients to go through due to noise, claustrophobia, and need to remain still and supine for prolonged period of time. Sometimes they are required to hold their breath intermittently. Patients frequently require anxiolytics or some degree of sedation to complete the test. Sometimes there are acute pain issues that are exacerbated by the supine position. Of even more concern are patients with cardiopulmonary issues such as CHF, COPD or sleep apnea that can be exacerbated by positioning and/or sedation. Many inpatients undergo MRI to evaluate for stroke. Frequently these patients have some baseline altered mental status and may require sedation, which subsequently affects neuro exam. We have had some unfortunate cases of patients being over-medicated for this procedure in an unsafe fashion. Physicians need to be careful on how they sedate their patients, needing to consider not only types of medications and doses, but also whether or not monitoring is needed.

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**Notice Anything New When Ordering Clostridium Difficile (C.diff)? Better Decision Support Now in Place.**

Submitted by Beverley Kuykendall,
Manager Infection Control, CRMC

Editor’s Note: An important 2015 JAMA study outlines in more detail the real difference between C.diff “positive” and C.diff infection, and the implications of various test results. That article also has several journal references. Uptodate.com has an excellent discussion of this topic.

An investigation of positive C.diff tests at CRMC revealed approximately 50% of the patients received a bowel regimen drug within 48 hours prior to the C.diff stool collection. All of them – despite having to receive a bowel regimen to produce a stool sample – received antimicrobial therapy. It was also noted that patients were being retested within 7 days from a previous positive or negative result and retested after completion of antibiotics. All these observations represent departures from the currently recommended approach to C.diff infection (CDI) diagnosis and management. As a result of these findings the following alerts and reminders have been added to the C.diff EPIC order screen:

- If patient has a positive (+) C.diff test result within the last 7 days; repeat testing is **NOT** needed.
- If patient has a negative (-) C.diff test result within the last 7 days; repeat testing is **NOT** indicated, unless the patient’s signs/symptoms (s/s) have changed.
- If patient has received a laxative/bowel regimen within the last 24 hours; C.diff should not be ordered until 24 hours after the last dose of laxative/bowel regimen was administered. One of the first principles of CDI diagnosis is not to test unless the patient has either diarrhea or radiographic evidence of ileus or toxic megacolon.

In addition, under the C.diff order, the “Ad-
The CyberKnife® system at Community Regional’s Charles & Ann Matoian Oncology Unit, was upgraded in October to enhance treatment for early-stage lung cancer patients. The addition of a “Lung Optimizing Treatment” means most lung cases can be treated without needing invasive surgical implantation of gold markers called fiducials at the tumor site. Before these upgrades, fiducials were required to guide CyberKnife laser treatments to accurately target the tumor while the lungs were moving during breathing.

“In many cases, this will reduce the number of procedures a patient requires prior to treatment,” said William Silveira M.D., Ph.D., a radiation oncologist at Community. “These advancements allow for improved tracking of lung tumor motion during radiosurgery. This will positively impact our patients with early stage lung cancer who are treated with stereotactic radiosurgery by CyberKnife, a non-invasive outpatient procedure. In addition, with new powerful planning hardware and software, we expect more efficient radiosurgery planning and treatment times. This will lead to a better experience for all of our patients.”

Kenneth Forster Ph.D., chief of medical physics who oversaw the modifications, described the upgrades, “We use two x-ray cameras that are fixed in the room to help determine where the tumor is in three dimensions. Previously we had to always implant small gold markers into the tumor to assess tumor position with the X-ray cameras. With our new software we can track many lung tumors without having to first implant fiducial markers. So the radiation beam is always focused on the tumor.”

Additional CyberKnife upgrades added new user interfaces which decrease treatment times. Patients will now spend 33% less time on the table. And updated hardware allows for faster and even more accurate dose calculation.

“Clinical trials on radiosurgery for lung tumors show it is as effective as surgical lobectomy,” said Dr. Forster. “The difference is in two weeks we’re done with treatment and there’s no recovery time. We have similar treatment times for prostate cancer, for which Cyberknife outcomes are also comparable to surgery for early stage tumors.”

It is important to remember that a C.diff PCR positive result indicates presence of the organism capable of producing the toxin, not that the organism is currently producing toxin or active disease. Therefore, a positive PCR test could indicate C.diff colonization, which – in absence of symptoms – may not require antibiotic treatment. Please consider the C.diff alerts along with the patient’s signs/symptoms and other potential diagnoses before ordering.

And… more good news… Along with many US hospitals who moved to PCR-only testing some years ago, CMC Labs will be adopting a multi-step algorithmic approach to C.diff testing. More information in next month’s newsletter.
Many doctors go to medical schools to make a difference in people's lives. They study hard, train for long hours and hone their skills to tackle the most challenging medical problems. But what if I tell you of a very simple medical problem that seriously impacts the lives of hundreds or even thousands of children each year, many of whom live their lives never smile nor show their face in public. Many of these children never attend school because they are teased constantly, tortured and bullied because of the way they look? And what if the solution is so simple, takes less than 2 hours to fix and can permanently fix all these problems and restore the happy smiling face to these poor children? What would you do? Would you jump to help? Of course you would, and that is exactly what drew me 10 years ago to volunteer with medical missions all over the Globe to help repair the cleft lips and palates of thousands of unfortunate children born with this deformity and to families who could not afford the medical costs of a surgical repair. Welcome to Smile missions.

There are many non-government organizations (NGO) around the World (several are in the US) which send medical teams of doctors and nurses all over the World to repair cleft lips and palates. I started to join these medical teams in 2006. At that time I wanted to help a friend who signed up for one of these missions but at the last minute, he could not go and asked me to fill in. From that first trip I got hooked.

I was so haunted by the looks of these children before surgery and the amazing transformation a 2 hours operation did to them and their families. I decided to take 2 years of sabbatical from my profession and dedicate my time to going on these medical missions. Most of my missions were to China. The need was vast. Children were suffering due to no fault of their own. They were born with a mild deformity but most of them were discarded in the streets like human garbage or abandoned in orphanages. Those who stayed with their parents, the extended family ostracized the parents or grandparents and many were kicked out of their homes in fear of bad luck being brought onto the family by the deformed cursed child. Other reasons for abandoning these children were unfounded myths about these children. Many believed these children are mentally retarded or can never be trained to hold a job or get married. In the pursuit of a perfect single child, the deformed child was discarded by many parents in their quest for a better child. In addition, cleft lips and palates are considered by the government insurance program as cosmetic aberration not a disease and repairing them is purely a cosmetic procedure thus is not covered by the public social healthcare insurance. All these factors created a large pool of unfortunate children lingering in squalid conditions.

In 1991 the first American medical team arrived to China for the sole purpose of helping these children. Over the last 3 decades more and more teams arrived, almost on monthly basis. The task is enormous. The deformity is fairly prevalent in China (1:600 live births). Sending medical teams from the US and Europe cannot build a sustainable system to deal with this issue. The local Chinese doctors and nurses need to be involved. The Chinese society needed to become involved to address this problem. The medical teams started to partner with the Chinese colleagues. Training on state of the art approaches to surgical repair and postoperative care became an integral part of each mission. Organizing missions, putting teams together, building a stock pile of equipment and supplies needed for surgical repair, and establishing strong collaboration with hospitals all over China became an essential component of each mission.

As time passed, local Chinese personnel took over. Missions are now organized by Chinese. The majority of the medical teams are now Chinese doctors and nurses. The Chinese society was also gradually transformed. Helped by super stars couple who had a child born with cleft lips and palate, the Chinese society has started to accept these children.

See Mission Possible on page 11
The Global Panel on Agriculture and Food Systems for Nutrition published a foresight report in September 2016 examining the role food systems play in diet quality across the globe. “Food Systems and Diets: Facing the Challenges of the 21st Century”, critically evaluates how food policy shapes the global food system and people’s health, with a focus on complications related to malnutrition. After linking policy and food systems with diet quality, the Global Panel calls on professionals and policy makers interested in public health and food systems to end all forms of malnutrition by reshaping the food system. Although the report focuses on low- to middle-income countries, its insights can be extended to Community Medical Centers’ (CMC) service area.

Today, malnutrition comes in many forms and can be the result of under- or over-nutrition. Malnutrition may exist when there is stunting, wasting, deficiencies of essential vitamins and minerals, obesity, and diet-related chronic diseases. The Global Panel cites that overweight and obese individuals in the world will increase from 1.33 billion in 2005 to 3.28 billion by 2030. And it’s not just developed countries experiencing an obesity epidemic. For example, the male population in sub-Saharan Africa is experiencing a higher growth rate in overweight and obesity than underweight. Areas in California are facing similar nutrition related issues. According to CMC’s 2016 Community Health Needs Assessment, 28% of Fresno County’s adult population is considered obese and 42% of children are overweight or obese, well above California averages (22% and 38% respectively). In neighboring Kings County, half the residents are considered obese.

Worldwide, under-nutrition has impacted child mortality through fetal growth restriction, suboptimal breastfeeding practices, stunting, wasting, and vitamin A and zinc deficiencies, resulting in 45.5% of all deaths for children under 5 years. California is also facing problems related to micronutrient deficiencies. Folate deficiency contributed to 2.08 cases of spina bifida per 10,000 births from 2001 to 2005 (Spina Bifida Association of California, 2016). And Hispanics are 1.5-2 times more likely to have an infant born with spina bifida than non-Hispanic whites. In Fresno County, where 51% of the population are Hispanic, this can have a profound effect. The Maternal and Infant Health Assessment (MIHA) Survey of 2013-2014 found that only 28.2% of mothers in California supplemented with folic acid one month before pregnancy (California Department of Public Health, 2016). To compound matters, obesity is linked to increased risk for folate deficiency in women, which the
Food Systems

Continued from page 11

Global Panel describes as the “double burden” of obesity and micronutrient deficiency. In April of this year, the Food and Drug Administration approved folic acid fortification of corn masa flour, a staple food among many Hispanics.

The Global Panel makes a call to combat malnutrition through policy changes that help improve diet quality. However, a high quality diet is difficult to define across cultures and geographic regions. The Global Panel aligns their recommendations with The World Health Organization, which promotes breastfeeding, consuming a diverse diet of fruits, vegetables, whole grains, nuts, and limiting added sugar, processed meats, and salt. While fruit and vegetable consumption is difficult to quantify, breastfeeding rates have been highly studied in the Fresno area. MIHA Survey data from 2013-2014 indicate that 18.2% of Fresno County mothers reported exclusively breastfeeding for three months after delivery (California Department of Public Health, 2016).

Through the Global Panel’s efforts, a tool kit was created that helps communities identify diet quality shortcomings and develop actions for food system solutions. Likewise, California activists and policy makers have taken steps to improve the diet quality of its residents. The passing of AB 1577 and AB 1321 are examples of such efforts. AB 1577 increased incentives to farmers and food packagers that donate food items to food banks and AB 1321 funded a campaign of more than $5 million to help low-income families afford California grown produce. However, a bill to impose a fee on distributors of sugary beverages has not been as successful. Improving the health of CMC’s community through diet goes beyond policy change. It involves awareness and promotion of available resources that are supported by policy. One example is the government funded, state run program of Women, Infants, and Children (WIC) that offers nutrient-dense foods and breastfeeding support. One small step like writing your elected official in support of a health policy or referring a pregnant mother to WIC is improving the health of our community.

References:
andHealthAssessment(MIHA)survey.aspx
Sheets/Archive/pr-2013-community-health-needs-assessment.pdf

ICD-10
CORNER

Diagnoses for Pacemaker Insertion


AVOID Queries for clarification by documenting specific diagnoses for Pacemaker insertion. Enhanced documentation of indications necessitating pacemaker insertion = assigning codes that accurately reflect the patient’s severity of illness and risk of mortality.

The Centers for Medicare and Medicaid Services (CMS) has initiated a change in the medical necessity criteria for pacemaker insertion, requiring one of the below detailed diagnoses:

- Non-reversible symptomatic bradycardia due to sinus node dysfunction
- Non-reversible symptomatic bradycardia due to second degree and/or third degree AV block.
- Sinoatrial node dysfunction/Sick Sinus Syndrome
- AV Block
- Mobitz (Type II) AV Block
- Congenital heart block

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

Tips to a Successful ICD-10 Transition

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

Prior ICD-9 Documentation

55 year old male with bradycardia, needs pacemaker placement.

Improved ICD-10 Documentation

55 year old male with non-reversible symptomatic bradycardia due to sinus node dysfunction, needs pacemaker placement.

The following documentation improvement is needed for Medical Necessity in ICD-10: Specific Type of dysrhythmia or conduction disorder
RECOMMENDATION STATEMENT

Statin Use for the Primary Prevention of Cardiovascular Disease in Adults

Editor's Note: Many readers may be aware of the latest high-profile, large public health issue to be tackled by the indefatigable US Preventive Services Task Force: Statin use for primary prevention.

Having endured the slings and arrows related to recent Statements on breast cancer screening and PSA testing, the USPSTF has now evaluated Statin use in the common primary prevention context. The Clinical Summary is below (JAMA, Nov. 15 2016).

Interested readers can learn more at: jamastatins.com (free access to this and related articles in JAMA network journals) USpreventiveservicestaskforce.org (this guideline is there, along with a large library of other guidelines of interest)

Statin Use for the Primary Prevention of CVD in Adults: Clinical Summary

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults aged 40–75 y with no history of CVD, ≥1 CVD risk factors, and calculated 10-y CVD event risk ≥10%</th>
<th>Adults aged 40–75 y with no history of CVD, ≥1 CVD risk factors, and calculated 10-y CVD event risk of 7.5%–10%</th>
<th>Adults 76 y and older with no history of CVD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation</td>
<td>Initiate use of low- to moderate-dose statins. Grade: B</td>
<td>Discuss with patient and selectively offer use of low- to moderate-dose statins. Grade: C</td>
<td>No recommendation. Grade: I (insufficient evidence)</td>
</tr>
</tbody>
</table>

Risk Assessment

Risk factors for CVD include dyslipidemia (LDL-C >130 mg/dL or HDL-C <40 mg/dL), diabetes, hypertension, and smoking. The USPSTF recommends using the ACC/AHA Pooled Cohort Equations to calculate 10-year risk of CVD events. The calculator derived from these equations takes into account age, sex, race, cholesterol levels, systolic blood pressure level, antihypertension treatment, presence of diabetes, and smoking status as risk factors.

Preventive Medication

Statins are a class of lipid-lowering medications that function by inhibiting the enzyme 3-hydroxy-3-methyl-glutaryl coenzyme A reductase. Statins reduce levels of total cholesterol and LDL-C and a lesser extent, triglycerides. The most directly applicable body of evidence for patients without a history of CVD demonstrates benefits with use of low- to moderate-dose statins.

Considerations for Implementation

The likelihood that a patient will benefit from statin use depends on his or her absolute baseline risk of having a future CVD event, a risk estimation that is imprecise based on the currently available risk estimation tools. Thus, clinicians should discuss with patients the potential risk of having a CVD event and the expected benefits and harms of statin use.

Balance of Benefits and Harms

The USPSTF concludes with moderate certainty that initiating use of low- to moderate-dose statins in this population has at least a moderate net benefit. The USPSTF concludes with moderate certainty that initiating use of low- to moderate-dose statins in this population has a small net benefit. The USPSTF concludes that the evidence is insufficient to determine the balance of benefits and harms of initiating statin use in this population.

Other Relevant USPSTF Recommendations

The USPSTF has made other recommendations relevant to the prevention of CVD in adults, including aspirin use for the prevention of CVD, screening for coronary heart disease using electrocardiography, use of nontraditional risk factors in CVD risk assessment, screening for high blood pressure, screening for abnormal blood glucose levels and type 2 diabetes mellitus, interventions for tobacco smoking cessation, behavioral counseling to promote a healthful diet and physical activity for CVD prevention in adults, and screening for and management of obesity in adults. These recommendations are available on the USPSTF website (https://www.uspreventiveservicestaskforce.org).

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to www.uspreventiveservicestaskforce.org.

We have covered our national and regional opioid abuse epidemic in this newsletter multiple times over the past year, and the topic will be among those featured at Sante Health Foundation’s Winter Symposium in 2017 (see wintersymposium.com). Dr. Murthy’s report is wide ranging, from epidemiology to neurobiology to collateral damage considerations to strategies for individual treatment and public health management. The report is easily searchable and is divided into well-named chapters to allow rapid drilling down to material of special interest.

Here are several things taken from the report. There is the chart below, which illustrates the problem (where “illicit” drugs include non-medical use of prescription drugs):

And a section (below), which will be of special interest to those who believe that this should be more of a public health matter than a criminal justice issue.

**A Cultural Shift Is Underway: Society Is Moving from a Criminal Justice-Based Model to a Public Health Approach**

Historically, society has treated substance use disorders as a moral weakness or as a willful rejection of societal norms, addressing these problems primarily through the criminal justice system.

Evidence now shows that addiction to alcohol or drugs is a chronic, but treatable, brain disorder that requires medical intervention, and has the potential for both recurrence and recovery.

Building on the federal public health approach, many states are developing public health approaches to address substance misuse in their communities. A public health approach seeks to understand the broad factors that influence substance misuse and substance use disorders and applies that knowledge to improve the health, safety, and well-being of the entire population.

Recent changes in health care financing and health insurance regulations support the integration of clinical prevention and treatment for substance use disorders into mainstream health care practice.

Let’s hope our next US Surgeon General remains engaged and continues this excellent work.
Editor's Note: This is just an introduction to this important new Platelet component. We anticipate medical staff and nursing questions about Intercept platelets. We have some decisions to make as a hospital system regarding how to best utilize them. For a while at least, regional hospital who wish to participate in the Intercept product will have a mixed inventory of “regular” and Intercept platelets. Readers are encouraged to learn more at Interceptbloodsystem.com.

Since the emergence of an FDA approved pathogen reduced platelet product (Cerus Intercept) in December 2014, US blood centers now have an ideal approach to enhancing the safety of platelet transfusion. Rather than rely on testing or other reactive measures to screen out safety threats like bacterial contamination, parasites, CMV or other viruses, including emerging pathogens, pathogen reduction takes a more proactive approach by preventing most classes of germs from being able to replicate. The Intercept platelet Cerus Corporation (Concord, CA) offers the first and currently only US licensed pathogen reduction system for platelets and plasma.

Nineteen US blood centers are already routinely producing Intercept platelets for their hospitals and 40 others including the American Red Cross and our own local center, Central California Blood Center (CCBC) are under contract with Cerus to begin producing them. In fact, CCBC – right here in the Central Valley – is expected to be the first California center to have them available in the first quarter 2017.

Over the decades, infection-related transfusion safety has improved so much that transfusion-associated infections are now very rare. Still, the risk of bacterial contamination from platelet transfusions has persisted in the US, even after FDA mandated that all platelets be tested for presence of bacterial prior to release by blood centers. It is by-far the largest transfusion infectious risk (see figure below). According to studies by Dumont, LJ, et al, the risk of bacterial contamination from conventional platelets is currently about 1:1,500 units. Kleinman S, et al., described the risk to be about 1:250 for patients who receive platelets, since many of them receive multiple units.

In response, the FDA issued a Draft Guidance for Industry,
was not part of the FDA submission. However, Cerus data showed that Intercept achieved a greater than 6.5 log reduction of ZIKA virus.

**Intercept** method is designed to be performed in blood centers. It involves the addition of a photoactive psoralen compound, called amotosalen HCL. Psoralens are found naturally in foods such as limes, celery and parsnips. Amotosalen was found to yield at least a 4 log reduction in a broad range of pathogenic viruses and bacteria while maintaining the functional properties of platelets and plasma. Following the addition of amotosalen to the collected platelet bag, the product is then exposed to an ultraviolet light source. When it encounters a pathogen, or a donor T-cell, the amotosalen penetrates it and docks between the DNA or RNA amino acid base pairs. The ultraviolet light then assures crosslinked bonding, which blocks replication, transcription and translation. A final step in the Intercept treatment of the platelet product involves removing residual amotosalen and its photoproducts with a compound adsorption device. The final platelet and plasma storage containers appear similar to standard platelet and plasma products.

Use of psoralen-treated platelets avoids blood centers and hospitals having to do costly and less efficient bacterial detection testing and thereby make platelets available to patients sooner after collection. This product also eliminates any need to irradiate or CMV test platelets prior to transfusion. The cost of a psoralen-treated platelet will be comparable to that of an irradiated plus CMV screened platelet. What about Red cells? That is being worked on but the challenges and logistics are of course different from platelets. We hope that FDA approval might happen in the next few years.

**Table 2 Pathogen Reduction**

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Log Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Virus (Enveloped)</strong></td>
<td></td>
</tr>
<tr>
<td>HIV-1 IIB, cell-associated</td>
<td>≥6.2</td>
</tr>
<tr>
<td>HIV-1 IIB cell-free</td>
<td>≥6.1</td>
</tr>
<tr>
<td>DHBV</td>
<td>≥4.4 to 4.5</td>
</tr>
<tr>
<td>BVDV</td>
<td>≥4.5</td>
</tr>
<tr>
<td>HTLV-I</td>
<td>≥4.1</td>
</tr>
<tr>
<td>HTLV-II</td>
<td>≥4.7</td>
</tr>
<tr>
<td>West Nile virus</td>
<td>≥6.7</td>
</tr>
<tr>
<td>SARS-Associated Cronavirus</td>
<td>≥4.0</td>
</tr>
<tr>
<td>Chikungunya virus (HIKV)</td>
<td>6.5</td>
</tr>
<tr>
<td>Influenza A virus (H5N1 Avian Influenza)</td>
<td>≥5.7</td>
</tr>
<tr>
<td><strong>Virus (Non-Enveloped)</strong></td>
<td></td>
</tr>
<tr>
<td>Parvovirus B19</td>
<td>1.8</td>
</tr>
<tr>
<td>Bluetongue virus</td>
<td>≥4.0</td>
</tr>
<tr>
<td>Adenovirus 5</td>
<td>≥5.6</td>
</tr>
<tr>
<td><strong>Bacteria</strong></td>
<td></td>
</tr>
<tr>
<td>Klebsiella pneumonia</td>
<td>≥6.7</td>
</tr>
<tr>
<td>Yersinia enterocolitica</td>
<td>≥6.6</td>
</tr>
<tr>
<td>Staphylococcus epidermidis</td>
<td>≥6.6</td>
</tr>
<tr>
<td>Treponema pallidum</td>
<td>≥5.4</td>
</tr>
<tr>
<td>Borrelia burgdorferi</td>
<td>≥9.9</td>
</tr>
<tr>
<td>Anaplasma phagocytophilum (HGE agent)</td>
<td>≥3.6</td>
</tr>
<tr>
<td><strong>Protozoan Parasite</strong></td>
<td></td>
</tr>
<tr>
<td>Plasmodium falciparum</td>
<td>≥5.9</td>
</tr>
<tr>
<td>Babesia microti</td>
<td>≥4.9</td>
</tr>
<tr>
<td>Trypanosoma cruzi</td>
<td>&gt;5.0</td>
</tr>
</tbody>
</table>

*DHBV model virus for HBV
*BVDV model virus for HCV

**JANUARY PHYSICIAN PHOTOGRAPHER**

**DAVID L. SLATER M.D., F.C.A.P.**
Pediatric Palliative Care: 
What is it?

Submitted by David Sine M.D., Pediatrics, Hospice and Palliative Care 
Patrick MacMillan M.D., Director, CRMC Palliative Care

Dr. David Sine has been a pediatrician for almost twenty years. He has worked with medically fragile and special needs children for his entire career as a board certified hospice and palliative care physician. With the addition of a Pediatric Intensive Care Unit and expansion of pediatric services at CRMC in affiliation with UCSF, our need for this vital aspect of palliative care services will grow.

With the addition of more and more life-saving equipment there are more terminally ill children living longer. There are more and more procedures and medical equipment that we can utilize to prolong life. However, sometimes this is not in the best interest of the child or family with regards to their quality of life. The team helps the medical team, patients and family work through these decisions together with a common goal of improved quality of life.

Dr. Sine hopes to be available to consult at CRMC soon. At the current time his primary inpatient team is at Valley Children’s Hospital with a full time NP and RN and two part-time palliative care physicians. Dr. Sine works as a member of this team and works with Tulare and Hinds Hospice to provide pediatric palliative care at home. Through these services he is able to coordinate care both within the hospital and at home.

An “Inpatient Peds Pall Program” is a service provided by a pediatric palliative team, and coordinates care for the following:

1. Initial consultation at diagnosis of a life-threatening or life-limiting diagnosis
2. Assessment and treatment of pain and various symptoms
3. Assist the primary care team with breaking bad news and planning for the best quality of life for these children.
4. Assist families and children in making difficult decisions

At the present time, Dr. Sine is happy to provide phone consults (559-967-0357) as needed while we work on expanding services to CRMC.
Because survival rates after CPR in older and chronically ill adults are poor and CPR is traumatic to both patients and their families, we look to avoid doing CPR on those folks for which it seems that the risks and harms greatly outweigh the benefits of the treatment.

The study involved using a standardized script when admitting patients to the hospital regarding code status choice. The script included assuring the patient that we would care for them and treat their disease, but if in the case they died despite our treatment efforts, would they prefer to Allow a Natural Death or more invasive measures such as CPR. The idea is to replace DNR (Do Not Resuscitate) which people see as cold, threatening, or not treating with AND (Allow Natural Death) which is more affirming. The study demonstrated that patients who were over 70 years old or had a chronic disease (i.e. those least likely to benefit from CPR), were twice as likely to choose AND as opposed to DNR when the script including “Allow Natural Death” was utilized.

At this point, no changes have been made to our numerous written documents which mention “DNR” and no script changes have been implemented for Community’s care givers. However, none of that prevents clinicians from moving – in private conversations with appropriate patients and their families – toward adopting the “Allow Natural Death” nomenclature when discussing what “DNR” actually means.

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**Does Changing the Name Influence Patients’ Code Status Choice?**

**Changing DNR (Do Not Resuscitate) to AND (Allow Natural Death)**

*Shane Lieberman M.D., UCSF Fresno, Hospice & Palliative Medicine Fellow*

**BACKGROUND**
- Survival to discharge after in-hospital CPR varies from 17-19% overall
- Older adults and those with chronic illness have worse outcomes after CPR
- Do not resuscitate (DNR) may be seen as “threatening” which might be interpreted as cold or cruel

**OBJECTIVE**
- Does using a script with the phrase “allow natural death” instead of “do not resuscitate” affect patients’ choice of code status?

**METHODS**
- Intervention: standardized script used during admissions to the Family Medicine service
- Measure: Code status (Full vs. DNR)
- Analysis:
  - Logistic regression model
  - Code status = Age + gender + group (control/intervention) + #diseases

**RESULTS**
- **Patients Choosing AND**
  - Overall
  - Gender
  - Age Group
  - Disease
  - Odds Ratio

**CONCLUSION**
- Using the script including allow natural death made a statistically significant difference
- Individuals were twice as likely to choose allow a natural death if those words were used
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.

January 2017: Dumbcane, Dieffenbachia

With beautiful leaves containing light and dark colors, Dieffenbachia (dumbcane) plants are commonly used to decorate homes, apartments and businesses. These plants are poisonous, and biting or chewing on the stems or leaves may cause burning of the lips and tongue as well as swelling. Severe swelling in the tongue and throat can be a life threatening emergency. Call Poison Control to help guide you to proper medical care.

Household Poisons

The most common things kids get into at home are personal care products. These include oral hygiene, perfumes/aftershave, hair care, make-up, and nail care. Do you know why children like these products?

- They are often left in easy-to-reach places and are not locked-up.
- They may see you put on makeup, brush your teeth, or use mouthwash and try to imitate you.
- They are brightly colored and may also smell good.

Don’t Guess. Be Sure.
**ANNOUNCING UPDATED ORDER SETS BEING RELEASED**

Submitted by Clinical Informatics/Clinical Content Team

Please see below for a list of Order Sets that were released into production between 10/25/2016 to 11/29/2016. If you identify a problem with one of the order sets please follow the procedure for corrective action or contact a member of the Clinical Content Team.

<table>
<thead>
<tr>
<th>Epic PRL#</th>
<th>Order Set Name</th>
<th>Description of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1855</td>
<td>Neutropenic Fever ED</td>
<td>Change Request: Modified laboratory section to have blood cultures x2 pre-selected</td>
</tr>
<tr>
<td>5</td>
<td>Acute Coronary Syndrome Module Z</td>
<td>Change Request: Modified Cardiology procedures to have correct name and priority</td>
</tr>
<tr>
<td>1367</td>
<td>Acute Ischemic Stroke / TIA Orders</td>
<td>Change Request: Modified Cardiology procedures to have correct naming of procedures with correct priority of attached to appropriate procedure</td>
</tr>
<tr>
<td>1170</td>
<td>Acute Ischemic Stroke Post tPA</td>
<td>Change Request: Modified Cardiology procedures to have correct naming of procedures with correct priority of attached to appropriate procedure</td>
</tr>
</tbody>
</table>
| 1170     | Acute Ischemic Stroke Post T-PA      | Biennial Review:  
  - Updated foley catheter insertion, maintenance, discontinuation and bladder scan instructions  
  - Modified respiratory section  
  - Updated Diagnostic procedures to meet stroke guidelines  
  - Modified nausea medications to include Zofran as needed for nausea  
  - Modified blood pressure management instructions to include parameters to notify physician |
| 1400     | Acute Stroke tPA Orders Emergency Dept. | Biennial Review:  
  - Updated new inclusion and exclusion criteria for administration of tPA  
  - Updated monitoring of vital signs to Stroke protocol standards  
  - Preselected clinical labs  
  - Added standard catheter insertion and maintenance language  
  - Modified Alteplase order with more specific administration instructions  
  - Modified blood pressure management medications adding monitoring parameters |
| 1351     | Adult Critical Care Glycemic Control | Change Request: Modified notification of physician parameters for delayed or missed blood glucose testing                                                    |
| 1637     | ALSA Cardiac Evaluation              | Change Request:  
  - Urine HCG lab test preselected for women of childbearing age  
  - Updated diagnostic procedures to include correct order for CT angiogram  
  - Modified dehydration panel to include discharge statement after IV fluids are complete |
| 1357     | Bariatric Surgery Postoperative Z     | Change Request: Modified to include follow-up labs after electrolyte replacement                                                                      |
| 1868     | CEC Feraheme Infusion                | New Order Set  
  - Specific to FHSH Comprehensive Evaluation Clinic (CEC)  
  - Specific monitoring instructions including, vital signs, signs and symptoms of hypersensitivity or allergic reaction, and reaction interventions  
  - IV and clinical labs for specific testing |
| 8        | CEC Post Transesophageal Echocardiography-Cardioversion | Biennial Review:  
  - Modified vital signs frequency  
  - Preselected 12 lead EKG post procedure and discharge instructions |
<p>| 8        | CEC Post Transesophageal Echocardiography-Cardioversion | Change Request: Capnography monitoring and instructions inserted for FHSH |
| 309      | Comfort Care for the Dying Patient Z | Change Request: Added UCSF to CRMC only palliative care order                                                                                         |
| 1309     | ECMO ECLS orders                     | Change Request: Removed embedded Adult Critical Care Glycemic Control order set and replaced with reference statement                                    |
| 1560     | ED Out-Patient DVT Management Protocol | Biennial Review: Updated Home Health Anticoagulation clinic referral address and numbers                                                                     |
| 231      | Epidural Spinal Analgesia            | Change Request: Capnography monitoring and instructions inserted for FHSH                                                                             |
| 528      | Esophageal Study                     | Change Request: Added Oxymetazoline (Afrin)/Lidocaine compound for FHSH                                                                               |</p>
<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Change Request/Review Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>602</td>
<td>Esophageal Study (AMB)</td>
<td>Added Oxymetazoline (Afrin)/Lidocaine compound for FHSH</td>
</tr>
<tr>
<td>1644</td>
<td>Heart Failure Module Z</td>
<td>Updated language to Echocardiogram Transthoracic to meet with Heart failure standards in the last 12 months</td>
</tr>
<tr>
<td>1644</td>
<td>Heart Failure Module Z</td>
<td>Added UCSF to CRMC palliative care order</td>
</tr>
<tr>
<td>1305</td>
<td>HIV Exposed Newborn Infant/ HIV Special Services</td>
<td>Biennial Review: Updated clinical labs to have current ordering of HIV labs and updated discharge orders to have correct follow-up in place</td>
</tr>
<tr>
<td>1472</td>
<td>ICU General Medical Admission</td>
<td>Change Request: Removed embedded Adult Critical Care Glycemic Control order set and replaced with reference statement</td>
</tr>
<tr>
<td>1342</td>
<td>ICU Medical Admission with Acute Ischemic Stroke Post T-PA</td>
<td>Change Request: Modified activity to display Elevate Head of Bed with 30 degrees preselected and Modified Cardiology procedures to have correct naming of procedures with correct priority of attached to appropriate procedure</td>
</tr>
<tr>
<td>1846</td>
<td>Inpatient LVAD work up</td>
<td>New Order Set: Created to fill the need for Ventricular Assistive Device inpatient work up</td>
</tr>
<tr>
<td>1290</td>
<td>Neonatal Parental Nutrition</td>
<td>Change Request: Updated units of additives to daily requirement (e.g., mL/day)</td>
</tr>
<tr>
<td>1253</td>
<td>Neuromuscular Blockade Infusion</td>
<td>Change Request: Removed propofol to benzodiazepine conversion language and modified language propofol alone is not an adequate sedative</td>
</tr>
<tr>
<td>1303</td>
<td>NICU Critical Care Infusion Orders</td>
<td>Biennial Review: Added Milrinone to order set with initiation and titration instructions and Added Neuromuscular blockade infusion orders and general considerations, such as use for intubated patients only</td>
</tr>
<tr>
<td>1281</td>
<td>OMFS Post Op Supplemental</td>
<td>Biennial Review: Modified Nursing orders to include drain care and flap checks, modified enoxaparin dose and frequency for recommended high risk patients, modified blood pressure management instructions to include parameters to notify physician</td>
</tr>
<tr>
<td>1848</td>
<td>Outpatient LVAD Workup (CEC)</td>
<td>New Order Set: Created to fill the need for Ventricular Assistive Device outpatient work up in the CEC at FHSH</td>
</tr>
<tr>
<td>305</td>
<td>Patient Controlled Analgesia Adult</td>
<td>Change Request: Capnography monitoring and instructions inserted for FHSH</td>
</tr>
<tr>
<td>1681</td>
<td>Pediatric Anesthesia Pre Op Orders</td>
<td>New Order Set: Created to fill the need for pediatric pre-op orders for anesthesia</td>
</tr>
<tr>
<td>1720</td>
<td>Pediatric Cystic Fibrosis Admission</td>
<td>New Order Set: Created to fill the need for Pediatric Cystic Fibrosis Admission</td>
</tr>
<tr>
<td>1821</td>
<td>Pediatric Ortho ER Admission</td>
<td>New Order Set: Created to fill the need for Pediatric Orthopedic Emergency admission</td>
</tr>
<tr>
<td>1824</td>
<td>Pediatric Ortho Post Op</td>
<td>New Order Set: Created to fill the need for Pediatric Orthopedic post-operative care</td>
</tr>
<tr>
<td>1856</td>
<td>Pediatric Orthopedic Post Op Spine</td>
<td>New Order Set: Created to fill the need for Pediatric Orthopedic spine post-operative care</td>
</tr>
<tr>
<td>1602</td>
<td>Pediatric Vasopressor Infusion</td>
<td>Biennial Review: Added Inotropic medication infusion, Added Anti-Arrhythmic medication infusion, and Added Anti-Hypertensive medication infusion</td>
</tr>
<tr>
<td>43</td>
<td>Post Anesthesia PACU</td>
<td>Change Request: Added maximum dose limit to ephedrine, phenylephrine, hydralazine, and labetalol</td>
</tr>
<tr>
<td>910</td>
<td>Post Op Breast Surgery</td>
<td>Change Request: Notification of provider for low urinary output, modified activity section, added bladder scan instructions and removal of indwelling urinary catheter, added specific drain care instructions, modified clinical laboratory separated STAT labs from routine labs, modified intravenous fluid section to most used IV fluids, modified antibiotics to meet SCIP guidelines</td>
</tr>
</tbody>
</table>

**January 2017 • Page 21**
### Epic PRL# Order Set Name Description of Changes

| 1549 | Post Op Orthopedic / Podiatry Lower Extremity Surgery Discharge | Change Request:  
| | |  
| | Modified Activity discharge orders to populate the after visit summary  
| | Diet orders updated  
| | Modified medications for pain, antibiotics, nausea, and constipation  
| 1376 | Post Op Thoracic Surgery | Change Request: Capnography monitoring and instructions inserted for FHSH  
| 1527 | Post Op Total Hip | Change Request: Modified Inpatient Consult to Physical therapy to have pre-selected indication for functional mobility, disposition and therapeutic exercises  
| 1546 | Post Op Total Knee | Change Request: Modified Inpatient Consult to Physical therapy to have pre-selected indication for functional mobility, disposition and therapeutic exercises  
| 1520 | Post Procedure Endoscopy | Change Request: Capnography monitoring and instructions inserted for FHSH  
| 304 | Post-Op Cardiothoracic Surgery | Change Request: Updated total dose of antibiotics based on SCIP antibiotic guidelines (complete antibiotics within 48 hour time frame)  
| 1356 | Post-Op Pacemaker Orders | Biennial Review: Updated total dose of antibiotics based on SCIP antibiotic guidelines (complete antibiotics within 48 hour time frame)  
| 1542 | Post-op Vascular | Change Request: Updated total dose of antibiotics based on SCIP antibiotic guidelines (complete antibiotics within 48 hour time frame)  
| 1363 | Pre Admission Cardiothoracic Surgery | Change Request:  
| | |  
| | Arterial Blood Gas order will not be pre-selected for both CRMC and FHSH  
| | Magnesium sulfate volume standardized for CRMC and FHSH  
| 974 | Pre Admit Breast Surgery | Change Request:  
| | |  
| | Modified Diet section including ASA guidelines  
| | Modified procedures to be performed to be specific to actual side and procedure  
| | Added Nursing orders for pre-surgical prep and nasal prep  
| | Added Diagnostic orders  
| | Modified clinical labs to most used and relevant for procedure  
| | Updated antibiotic section to meet SCIP guidelines  
| 1703 | Pre Admit Transesophageal Echocardiogram | New Order Set: Created to fill the need for Outpatient pre-scheduled procedure for FHSH CEC only  
| 1584 | Pre Op Breast Surgery | Change Request:  
| | |  
| | Modified Diet section including ASA guidelines  
| | Modified procedures to be performed to be specific to actual side and procedure  
| | Added Nursing orders for pre-surgical prep and nasal prep  
| | Added Diagnostic orders  
| | Modified clinical labs to most used and relevant for procedure  
| | Updated antibiotic section to meet SCIP guidelines  
| 558 | Pre Procedural Sedation Orders | Biennial Review  
| | |  
| | Modified Respiratory care including oxygen delivery and oxygen titration  
| | Added nursing communication to discontinue capnography and instructions if patient requires reversal agents  
| | Added Hurricane One non aerosol spray for CCMC/FHSH  
| 1513 | Pre Procedure Endoscopy (AMB) | Biennial Review:  
| | |  
| | Added nursing communication for clarity on bowel prep instructions  
| | Removed incentive spirometer orders  
| | Removed pre-procedure bowel prep orders (MD would prescribe separately in office)  
| 1352 | Pre Transesophageal Echo | Change Request: Replaced Cetacaine spray with Hurricane individual dose spray for FHSH/CCMC  
<p>| 1375 | Pre-Op Cardiothoracic Surgery | Change Request: Modified language for last Transthoracic Echocardiogram if not done within last 30 days. |</p>
<table>
<thead>
<tr>
<th>PRL#</th>
<th>Order Set Name</th>
<th>Reason for Retirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1496</td>
<td>ED Eye Treatment</td>
<td>Biennial Review: Zero usage within the past year</td>
</tr>
<tr>
<td>U307</td>
<td>Universal Medication Hemodialysis-Outpatient</td>
<td>Biennial Review: Zero usage within the past year</td>
</tr>
<tr>
<td>U311</td>
<td>Universal Medication Peritoneal Dialysis-Outpatient</td>
<td>Biennial Review: Zero usage within the past year</td>
</tr>
</tbody>
</table>
UCSF Fresno Department of Psychiatry Presents:

Title: “Alert and Oriented x 3? Are you Serious?! Selected Overview of Neurocognitive Disorders”
Date: Thursday, January 12, 2017
Speakers: Stephen Hurwitz M.D.
Time: 4:00 p.m.
Place: UCSF Fresno Center, 155 N. Fresno Street, Room 116
CME: 1 CME

Title: “Do You See What I See? Hallucinations in the Elderly And Their Utility in the Clinical Setting”
Date: Thursday, January 26, 2017
Speakers: Loren Alving M.D.
Time: 4:00 p.m.
Place: UCSF Fresno Center, 155 N. Fresno Street, Room 116
CME: 1 CME

CRMC Perinatal M & M
Title: “Diagnosis and Prenatal Triage of Congenital Heart Defects”
Date: Wednesday, January 18, 2017
Speaker: Drs. Amerin, Aguilar, Woods, Coll, Nair, Partridge and Chetty
Time: 12:30 p.m.-1:30 p.m.
Place: UCSF Fresno Center, 155 N. Fresno St., Fresno, CA 93701, Rm 136
CME: 1 CME

Patient Blood Managament
Date: Wednesday, January 18, 2017
Speaker: Carolyn Burns M.D.
Time: 12:30 p.m.-1:30 p.m.
Place: CRMC Campus, TCCB3 Conference Room
CME: 1 AMA PRA Category 1

Title: “Diagnosis and Prenatal Triage of Congenital Heart Defects”
Date: Wednesday, January 18, 2017
Speaker: Drs. Amerin, Aguilar, Woods, Coll, Nair, Partridge and Chetty
Time: 12:30 p.m.-1:30 p.m.
Place: UCSF Fresno Center, 155 N. Fresno St., Fresno, CA 93701, Rm 136
CME: 1 CME

Clovis Community presents:
Date: Thursday, January 19, 2017
Speakers: Carolyn Burns M.D.
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
CME: 1.0

Please also see the enclosed individual flyers for more on these & other upcoming local CME activities to meet your CME needs.
Isle Royale
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)
Community Medical Centers

Brain Tumor Support Group

Speaker: Tammy Petrossian, RD, CLC, CSP, CNSC
Registered Dietitian

Jump Starting the New Year

Family members and caregivers are encouraged to attend

Refreshments are included, the program is free
Drop-ins are always welcome

For more information, please call (559) 447-4050

When: Thursday, January 5, 2017
6:00pm-7:30pm

Where: California Cancer Center
2nd Floor Conference Room
7257 N. Fresno Street 93720
Community Medical Centers

Brain Tumor Support Group

1st Thursday of every month from 6:00 pm – 7:30 pm

There will be a speaker every month followed by support group discussion

Family members and caregivers are encouraged to attend

Refreshments are included, the program is free and drop-ins are always welcome.

For more information, please call (559) 447-4050

Where: California Cancer Center
2nd Floor Conference Room
7257 N. Fresno Street 93720
Perinatal M & M Presents:

Diagnosis and Prenatal Triage of Congenital Heart Defects

Wednesday, January 18, 2017 from 12:30pm – 1:30pm
UCSF – Fresno, Room: Auditorium
(Lunch in 137)
155 N. Fresno Street, Fresno, CA 93701

Case Presentation
Obstetrics: Dr. Courtney Amerin
Neonatology: Dr. David Aguilar
Perinatology: Dr. Elizabeth Woods

Principal Discussants
Pediatric Cardiologist: Dr. Ana Coll
Pediatric Cardiologist: Dr. Athria Nair
Neonatology: Dr. Colin Partridge (UCSF Benioff Children's Hospital)
Perinatologist: Dr. Shilpa Chetty (UCSF Benioff Children's Hospital)

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

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

1) Apply to practice, current clinical evidence and guidelines relating to diagnosis and prenatal triage of congenital heart defects.
2) Gain insight into diagnosis and prenatal triage of congenital heart defects, 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.
Patient Blood Management

Speaker:
Carolyn Burns, MD – Mediware Consulting & Analytics

LEARNING OBJECTIVES
Upon completion of this activity, participants should be able to:

1. Define the current risks and benefit of transfusion.
2. Review studies re: RBC transfusion within various patient populations understanding its measurable morbidity on patients
3. Employ strategies to implement a restrictive approach to blood management principles
4. Restate restrictive strategies for plasma and platelet blood management principles.
5. Discuss update on the “storage lesion” outlining its adverse effects on the patient.
6. Apply the concepts learned from this presentation into practice

GOAL
Understand the most current evidence surrounding transfusion practice in the U.S. in order to carry out safe and effective transfusions.

DATE:
Wednesday, January 18, 2017
12:30 pm – 1:30 pm
Lunch will be provided

LOCATION:
CRMC Campus
TCCB3 Conference Room

TARGET AUDIENCE:
All Physicians, Nurses and Allied Health Professionals.

For More Information:
Edilia Bourbon-Cervantes at:
(559) 724-4295
ecervantes@communitymedical.org

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Academy for Continued Healthcare Learning (ACHL) and Mediware Information Systems, Inc. ACHL is accredited by the ACCME to provide continuing medical education for physicians.
**GOAL**
Understand the most current evidence surrounding transfusion practice in the U.S. in order to carry out safe and effective transfusions.

**LEARNING OBJECTIVES**
Upon completion of this activity, participants should be able to:

1. Define the current risks and benefit of transfusion.
2. Review studies re: RBC transfusion within various patient populations understanding its measurable morbidity on patients.
3. Employ strategies to implement a restrictive approach to blood management principles.
4. Restate restrictive strategies for plasma and platelet blood management principles.
5. Discuss update on the “storage lesion” outlining its adverse effects on the patient.
6. Apply the concepts learned from this presentation into practice.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Academy for Continued Healthcare Learning (ACHL) and Mediware Information Systems, Inc. ACHL is accredited by the ACCME to provide continuing medical education for physicians.

**Date:** Thursday, January 19, 2017 | 12:30 – 1:30 PM
**Location:** H. Marcus Radin Conference Center – the Palm Room
**RSVP:** Jessica Lipsius at jilipsius@communitymedical.org or 559-324-4002

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SAVE THE DATE

DATE:
Tuesday, February 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
January 2016

January 5
Resident Open Meeting – No Grand Rounds

January 12
“Alert and Oriented x 3? Are you Serious?! Selected Overview of Neurocognitive Disorders”
Stephen Hurwitz, MD
HS Associate Clinical Professor
UCSF Fresno Psychiatry Residency Program

January 19
“Huntington’s: Dance with Depression”
Karndee Samran, MD, Presenter
Joanna Gedzior, MD, Discussant
UCSF Fresno Medical Education Program

January 26
“Do You See What I See? Hallucinations in the Elderly And Their Utility in the Clinical Setting”
Loren Alving, MD
HS Clinical Professor
UCSF Fresno Medical Education Program

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.
SAFE Opioid Prescribing

The healthcare community in Central Valley has seen an increase in problems arising from the use of prescription pain management medications.

The Central Valley Opioid Safety Coalition has planned a lecture series that will raise the level of understanding of this critical issue. The 3-part lecture series includes topics about Understanding Pain, the Management of Chronic Pain, and Safe Prescribing.

- September 21, 2016 - Understanding Pain - **Completed**
- November 9, 2016 - Management of Chronic Pain - **Completed**
- January 25, 2017 - Safe Prescribing

**Wednesday, January 25, 2017**

**Roneet Lev, MD**
Emergency Medicine

Director of Operations Emergency Department, Scripps Mercy, San Diego

**CME Dinner Event**

1.5 CME
January 25, 2017 - 6 PM
Fort Washington Country Club
10272 N Millbrook Ave., Fresno, CA

**Preregistration is required - No charge**

Please register online at www.fmms.org or by calling (559) 224-4224. Registration must be received by January 23 to be a guarantee participant.

Accreditation Statement: The Fresno Madera Medical Society (FMMS) is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians.

Credit Designation Statement: FMMS designates this live activity for a maximum of 1.5 hours AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Join UCSF Fresno for our 2017 Sip & Savor—a fun night inspired by the Las Vegas Strip, with over 50 local vendors of specialty food and beverage tastings featuring local culinary artisans, and an array of wine and beer. Plus, enjoy casino night gaming and live music by Rockville!

**TICKETS**
- $100 PER PERSON
- $1,000 PER TABLE

**WWW.SIPANDSAVORFRESNO.COM**

ALL PROCEEDS BENEFIT UCSF FRESNO MEDICAL EDUCATION PROGRAMS
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.
California’s central valley remains a magnet for immigrants and travelers from all over the world. In today’s interconnected and rapidly changing world, keeping up with world-wide disease trends and diverse approaches to health care is not a luxury—it is standard of care.

Here at UCSF Fresno Medical Center, we are fortunate to have faculty, resident and staff who have done groundbreaking projects all over the world. They bring their life experience and clinical expertise to serve our truly diverse patient population, and the Global Health Curriculum provides a unique, multi-disciplinary forum for these practitioners to teach others about their international health care experiences.

Founded in 2008, the Global Health educational curriculum incorporates didactics on a range of topics of importance in global health, and presentations by residents who have done an overseas clinical elective. Meetings and events are typically held in conjunction with the department overseeing the project, or sometimes as a campus-wide Grand Rounds seminar. All disciplines of health care professionals are welcome to attend all of our lectures and events.

The UCSF Fresno Global Health Curriculum represents a group of dedicated providers associated with the UCSF Fresno Medical Education Program. Our events highlight local connections to international medical projects and overseas clinical opportunities. Attendance is open to healthcare staff and clinical providers from all departments and disciplines, including physicians, nurses, therapists, and staff.

Are you interested in Global trends in illness and healthcare? Do you want to learn more about culture-based health care practices in the highly diverse patient population of the Central Valley? Do you enjoy meeting folks who have done amazing medical projects abroad and see how they encountered both unique obstacles and life-changing opportunities? If you’re saying yes to any of the above, the UCSF Fresno Global Health Curriculum is designed for you!

FOR MORE INFORMATION ON UPCOMING EVENTS OR TO SIGN UP FOR OUR EMAIL LIST, PLEASE CONTACT: rvohra@fresno.ucsf.edu

Join us on our facebook page and join the conversation! https://www.facebook.com/groups/368994383236895/
Does Changing the Name Influence Patients’ Code Status Choice?

Changing DNR (Do Not Resuscitate) to AND (Allow Natural Death)  
Shane Lieberman M.D., UCSF Fresno, Hospice & Palliative Medicine Fellow

BACKGROUND
- Survival to discharge after in-hospital CPR varies from 17-19% overall
- Older adults and those with chronic illness have worse outcomes after CPR
- Do not resuscitate (DNR) may be seen as “threatening” which might be interpreted as cold or cruel

OBJECTIVE
- Does using a script with the phrase “allow natural death” instead of “do not resuscitate” affect patients’ choice of code status?

METHODS
- Intervention: standardized script used during admissions to the Family Medicine service
- Measure: Code status (Full vs. DNR)
- Analysis:
  - Logistic regression model
  - Code status = Age + gender + group (control/intervention) + #diseases

INTERVENTION
“...hospital for (admission diagnosis). You have the following chronic medical conditions (list). If you die despite our best efforts to treat your diseases would you prefer interventions such as chest compressions, cardioversion and intubation or would you like us to allow a natural death?”

RESULTS
- Patients Choosing AND
  - Overall
  - Gender
  - Age Group
  - Disease

CONCLUSION
- Using the script including allow natural death made a statistically significant difference
- Individuals were twice as likely to choose allow a natural death if those words were used
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<td>Ortho Surg.-Foot/Ankle/Hand SPOC</td>
<td>Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm</td>
<td>Chest Conference UCSF # 116</td>
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<td>FP Faculty Development UCSF Rm. 329</td>
<td>Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>HPB Planning Conf. CRMC-Sequoia West Conf Rm</td>
<td>Surgical Grand Rounds CRMC- Sequoia West Conf. Rm</td>
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<td>Emergency Medicine UCSF Rm 136</td>
<td>Surgery Clinical Case Rev. CRMC-Sequoia West Conf. Rm</td>
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<td>12:30pm Infection Control Committee CCMC Sequoia East Room</td>
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<td>12:30pm CRMC Pediatrics CRMC Sequoia West Room</td>
<td>6:30am CCMC Anesthesia Subcommittee CCMC Outpatient Conference Room</td>
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<td>12:30pm CCMC Ob-Gyn CRMC Sequoia East Room</td>
<td>5:00pm Transfusion Committee CRMC Sequoia East Room</td>
<td>6:00pm CCMC Facility Executive Committee MRCC Palm Room</td>
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<td>12:30pm CRMC EKG Review CRMC Sequoia West Room</td>
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<td>2:00pm CRMC Utilization Review CRMC Sequoia East Room</td>
<td>9:00am CRMC Emergency Medicine UCSF Fresno 116</td>
<td>6:00pm CCMC Facility Executive Committee MRCC Palm Room</td>
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<td>25</td>
<td>5:30pm CCMC/CRMC Radiology Committee CII Conference Room</td>
<td>12:30pm CRMC EKG Review CRMC Sequoia West Room</td>
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<td>26</td>
<td>9:00am CRMC Emergency Medicine UCSF Fresno 116</td>
<td>2:00pm Pharmacy &amp; Therapeutics CRMC Sequoia West Room</td>
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<td>12:30pm Ethics Committee CRMC Sequoia East Room</td>
<td>6:00pm CCMC Facility Executive Committee MRCC Palm Room</td>
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<td>27</td>
<td>6:00pm FHSH Facility Executive Advisory Committee FHSH Education Conference Room</td>
<td>6:00pm Medical Executive Committee CRMC Sequoia West Room</td>
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Walk with a Doc
Take a Step Towards Better Health

Walk with a Doc is a FREE walking program for anyone who is interested in taking steps to improve their heart health.

Each walk is hosted by a friendly, local physician. In addition to numerous health benefits received just by walking, you will also get the chance to talk with a doc.

2016 SCHEDULE

FRESNO

Where: San Joaquin River Parkway & Trust
11605 Old Friant Rd
Fresno, CA 93730
When: 3rd Saturday
Time: 8:30 am
Dates for Fresno
February 20
March 19
April 16
May 21
June 18
July 16
August 20
September 17
October 15
November 19
December 17

MADERA

Where: Lions Town & Country Park- Pavilion
2300 Howard Rd
Madera, CA 93637
When: 1st Saturday
Time: 8:30 am
Dates for Madera
February 6
March 5
April 2
May 7
June 4
July 2
August 6
September 3
October 1
November 5
December 3

Join us for Walk with a Doc
For more information or questions, please call (559) 224-4224 or visit www.fmms.org.
Fresno Madera Medical Society
CME Cruise to Alaska

July 22, 2017
7-day Cruise Sailing from Seattle, WA
Aboard the Ruby Princess

Fresno Madera Medical Society is hosting its first Continuing Medical Education while cruising Alaska. Earn up to 12 hours of CME while enjoying the cruise with Family, Friends, and Colleagues. Please join us and book by March for the discount.

For more information or to book now contact
Air KingTravel & Tours at
1.888.565.5050
or by email at nita@airkingtours.com

CME $295 for Physicians - $225 for Physician Assistants, Nurse Practitioners, Nurses & Others
Target Audience: Physicians, Physician Assistants, Nurses, Nurse Practitioners