In This Issue:

3........ CEO Corner
4........ Leadership Changes from Craig Castro
6........ Leadership Changes from Craig Wagoner
7........ Initial & AHP Appointments
8........ Physicians’ Edition Goes Online; Your Email Requested
9........ CAP’s Gift Supports Cancer Center Construction
10...... An Evening in Monte Carlo
11...... Winter Symposium 2017 Recap
12...... Peer Review
14...... Quality Corner
16...... From the Desk of Judi Binderman M.D.
17...... Community Cancer Center Acquires Fully Digital PET/CT Scanner
18...... Blood Banks Mark 80th Anniversary
19...... ICD-10 Corner
20...... C.diff Testing
21...... Laboratory Corner
24...... Inpatient Consult to Pharmacy
25...... Pharmacy Corner
27...... Palliative Care
28...... CURES
28...... Tox Tidbits
29...... Your Community at Work
30...... Choosing Wisely
32...... Clinical Content
35...... CME Highlights
36...... Physician Photographer

MAY PHYSICIAN PHOTOGRAPHER
SCOTT AHLES M.D.

This month’s photos are of the slot canyons near Page, Arizona; just east of the Grand Canyon in the heart of Navajo country. Just as the Grand Canyon was carved by the waters of the Colorado River, these slot canyons were carved by seasonal streams running through sandstone. They are, of course, much smaller and more intricate. In fact, in most areas there is just enough room for one person to walk through the canyon. The openings at the top of the canyons are quite narrow, so the amount of light entering each canyon is very dependent on the time of day and the position of the sun. The always-changing lighting on the rocks creates interesting and variable photographic opportunities. I hope you enjoy these photographs of the slots!

Physician Editor:  
David L. Slater M.D., F.C.A.P.

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Laurie Smith  
Manager, Physician Education and Communication

Deadline to submit articles for the June 2017 issue of Physicians’ Edition is Friday, May 19.
Celebrating our 2017 Joint Commission Accreditation
By Tim Joslin, President & CEO

Last month, I was proud to report on our hospitals’ recent successes in comprehensive surveys to our Board of Trustees. We performed remarkably well, actually, and I’m writing now to acknowledge the support of our physician partners.

Although we face growing uncertainty in the healthcare industry and increasing challenges to be cost efficient amid high demand for services, Community has a lot to be proud of.

Arriving earlier than expected, Joint Commission survey teams visited our hospitals in February and March for full-scale, triennial surveys. The result was compliance rates of over 98% for our hospitals and no “significant findings” – something only 30% of all the hospitals achieve.

Then, on the heels of its Joint Commission survey, Clovis Community completed a facility-wide CMS validation survey, which also concluded with a preliminary report of no deficiencies.

These results are a testament to the highly engaged and talented employees and physicians across our organization. I’m honored to be part of this amazing team and confident we’re ready for surveyors whenever they appear. You put our patients first in all circumstances, and so often we impress and inspire those who walk through our hospital doors.

Thanks again for all you do for CMC!
First, I would like to start this message by expressing my thanks and gratitude to each of you for your support during the past months as I transition into a corporate leadership role. Your support is essential for myself and Community as we adapt to the changes in health care and continue to serve those who trust us with care and health. Thank you!

Over the past decade, Community has operated in a manner, with considerable decision-making authority and autonomy vested in our distinct facilities and business units, close to the points of service. I’m proud that, under that model, we have achieved significant gains in patient satisfaction, quality, employee engagement, physician alignment, and service-line growth. We’re now the hospital and health system of choice for some 923,000 inpatients and outpatients a year.

Today, however, I believe we must achieve even more efficient and seamless ways to continue to deliver high quality care. To achieve that, we must first organize our management team, facilities and business units such that we make streamlined decisions and manage as a health system. This necessitates a shift toward greater centralization and consolidation. Though Community wasn’t master-designed as one unified system, today we must operate as one. Toward that end, I’m pleased to announce these organizational changes, effective immediately:

**Craig Wagoner** is assuming the CEO role for Clovis Community Medical Center (CCMC) in addition to his CEO position at Community Regional. So, in effect, he is now the CEO for all patient care facilities/operations under the licenses of CCMC and Community Regional (including Fresno Heart, the Behavioral Health Center, the California Cancer Center, Community Skilled & Transitional Care Center), and the new cancer center under construction at Clovis. Craig reports directly to me and will maintain offices downtown, at CCMC and at the corporate building in Clovis.

**Aldo De La Torre**, the Senior VP responsible for contracting with insurance plans and operating our own Community Care Health Plan, is assuming an expanded role as “Senior VP for Network Development and Insurance Services.” He will oversee all CMC insurance-related services, including

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**From Craig Castro, dated April 24, 2017**

Editor’s Note: CMC has experienced recent significant changes in its senior leadership, the rationale for which is outlined in the communications below from Craig Castro and Craig Wagoner. Memos with this information were already sent to the medical staff, but the information in both of these communications is important and exciting, and so their content is again communicated below.
worker’s compensation and employee healthcare coverage. He will also design and operate a new “network development” department that will evaluate business opportunities and interface with the Santé Health Foundation to expand patient access and improve efficiency. Many of CMC’s strategic initiatives will be managed by Aldo, who will report to me.

Vivian Cheung, previously the VP for Strategic and Business Planning at CRMC, will now report to Aldo and serve in a broader, corporate role: VP for Network Planning. She will analyze data and business opportunities, coordinate business planning with the facilities, and assist in preparing planning documents for the Board and senior management.

John Strubert will replace Paul Ortiz as Vice President for Cancer Services and transition from his VP and Chief Administrative Officer role at CCMC over the next several months. John will report to Craig Wagoner. Paul Ortiz will now serve in a director position supporting cancer services and report to John Strubert.

Patrick Ramirez is being promoted to Vice President, Corporate Services and will report to me with a focus on managing special projects. However, he will remain in his VP, Professional Support Services role at CCMC, reporting to Craig Wagoner, while he transitions into his new role over the next several months.

Michelle Von Tersch, VP for Corporate Communications, will take on new responsibilities that include government and community relations for the corporation. She will add “Public Affairs” to her title and will continue to report to John Zelezny, Senior VP and Chief Communications Officer.

David Clark will assume a new role as Chief Administrative Officer for Community Regional while Chip Neuman transitions from his current role as Community Regional’s CFO to COO for Community Regional, both reporting to Craig Wagoner.

All of the above changes reflect our increased commitment to system-wide coordination and efficiency. However, just as importantly, the changes evidence our management philosophy: to develop our talent internally and then offer career advancement opportunities, whenever possible, to CMC’s own high performers.

Naturally, these changes will prompt some additional role shifts and refinements – especially within the facility administrative teams – as we seek to take advantage of our managerial talent for the greatest possible system-wide benefit. We expect to announce those additional refinements next week.

Thank you for your continued support.
From Craig Wagoner, dated May 3, 2017

I’d first like to say how incredibly honored and excited I am to serve our great healthcare system in my new role, which includes CEO of Clovis Community Medical Center as well as Community Regional Medical Center, Fresno Heart and Surgical Hospital, Community Behavioral Health Center and our other associated facilities. I attended a Clovis leadership team meeting last week and was overwhelmed by the flood of well-wishes. There are many new faces that I look forward to getting to know, and there are some familiar faces that I’m thrilled to be working with again. Thank you for your support as I transition into my new role.

Last week, Craig Castro announced some organizational changes, which prompted additional role shifts that will pave the way for more seamless and efficient delivery of top-notch care. I’m happy to announce the following leadership changes, effective immediately:

“Tracy Kiritani will expand her CFO role and serve as CFO for both Clovis and Community Regional Medical Centers. Reporting to Tracy and also assuming system-wide responsibilities is Lucky Malhi and James McCurley. Lucky has been promoted from Director of CRMC Materials Management to VP of Materials Management for CRMC and CCMC and will oversee CRMC Security. Formerly CRMC Director of Finance, James is now VP, Assistant CFO for CRMC and CCMC overseeing Finance, Admitting and Analysis services for both.

Heather Rodriquez, RN will expand her nursing leadership responsibilities and serve as Interim Chief Nursing Officer for both CRMC and CCMC. Bonnie Brock, RN who has served in a corporate Clinical Informatics role, was promoted to VP, Assistant CNO for CCMC and will report to Heather.

I look forward to continued operational excellence with John Kass and Chip Neuman as Chief Operating Officers for Clovis Community and Community Regional, respectively.

I’d like to reemphasize that these adjustments in leadership responsibilities reflect our focus and commitment to system-wide coordination and efficiency. Please join me in congratulating and supporting these leaders in their newly expanded roles.

Thanks in advance for communicating these leadership changes to your staff. These changes will require a period of transition and certainly refinements along the way. Your feedback has been, and will continue to be, incredibly valuable to me and our management team. So please continue to share your ideas about how we can better coordinate to provide exceptional service to our patients and each other.

Again, I’m so proud to serve as your CEO for our great hospitals and clinics, and honored to work alongside staff that demonstrate such an unwavering commitment to our patients. I can’t think of another organization more vital to Valley residents. Thanks for everything you do to make our Community a great place to work, practice and receive care.
Initial Appointment to the
Medical Staff effective April 13, 2017

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

Hovig Artinian MD
Department: Pediatrics
Specialty: Pediatrics

Andres Escobar-Naranjo MD
Department: Medicine
Specialty: Internal Medicine

Brent Lanier MD
Department: Surgery
Specialty: Otolaryngology

Christine Nelson MD
Department: Pediatrics
Specialty: Pediatrics

Michael Scott Bohlman MD
Department: Surgery
Specialty: Advanced Wound Care

Jeffrey Garcia DDS
Department: Surgery
Specialty: Oral-Maxillofacial

Isabella King MD
Department: Pediatrics
Specialty: Pediatric Intensive Care

Initial Appointment to the
Medical Staff effective April 13, 2017

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

Tarisha Thapar N.P.
Department: Pediatrics
Specialty: Pediatrics

Marcelia Black L.C.S.W.
Department: DOCS
Specialty: Psychiatry

MAY PHYSICIAN PHOTOGRAPHER
SCOTT AHLES M.D.
See page 2 for details
Editor’s Note: We have all witnessed communications in personal and professional domains moving progressively to electronic-only formats. This offers new content and style opportunities, means considerable operational efficiencies for publishers, is more device-friendly, and increasingly is how consumers prefer information to be delivered.

We are pleased to announce that Community’s Physicians’ Edition newsletter will be moving to an exclusively online format. The electronic publication will be easier to read on your smartphone or tablet than the current PDF-based version. The revised Physicians’ Edition, which will debut next month, will feature video and photo flipbooks (we know the photo themes are well-liked), along with the high quality articles and CME fliers we’ve always provided.

In an effort to be more efficient with our resources and make full use of electronic format options, the printed newsletter will be phased out. In order to continue receiving news that keeps you informed about Community Medical Centers, we need to have a current e-mail for you – one that you actually check on a regular basis. If you already receive an e-mailed announcement and link for the monthly newsletter, then no changes are needed.

If we don’t have your preferred e-mail information and you are accustomed to seeing only the print version of the newsletter, please e-mail either of our medical staff coordinators:

Erika Lopez: ELopez5@communitymedical.org
Angela Vasquez: CVasquez4@communitymedical.org

Include your first name and last name and your medical specialty. Please write “Physicians’ Edition” in the subject line. Our last printed edition will be May, 2017, so don’t delay in continuing your subscribing by email. We thank you for your readership – and in the case of many of you, your contributions of content to our Physicians’ Edition.

MAY PHYSICIAN PHOTOGRAPHER
SCOTT AHLES M.D.
See page 2 for details
A $100,000 gift from Community Anesthesia Providers (CAP) will support Community Medical Centers’ soon-to-be-built Cancer Center on its Clovis campus near Highway 168 and Temperance Avenue.

CAP wanted to be among the first physician groups to support the new Cancer Center in a major way said CAP president, Dr. Oji Oji.

“When we heard about the need to raise funds for the new comprehensive Cancer Center, Community Anesthesia Providers wanted to be among the first physician groups to step up and make a pledge,” said Dr. Oji. “As part of the Community family, we know how important this is to the people we care for in the Valley.”

The new facility will be the only comprehensive cancer center of its kind in the San Joaquin Valley and will combine services and expertise currently provided in multiple locations to create a seamless patient experience. The center will be designed to expedite care and speed treatment for Valley cancer patients. It’s expected to open as early as 2018.

About CAP
CAP has given more than $350,000 since 2004 and is an all-MD group of board certified, board eligible and fellowship trained anesthesiologists in all the accredited anesthesia subspecialties. At each of the facilities, CAP physicians offer the full range of anesthesia services for pediatric and adult patients.

CAP has about 34 providers and was incorporated in 1999 to address the need for top quality anesthesia services at Community’s three hospitals.

Dr. Oji Oji, president of Community Anesthesia Providers, monitors a patient’s vitals during a case at Fresno Heart & Surgical Hospital. The physician group, which provides anesthesiology services for all of Community’s hospitals, is supporting construction of Community’s new cancer center on the Clovis Community Medical Center campus.

MAY PHYSICIAN PHOTOGRAPHER
SCOTT AHLES M.D.
See page 2 for details
An Evening in Monte Carlo
PRESENTED BY SANTÉ HEALTH FOUNDATION
Saturday, May 13, 2017
6 O’clock PM
Clovis Community Medical Center Campus

Santé Health Foundation is preparing to launch our
2nd annual Spring Spectacular, a black-tie Evening in Monte Carlo,
benefiting the new Regional Cancer Treatment and Research Center
to be built on the Clovis Community Campus

There are many sponsorship and donation opportunities available!

Please contact Santé at (559) 228-4308 to receive a sponsorship packet
and to purchase a table

We would love for you to join us!

Santé Health Foundation. Improving The Health of The People in our Community.
In case you missed it, this past February’s Winter Symposium was reported as a great success by attendees. Educational sessions were clinically relevant and presented by nationally recognized speakers. Numerous evening socials and a golf tournament brought colleagues and significant others together in relaxed and elegant settings at the beautiful Fairmont Scottsdale Princess. Below are some of this year’s Program Highlights:

A respected speaker on healthcare policy, Mark Smith M.D., M.B.A. discussed what “Volume to Value” meant to Community Medical Centers, highlighting the growing need for providers to accept practice paradigm shifts. Enabling patients to be more engaged in self-care, such as introducing a diagnostic kiosk prior to discussion with a provider, could revolutionize the patient care encounter.


The CRMC Facility Spotlight: “Multidisciplinary Approach to Complex Cancer & GI Surgery at CRMC” was presented by Amir H. Fathi M.D. and Babak Eghbalieh M.D. The audience was inspired by the spectrum of surgical interventions for complex GI cancers and chronic pancreatitis, including neo-adjunctive chemotherapy. This program will see significant growth, with GI cancer incidence anticipated to rise and the offering of cutting edge treatments not available in most of California.

Jeb Bush regaled the evening audience with the backstories on his father’s coin flip at the Super Bowl as well as insights on current events from the perspective of a former Presidential candidate and seasoned politician. Although none were closer to understanding the impact of proposed policy changes to Affordable Care Act, Mr. Bush’s friendly demeanor, meeting with cell-phone-ready attendees and engagement in the Q&A, set him apart as our most approachable political spotlight speaker to date.

Jamie Franklin and Eric Saff addressed the challenges facing both personal and corporate Cybersecurity. They encouraged regular recycling of complex personal passwords, secure (tiger) texting for all PHI, and exercising significant caution when downloading email attachments. When in doubt (especially if on a hospital computer), DELETE!

Dr. Andrew Kolodny took us through the factors leading to the current opioid crisis, described it as a Caucasian disease process, and educated physicians in their role in combatting these preventable deaths by considering buprenorphine use and implementing opioid prescription policies. Dr. Kolodny will be returning to the Fresno area.
Winter Symposium

Continued from page 11

for an encore presentation in the summer, so keep your eyes on the CME calendar.

Janis M. Orlowski M.D. gave another informed update on the Association of American Medical Colleges, focusing on socio-economic impact on quality measurements. She used Community’s data to demonstrate our outliers, emphasizing partnership between CMC and providers as instrumental to impacting these metrics.

Michael Ball, Esquire, coached us in medical liability: the dangers of sending unsecured patient information, the expectation that ALL tests be followed up by the ordering physician, and respectfully addressing disruptive physician behavior to reduce both patient safety and malpractice risks.

The conference concluded on “The Road to Physician Wellness” by Lori Weichenthal M.D., F.A.C.E.P., R.Y.T. Defining physician burnout and reviewing evidence on wellness strategies, participants learned to incorporate daily mindfulness activities into practice. From a take-home self-assessment handout to remembering to pause after a difficult encounter, the advice in this hour was practical and easy to implement.

Planning for the 2018 Winter Symposium is already underway, with the dates set for February 7-10, once again at the lovely Scottsdale Fairmont Princes. If you’ve never been, please plan to make next year your first! You’ll see after just one Symposium, why you will join other prior attendees in making it an annual must-do event!

Peer Review at Community Regional – New Directions

Submitted by Chantal Fletcher M.D., Chair CRMC MSPRC
Jeff Uller M.D., Vice-Chair, CRMC MSPRC

In 2011, CMC initiated “multi-specialty peer review” based on the recommendations of a nation-wide consulting firm for best practice in peer review. Since that time, hundreds of physician and allied health professional cases have been reviewed, and feedback provided with the goal of improving the quality of care we provide to our patients.

Currently, Community Regional Medical Center (CRMC) is striving to become a High Reliability Organization, one that continues to improve our hospital system and culture. As a result, peer review is changing as well to better align this activity with this mission. As medical staff members we all share the goal of providing the highest possible quality of care. And peer review is an integral part of this process.

Since the inception of MSPRC (multi-specialty peer review committee) in 2011, we’ve learned a lot of lessons. We have taken stock of our current process and looked at ways in which we could modify our approach to better achieve educational goals and promote a high-quality culture within the medical staff. We want the process to be collegial so that practitioners want to participate. We think this is the best way to achieve our purpose. To that end, we are making significant changes in how we do peer review at CRMC.

We who serve as MSPRC members share the goal of providing high quality of care within an efficient and safe health care system. We believe this a universally shared goal among medical staff members. We look forward to your participation in achieving our High Reliability goal.

See page 13 for more information on Peer Review Changes.
We have eliminated ratings

Starting in 2011 for every case reviewed, we have assigned a rating (“care appropriate, minor variance, or variance”) to the care provided by each practitioner as per our charter. We have now eliminated these ratings. Instead, we are focusing our review on identifying the issues and educational needs of the provider. For instance, in some cases we may find there is “No Issue” with the care provided so no education is needed. In other cases, we may find that education on documentation or hospital/system processes would be helpful or perhaps that feedback about clinical practices may be needed.

Over the last couple of years, MSPRC at CRMC has been striving to provide more detailed educational feedback along with the case ratings. However, we believe that assigning ratings such as minor variance or variance does less to promote our goal of improving quality of care than a purely educational approach is likely to achieve. Because ratings may feel punitive and make us feel defensive, we may miss what we can learn from any educational points that were provided. And sometimes, cases don’t fall clearly into one of the three rating buckets. The intent of peer review is to figure out whether, and then what form of, education is important. It puts the focus where it belongs – on improving patient care.

We have changed how we will communicate with you

From gathering information to providing feedback on the case, we want to make the process more collegial. At CRMC, our intent is to use email, phone calls, or in-person discussions to achieve this goal.

We’ve changed how we get information from you about cases being reviewed

We will no longer be sending inquiry letters by certified mail to gain additional information from you about the case. Instead, we will be doing informational interviews with you for the ‘rest of the story’. The intention is to encourage a collegial and thoughtful discussion of the case.

Our approach now is to contact you and set up a time to discuss the case, either in person or on the phone, depending on the complexity of the case. Prior to the discussion, you will be given the medical record number, dates of interest, and our questions and concerns, so you have time to review the case and refresh your memory ahead of time. The discussion will be summarized in writing by the physician reviewer and included as part of the case review.

Our goal here is to do the best job possible in gathering information, while minimizing the time burden on practitioners. The information is used by the MSRPC to determine what, if any, educational feedback is needed and what system issues need to be addressed.

We’ve changed how we provide education and feedback

We believe personal communication, rather than certified letters, is the most effective and meaningful way to provide feedback, especially in complex cases. It allows a back and forth discussion, and promotes a clearer understanding of issues than can be transmitted in a letter. For cases requiring education, the practitioner will be contacted and a meeting or phone call will be arranged so that the discussion can take place.

We have already found there are times during the information-gathering process where the practitioner realizes the issues and identifies changes in practice that need to be made. In those cases, we don’t need another meeting or phone call, and only a follow up letter to “close the loop” will be sent. Occasionally, the issue may be very minor, or related to documentation or navigating the hospital system, and only a brief informational or educational letter will be sent. In all cases, a written summary of the educational piece will be generated and you will receive a copy of it.

We want to use e-mail as much as possible

Our goal is to make our communications as efficient as possible. We think using e-mail for written communications is the ideal. However, since peer review information includes patient health information and is protected from discovery under state of California statute 1157, it must be transmitted using secure e-mail systems. If you already have a CMC email address, that is how we will communicate with you. Otherwise, we will be communicating through encrypted e-mail. We therefore encourage all members of the medical staff to obtain an email account with CMC, which can be done by contacting the Medical Staff Office at 459-3948.

These process changes are now in place for our CRMC MSPRC. As the year progresses, if further modifications are made we will keep you in the loop regarding them.
The Society of Critical Care Medicine (SCCM) and the European Society of Intensive Care Medicine (ESICM) brought together a panel of 59 members to assess the current data and review and update the guidelines for the Surviving Sepsis Campaign from 2012 (please see Recommended Links on page 15). Dr. Andrew Rhodes, co-chair of the panel, reiterated the current care remains valid however, care can be improved with some modifications.

Initially, a change in terminology sets the stage for changes. The term “Severe Sepsis” was replaced with “Sepsis” as clinical criteria (e.g. the quick Sepsis-related Organ Failure Assessment Score, qSOFA) were not used in studies, which informed the recommendations of this revision.

The group cautioned, guidelines are not meant to take the place of clinical assessment and decision making on a case by case basis. The judgement of the provider remains essential to effective treatment.

Initial Resuscitation

The 2012 guidelines leaned toward goals of resuscitation with a target to be achieved within the first 6 hours; however, its content and urgency have been upgraded. The guidelines begin with this best practice statement: (BPS) “Sepsis and septic shock are medical emergencies and we recommend treatment and resuscitation begin immediately.”

Fluid resuscitation in 2012 was focused on “goals in the first 6 hours,” however in 2016 this was modified to a more specific goal and tighter timeline. “We recommend in the resuscitation from sepsis induced hypoperfusion, at least 30ml/kg of IV crystalloid fluid be given within the first 3 hours.” This is closely followed by the subsequent statement, “We recommend following initial fluid resuscitation, additional fluids be guided by frequent reassessment of hemodynamic status.” (BPS) While further recommendations endorse an initial MAP of 65 as a target, the emphasis is on re-evaluation of the patient's hemodynamic status for further fluid resuscitation efforts. And finally, “We suggest guiding resuscitation to normalize lactate in patients with elevated lactate levels as a marker of tissue hypoperfusion.”

Fluid Therapy

Fluid type remains constant from 2012, “We recommend crystalloids as the fluid of choice for initial resuscitation and subsequent intravascular volume replacement in patients with sepsis and septic shock.” When a large amount of volume is required for proper resuscitation, “We suggest using albumin in addition to crystalloids when patients require substantial amounts of crystalloids.”

Diagnosis

With regard to diagnostic work-up the guideline states, “We recommend appropriate routine microbiologic cultures (including blood) be obtained before starting antimicrobial therapy in patients with suspected sepsis or septic shock, if doing so results in no substantial delay in the start of microbials.” (BPA)

Source Control

For source control the BPS is as follows: “We recommend a specific anatomic diagnosis of infection requiring emergent source control be identified or excluded as rapidly as possible... and any required source control intervention be implemented as soon as medically and logistically practical after diagnosis is made.” Consistent with the 2012 guidelines, the recommendation stands to remove any intravascular access devices, which are possible sources of infection after other vascular access has been established.

Antimicrobial Therapy

Antimicrobial therapy guidelines begin with a time frame the panel admits may be potentially difficult, but stands by their strong recommendation, “We recommend the administration of IV antimicrobials be initiated as soon as possible after recognition and within 1 hour for both sepsis and septic shock.” In addition, the panel recommends “…empiric broad spectrum therapy with one or more antimicrobials to cover all likely pathogens.”

The panel makes a new recommendation regarding duration of antimicrobial therapy. “We suggest an antimicrobial treatment duration of 7 to 10 days is adequate for most serious infections associated with sepsis and septic shock.”

Vasoactive Medications

In vasopressor therapy, norepinephrine continues to be the recommended first choice. In addition, “We suggest adding either vasopressin (up to 0.03 units/min) or epinephrine to the norepinephrine with the intent of raising MAP to target, or adding vasopressin to decrease norepinephrine dosage.”
**Corticosteroids**

The committee did address this issue, as it is still seen, although they emphasized the importance of using fluid resuscitation and vasopressor therapy as a first-line treatment and only using corticosteroids as a last resort. “We suggest against using IV hydrocortisone to treat septic shock patients if adequate fluid resuscitation and vasopressor therapy are able to restore hemodynamic stability. If this is not achievable, we suggest IV hydrocortisone at a dose of 200 mg per day.”

**Mechanical Ventilation**

Regarding mechanical ventilation, the panel is a little more specific than in 2012. “We recommend using a target tidal volume of 6mL/kg predicted body weight (PBW) compared with 12mL/kg in adult patients with sepsis-induced ARDS.” Additionally they add, “We recommend using an upper limit goal for plateau pressures of 30cm H2O over higher plateau pressures in adult patients with sepsis-induced severe ARDS.” Positioning is addressed as well, “We recommend using prone over supine position in adult patients with sepsis-induced ARDS and a Pao2/Fio2 ratio < 150.”

The important points above are just a selection of what is covered in each area. These topics along with other diagnostic and management recommendations are addressed in detail in the *Critical Care Medicine* article linked below.

Blood products, immunoglobulins, anticoagulants, sedation and analgesia, glucose control, VTE prophylaxis and an extensive section on nutrition are just some of the additional topics discussed.

**Recommended Links**

- Critical Care Medicine, detailed journal article: https://www.immunizenevada.org/sites/default/files/NILE/2016%20Surviving%20Sepsis.pdf
- The live presentation of the new guidelines: https://www.youtube.com/watch?v=FTLChUbwXHM

“No kindness is a language which the deaf can hear and the blind can see.”

— Mark Twain

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**CMC Sepsis Core Measure (SEP-1) Compliance**

New CMS Core Measure as of October of 2015, which is a composite of up to 7 components. Facilities are struggling with meeting and documenting the timed elements and the measures have gone through multiple revisions. CMS does not plan to report publicly in FY 2018

- **All components of the measure** are required to meet the measure.
  - Within 3 hours:
    - Initial lactate level
    - Broad spectrum antibiotics
    - Blood cultures drawn prior to antibiotics
    - If initial hypotension, lactate level >4 mmol/L or septic shock present, resuscitation with 30ml/kg crystalloid fluids
  - Within 6 hours:
    - Repeat lactate level
    - If persistent hypotension after fluid administration, vasopressors
    - If hypotension persists after fluid administration or initial lactate >4mmol/L, repeat volume status and tissue perfusion assessment

- **Q4 2016 CMC composite compliance**
  - Trending up (Q4 2016) = 23.5% Compliance with individual measures much higher, but often miss the timing on one element.

- **Key Elements to Improve:**
  - Broad spectrum antibiotic within 3 hours, repeat lactic acid within 6 hours if initial level >2mmol/L, administration of 30ml/kg fluids started within 3 hours.

- **CMC Current Work:** Sepsis Order Set (OS) for ED is live; Inpatient OS being finalized; Inpatient Physician, Nursing and Pharmacist education regarding the measure ongoing; In depth review of cases which do not meet the core measure; Multi-disciplinary Sepsis Steering Committee assessing progress and opportunities for improvement.

- **Order set use encouraged!** Use of the sepsis order set is associated with enhanced compliance: OS Used = 52.4% compliance vs. OS not used 19.4%.

- **Improvement work continuing** at each of the facilities
As we continue to work on changes that inevitably come with an upgrade, it occurs to me that the phrase ‘spring cleaning’ is a perfect label for all the activities happening these days.

We’ve taken the perspective that all the items brought forward to various groups for review and approval support our goals of provider and nursing efficiency and patient engagement… but we’re also looking to streamline workflows and get rid of the clutter, while continuing to keep an eye on future upgrades happening faster, with less IT/Informatics build effort to complete. And, we’ve continued to request, (no, let’s call a spade a spade)… push for increased operations and medical staff involvement in decision-making around how we deliver care, use the electronic record, document and manage our throughput.

We’re still working diligently to get ready for the upgrade and Radiant in early Fall. Monthly enhancements still continue, and the nursing documentation optimization project is moving on to the next area of focus, having completed the Admission navigator review.

Additional focus has been put on being compliant with required processes – secure texting and messaging among care teams, to protect personal health information for patients; provision of indications for pain medication, with the introduction of the modular pain management order set; and continuing to look at tools available for better documentation of the patient story, not only to accurately reflect the severity of our patients, but also to ensure that the patient journey is clear to all those involved with patient care, both within the hospital and outside, in the community.

Spring cleaning – a way to actively reduce clutter and engage in defining the results of interaction with the electronic record. Involvement in what happens to you allows you to choose who to become – an active, efficient provider in a technology-enhanced environment, or one who struggles daily to get through the work of patient care.

Let’s team up and work toward a common goal – easier, simpler, cleaner.

As always, please feel free to reach out if you have questions or concerns. My door is always open!

MAY PHYSICIAN PHOTOGRAPHER
SCOTT AHLES M.D.
See page 2 for details
The 100,000-square-foot cancer treatment and research center being built on the Clovis Community Medical Center campus will have the latest nuclear imaging technology – one of only a handful in the nation - fully digital PET/CT (Positron Emission Tomography and Computed Tomography) scanner.

Today the only other fully digital PET/CT scanner is in a research facility at Ohio State University Wexner Medical Center. In the early clinical trials, patients were first imaged on the Cancer center's state of the art PET/CT scanner, and then imaged at Wexner's Wright Center of Innovation in Biomedical Imaging. The director of the Biomedical imaging center, Dr. Knopp, was able to demonstrate this new digital scanner could detect much smaller lesions that were missed using a conventional PET/CT.

Community purchased the technology mostly because it detects cancer better. "Right now we are limited to detecting lesions that 5 - 8 millimeters in diameter. We will be able to see lesions as small as 2 millimeters on this new scanner," said Ken Forster, PhD, chief medical physicist at California Cancer Center.

The digital Philips Voceros PET/CT scanner has additional advantages both for clinician using the scanner and for patients, said Dr. Forster. "It’s much, much faster at capturing an image. Normally if a PET/CT scan is 30 minutes, it would now be reduced down to about 5-10 minutes for the a full scan," Dr. Forster said. "And it’s simpler to operate."

Dr. Forster, said because of its sensitivity, the PET/CT scanner can capture even small tumors in motion. “It’s really four-dimensional imaging because it can track the lesion and generate movie loops. We would miss these tiny lesions in the past, especially in the lung because they were moving during respiration,” explained Dr. Forster. Dr. Forster had previously been part of a collaboration with Philips to develop this technology.

The manufacturer touts the advantages of the digital PET/CT as more than doubling the resolution and accuracy to provide higher quality images that will ultimately improve treatment planning and provide faster workflows. The work done at Ohio State University has also demonstrated this can all be done while reducing the radiation dose given to the patient.

The $68 million cancer center planned to open as early as summer 2018 will also include a fully digital 3Tesla MRI (magnetic resonance imaging) for soft tissue imaging. Dr. Forster calls this MRI the “gold-standard” because it provides high resolution images and for some cases can generate CT images for radiation therapy planning eliminating a CT scan for these patients. The nearest fully digital 3Tesla MRI currently is in the Bay Area.
Earlier this month, we marked the 80th anniversary of the world’s first blood bank. It’s hard to overstate the importance of blood banking in the history of modern medicine, or the changes that have occurred in blood banking and transfusion in the last century.

Today, blood collecting centers collect and screen blood for infectious diseases, and blood banks store blood, ensuring that blood is available when patients need it for transfusions or other medical procedures. On average, every two seconds someone in the U.S. receives a blood transfusion. Today, the nation’s approximately 3,400 blood banks play a vital role in our nation’s healthcare system. Blood collecting centers carefully screen all donated blood for hepatitis B, hepatitis C, HIV, Zika, and other viruses and infectious agents. Ensuring that safe blood and tissue products are available when they are needed is important to the health and wellbeing of Americans. In addition to the HIV and viral hepatitis activities you may be familiar with, the Office of HIV/AIDS and Infectious Disease Policy coordinates HHS activities related to blood and tissue safety and availability.

Eighty years ago, Dr. Bernard Fantus established the first blood bank at Cook County Hospital in Chicago, Illinois, on March 16, 1937. This blood bank allowed blood to be stored for a then-unheard of 10 days inside the hospital. This technical achievement was a drastic improvement over the standard practice of the era: direct blood transfusion from donor to patient. Prior to blood banks, a roster of volunteer blood donors was kept at hospitals, with both their blood type and phone number. When a patient needed blood, the hospital would call one of these volunteers and ask them to rush to the hospital to donate. However, with the establishment of blood banks, donors could instead donate at their convenience and doctors no longer had to scramble to find a matched donor for their patients. Now blood banks could maintain an inventory of different blood types, available when needed. Dr. Fantus’ blood bank was nothing short of revolutionary.

Since Dr. Fantus’ innovation, blood banks have become the standard worldwide and each year, almost 5 million Americans alone need blood transfusions. Doctors and patients alike rely on the readily available supply of blood for treatments of a wide range of diagnoses. Blood banking has also allowed for the development of many surgeries common today, which would have been impossible without it. In addition to acute illness, millions of people who suffer from blood disorders benefit from frequent blood transfusion or blood-derived products.

The technology of blood banking has come a long way as well. In Dr. Fantus’ time, whole blood could be stored for only 10 days; today it can be maintained for up to 35 days. When blood is split into its components, standard practice today, red blood cells can last up 42 days and plasma can last up to one year. Our knowledge of blood types has expanded too, improving cross-matching and reducing severe reactions.

The layers of safety built into our systems for collection and storage of blood have also evolved substantially over the decades since the establishment of that first blood bank. For example, when Dr. Fantus started banking blood, no screening tests for infectious diseases had been developed. Indeed, most of the blood-borne infectious diseases that we are most concerned about today had yet to be discovered. Today, we have comprehensive system for making sure that blood is safe. It includes donor eligibility criteria and screening questions (e.g., health history, risk behaviors, travel), donor deferral guidelines, and testing donated blood for infectious agents, including HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), Zika, and other infectious agents.

These protections have eliminated the spread of known infections by blood transfusion. Many people in the United States and around the world contracted HIV from a blood transfusion or blood products before testing became available in 1985 and blood products used by hemophiliacs were sterilized with heat. In the U.S., it is estimated that more than 14,000 persons have contracted HIV from blood or blood products, most of them prior to 1985. Now, the risk of contracting HIV from a blood transfusion is extremely low.
According to NIH’s National Heart, Lung, and Blood Institute, the risk of catching a virus from a blood transfusion is very low. Your risk of getting HIV from a blood transfusion is lower than your risk of getting killed by lightning. Only about one in 2 million donations might carry HIV and transmit HIV if given to a patient. Because of this success and the continued improvement of HIV screening tests, the FDA has changed its donor deferral rules for men who have sex with men.

“The safety of the blood supply has significantly improved since the advent of blood banks in 1937. While performing their life-saving work ensuring that safe blood and blood products are available in all states, blood banks also have been partners throughout our national responses to HIV and viral hepatitis,” noted Dr. Richard Wolitski, Director of the HHS Office of HIV/AIDS and Infectious Disease Policy. “The blood supply is an invaluable resource that exists for the public good. I am worried today, however, that economic conditions are changing and that the survival of some of these blood collecting centers could be at stake. This is an issue that is being assessed by the Advisory Committee on Blood and Tissue Safety Availability that advises the Secretary of Health and Human Services as well as the Blood, Organ, Tissue Senior Executive Council that coordinates these efforts across HHS.

In addition to economic issues, blood centers are certain to face new and unknown challenges as new infections emerge that are transmitted by blood, blood products, and tissue. The field is looking ahead to solutions that might allow blood centers to prevent transmission of new infections even before they have been recognized.

One of those new technologies is pathogen inactivation technology, which is making the blood products safer yet. This pathogen inactivation process destroys many viruses, including HIV, HBV, and HCV. In principle, pathogen inactivation technologies have the potential to make the blood supply safe by broadly reducing or eliminating infectious organisms without the need to screen or test for specific pathogens. Currently, the FDA has only approved pathogen reduction technology for platelets and plasma. Work is being conducted to obtain pathogen reduction technology for red blood cells and whole blood. This is important as it would destroy pathogens from donors who do not appear symptomatic for known infectious diseases as well as any emerging infectious disease where a screening test has not yet been identified.

Although it is not clear what opportunities and challenges the future will bring, the next 80 years of blood banking are certain to be as transformative as Dr. Fantus’ innovation. But one thing is certain: the life-saving work that lies ahead will be built upon his revolutionary idea to start a blood bank and on the commitment and hard work of the dedicated people who operate the nation’s blood centers that continue that work today.

PSI: Documentation of Post-Operative Sepsis Complication

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

AVOID Queries for clarification by linking Sepsis as a complication of surgery, when they are related. Enhanced documentation of post-operative Sepsis = assigning codes that reflect a true complication, in addition to severity of illness and risk of mortality.

Stating “Post-op” is not sufficient to associate sepsis with the surgery; the terms “complication”, “due to” or “secondary to” should be used to identify a cause-and-effect relationship.

Post-operative sepsis should be further specified by:
• Causal Organism
• Shock, if present
• Present on Admission, when that is the case

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 for Sustaining the ICD-10 Transition

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

Inadequate and Imprecise Documentation

65 year old male admitted for aortic valve replacement, developed sepsis post-operatively.

Improved (and Required) ICD-10 Documentation

65 year old male admitted for aortic valve replacement. Developed sepsis post-operatively that was determined to be due to the surgery.
Editor's Note: The modified C. diff testing algorithm has been active for several months now. The lab has provided test comments to clarify the need to interpret both PCR and EIA tests together, in the case of an initial positive toxin PCR assay. Lab has become more vigilant about rejecting non-diarrheal stools – that stance is fully supported by best practice guidelines. Please contact Dr. Slater (CRMC) or Dr. Harding (CCMC) or Dr. Honda (FHSH) via CMC Outlook if you have questions or suggestions regarding this testing change.

Repeat testing after treatment and resolution of signs/symptoms (s/s) is NOT indicated; repeat testing is not to be done as a test of cure.

### C. diff Testing and Treatment for Practitioners

<table>
<thead>
<tr>
<th>Patient had a positive or negative C. diff test in the previous 7 days?</th>
<th>YES</th>
<th>Testing NOT indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>Patient having liquid stools?</td>
<td>NO</td>
</tr>
<tr>
<td>YES</td>
<td>Patient had a laxative or bowel regimen drug in the last 24 hours?</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>Patient had fever or WBCs &gt; 15,000 with no other cause?</td>
<td>NO</td>
</tr>
<tr>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Order C Diff Testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCR Test Result</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCR alone does not indicate need for treatment. Clinically correlate with patient signs and symptoms in conjunction with EIA test results</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EIA Toxin A/B Test Result</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOXIGENIC C. diff DETECTED</td>
<td></td>
</tr>
<tr>
<td>Mild/Moderate/Severe</td>
<td>Any inciting antimicrobials should be discontinued, if possible. Patients condition should improve in 7-10 days; if not consider alternate sources of infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOXIGENIC C. diff TREATMENT MATRIX</td>
<td></td>
</tr>
<tr>
<td>SEVERITY</td>
<td>CRITERIA</td>
<td>TREATMENT</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Mild to Moderate</td>
<td>WBC &lt; 15,000 AND CREAT &lt; 1.5 Base</td>
<td>Metronidazole 500 MG TID PO X 10-14 D</td>
</tr>
<tr>
<td>Severe</td>
<td>WBC &gt; 15,000 OR CREAT &gt; 1.5 Base</td>
<td>Vancomycin 125 MG QID PO X 10-14 D</td>
</tr>
<tr>
<td>Severe Complicated</td>
<td>Hypotension/shock, ileus, Megacolon</td>
<td>Vancomycin 500 MG PO/QID QID AND Metronidazole 500 MG Q8H IV Rectal Vancomycin per ID only for complicated ileus</td>
</tr>
<tr>
<td>First Recurrence</td>
<td>Same as initial episode</td>
<td></td>
</tr>
<tr>
<td>Second Recurrence</td>
<td>Vancomycin in tapered or prolonged Rx</td>
<td></td>
</tr>
</tbody>
</table>
Platelet Counts and Interventional Radiology Procedures: New Study and Literature Review

By David Slater M.D., CRMC Transfusion Service Medical Director

Editor's Note: In our March issue we featured two Mayo Clinic articles on PLASMA use in advance of invasive IR procedures and also non-cardiac surgical procedures. If you don’t recall all the details, electronic readers can follow the links above to those abstracts – but the short summary is that there was no evidence that plasma reduced bleeding or RBC transfusion, in patients whose pre-procedure INR exceeded 1.5.

This month we feature a Mayo Clinic study on thrombocytopenia in advance of IR procedures. I estimate that about 20% of our orders for platelets are in conjunction with IR procedures. We have many high-risk, very ill patients who need one or more IR procedures, and whose management is challenging. We all need to stay connected with literature regarding that clinical scenario.

Preprocedural platelet transfusion for patients with thrombocytopenia undergoing interventional radiology procedures is not associated with reduced bleeding complications

Matthew A. Warner, David Woodrum, Andrew Hanson, Darrell R. Schroeder, Gregory Wilson, and Daryl J. Kor
(Transfusion volume 57, April 2017)

Background: Platelet (PLT) transfusion before interventional radiology procedures is commonly performed in patients with thrombocytopenia. However, it is unclear if PLT transfusion is associated with reduced bleeding complications.

Study Design and Methods: This is a retrospective cohort study of adults undergoing interventional radiology procedures between January 1, 2009, and December 31, 2013. Baseline characteristics, coagulation variables, transfusion requirements, and procedural details were evaluated. Propensity-matched analyses were used to assess relationships between PLT transfusions and the outcomes of interest, including a primary outcome of periprocedural red blood cell (RBC) transfusion during the procedure or within the first 24 hours after procedure.

Results: A total of 18,204 participants met inclusion criteria, and 2060 (11.3%) had a PLT count of not more than 100 3 10^9/L before their procedure. Of these, 203 patients (9.9) received preprocedural PLTs. There was no significant difference in RBC requirements between those receiving or not receiving preprocedural PLTs in propensity-matched analysis (odds ratio [OR], 1.45; 95% confidence interval [CI], 0.95-2.21; p 5 0.085). PLT transfusion was associated with increased rates of intensive care unit admission (OR [95% CI], 1.57 [1.07-2.32]; p 5 0.022).

Conclusion: In patients with thrombocytopenia undergoing interventional radiology procedures, preprocedural PLT transfusion was not associated with reduced periprocedural RBC requirements. These findings suggest that prophylactic PLT transfusions are not warranted in nonbleeding patients with preprocedural PLT counts exceeding 50 3 10^9/L. Future clinical trials are needed to further define relationships between prophylactic PLT administration and bleeding complications, especially at more severe levels of thrombocytopenia or in the presence of PLT dysfunction.

The Mayo study was designed to evaluate a platelet threshold of 50,000/uL – and it found no increased bleeding risk across a wide range of IR procedures when platelets were above that level. However, the issue of the need for platelets at counts less than 50,000/uL is also important – and is a common scenario at CMC facilities. There is less agreement at lower platelet counts. Here are two resources.

The first, a “consensus” statement (J. Vasc Interv Radiol 2009;20:S240-S249), takes a more liberal approach and admits that not all of it is evidence-based (indeed, in view of the recent Mayo Clinic studies on plasma use, these 2009 guidelines clearly are NOT evidence-based with respect to INRs). But even in this Guideline MANY common IR procedures are identified which can generally be done safely at lower platelet counts (and a significantly elevated INR):

See page 22 for charts
### Category 1: Procedures with Low Risk of Bleeding, Easily Detected and Controllable

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Preprocedure Laboratory Testing</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vascular</strong></td>
<td>INR: Routinely recommended for patients receiving warfarin anticoagulation or with known or suspected liver disease</td>
<td>INR &gt;2.0: Threshold for treatment (ie, FFP, vitamin K)</td>
</tr>
<tr>
<td>Dialysis access interventions</td>
<td>Activated PTT: Routinely recommended for patients receiving intravenous unfractionated heparin.</td>
<td>PTT: No consensus</td>
</tr>
<tr>
<td>Venography</td>
<td>Platelet count: Not routinely recommended</td>
<td>Platelets: Transfusion recommended for counts &lt;50,000/UL</td>
</tr>
<tr>
<td>Central line removal</td>
<td>Hematocrit: Not routinely recommended</td>
<td>Plavix: Do not withhold</td>
</tr>
<tr>
<td>IVC filter placement</td>
<td></td>
<td>Low-molecular-weight heparin (therapeutic dose): Withhold one dose before procedure</td>
</tr>
<tr>
<td>PICC line placement</td>
<td></td>
<td>DDAVP: Not indicated</td>
</tr>
<tr>
<td><strong>Nonvascular</strong></td>
<td>Platelet count: Not routinely recommended</td>
<td></td>
</tr>
<tr>
<td>Drainage catheter exchange (biliary, nephrostomy, abscess catheter)</td>
<td>Hematocrit: Not routinely recommended</td>
<td></td>
</tr>
<tr>
<td>Thoracentesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paracentesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Superficial aspiration and biopsy (excludes intrathoracic or intraabdominal sites): thyroid, superficial lymph node</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Superficial abscess drainage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There was an 80% consensus for each of these recommendations unless otherwise stated. The management recommendations for each coagulation defect and drug assume that no other coagulation defect is present and that no other drug that might affect coagulation status has been administered.

### Category 2: Procedures with Moderate Risk of Bleeding

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Preprocedure Laboratory Testing</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vascular</strong></td>
<td>INR: Recommended</td>
<td>INR: Correct above 1.5 (89% consensus)</td>
</tr>
<tr>
<td>Angiography, arterial intervention with access size up to 7 F</td>
<td>Activated PTT: Recommended in patients receiving intravenous unfractionated heparin</td>
<td>Activated PTT: No consensus (trend toward correcting for values &gt;1.5 times control, 73%)</td>
</tr>
<tr>
<td>Venous interventions</td>
<td>Platelet count: Not routinely recommended</td>
<td>Platelets: Transfusion recommended for counts &lt;50,000/UL</td>
</tr>
<tr>
<td>Chemoembolization</td>
<td>Hematocrit: Not routinely recommended</td>
<td>Hematocrit: No recommended threshold for transfusion</td>
</tr>
<tr>
<td>Uterine fibroid embolization</td>
<td></td>
<td>Plavix: Withhold for 5 d before procedure</td>
</tr>
<tr>
<td>Transjugular liver biopsy</td>
<td></td>
<td>Aspirin: Do not withhold</td>
</tr>
<tr>
<td>Tunneled central venous catheter</td>
<td></td>
<td>Low-molecular-weight heparin (therapeutic dose): Withhold one dose before procedure</td>
</tr>
<tr>
<td>Subcutaneous port device</td>
<td></td>
<td>DDAVP: not indicated</td>
</tr>
<tr>
<td><strong>Nonvascular</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intraabdominal, chest wall, or retroperitoneal abscess drainage or biopsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung biopsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transabdominal liver biopsy (core needle)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percutaneous cholecystostomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrostomy tube: initial placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiofrequency ablation: straightforward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spine procedures (vertebroplasty, kyphoplasty, lumbar puncture, epidural injection, facet block)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There was an 80% consensus on each of these recommendations unless otherwise stated. The management recommendations for each coagulation defect and drug assume that no other coagulation defect is present and that no other drug that might affect coagulation status has been administered.

### Category 3: Procedures with Significant Bleeding Risk, Difficult to Detect or Control

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Preprocedure Laboratory Testing</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vascular</strong></td>
<td>INR: Routinely recommended</td>
<td>INR: Correct above 1.5 (95% consensus)</td>
</tr>
<tr>
<td>Transjugular intrahepatic porto-systemic shunt</td>
<td>Activated PTT: Routinely recommended in patients receiving intravenous unfractionated heparin infusion. No consensus on patients not receiving heparin</td>
<td>Activated PTT: Stop or reverse heparin for values &gt;1.5 times control)</td>
</tr>
<tr>
<td><strong>Nonvascular</strong></td>
<td>Platelet count: Routinely recommended</td>
<td>Platelets &lt;50,000: Transfuse</td>
</tr>
<tr>
<td>Renal biopsy</td>
<td>Hematocrit: Routinely recommended</td>
<td>Hematocrit: No recommended threshold for transfusion</td>
</tr>
<tr>
<td>Biliary interventions (new tract)</td>
<td></td>
<td>Plavix: Withhold for 5 d before procedure</td>
</tr>
<tr>
<td>Nephrostomy tube placement</td>
<td></td>
<td>Aspirin: Withhold for 5 d</td>
</tr>
<tr>
<td>Radiofrequency ablation: complex</td>
<td>Fractionated heparin: withhold for 24 h or up to two doses</td>
<td>DDAVP: Not indicated</td>
</tr>
</tbody>
</table>

There was an 80% consensus on each of these recommendations unless otherwise stated. The management recommendations for each coagulation defect and drug assume that no other coagulation defect is present and that no other drug that might affect coagulation status has been administered.
Laboratory Corner

Continued from page 22

A second, more evidence-based guideline, also from 2009 and published in American Journal of Radiology (O’Connor et al, Vol 193. Dec 2009), stated:

A platelet count of 50,000/μL is often used as a threshold value for performing invasive procedures, although there is little evidence to support this threshold. This cutoff may need to be reconsidered for minor procedures. For example, lumbar puncture was safe at counts down to 10,000/μL in one study without the needle size given and 30,000/μL when using 24-gauge needles in another. Five-to 12-French vascular catheter insertion has been shown to be safe without restrictions on platelet counts.

Paracentesis was performed without major bleeding using sheaths over 18-gauge needles at counts down to 6,000/μL, with a total of 667 patients below 50,000/μL from two studies. Abnormal bleeding was not observed after laparoscopic liver biopsies using 15-gauge needles in patients with platelet counts as low as 30,000/μL.

It should be emphasized that the bleeding risk associated with thrombocytopenia depends on the cause of the low platelet count. Thrombocytopenia due to platelet consumption, particularly autoimmune consumption, is generally considered to be less likely to cause bleeding at any given platelet count than thrombocytopenia due to decreased platelet production because circulating platelets in consumptive thrombocytopenia tend to be larger and relatively hyperfunctional. The presence of concurrent conditions, such as uremia, that adversely affect platelet function also must be taken into account when considering the bleeding risk associated with thrombocytopenia.

Although the entire clinical situation of each patient needs to be taken into account, we believe that the standard lower limit for platelet count before an interventional procedure can be reduced from 50,000 to 25,000/μL (Table 2).

And here is Table 2:

<table>
<thead>
<tr>
<th>Intervention</th>
<th>INR</th>
<th>Platelets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fine-needle aspiration, 20-gauge or smaller needle</td>
<td>Any</td>
<td>Any</td>
</tr>
<tr>
<td>Paracentesis</td>
<td>≥ 3.0</td>
<td>≥ 25,000</td>
</tr>
<tr>
<td>Thoracentesis, liver biopsy, or other invasive procedure</td>
<td>≥ 2.0</td>
<td>≥ 25,000</td>
</tr>
</tbody>
</table>

Note—INR = international normalized ratio.

CMC physicians should realize there is not an absolute standard of practice regarding the need to achieve a platelet count of at least 50,000/μL prior to IR procedures. Please familiarize yourself with our own platelet transfusion guidelines, which delineate varying INR and platelet count thresholds for higher and lower risk IR procedures. (Print readers can find the guidelines at CMC Forum > Departments > Laboratory > scroll to bottom of page. The guidelines are also linked directly from the Transfusion Order Set.

“Money doesn’t change men. It merely unmasks them.”

– Henry Ford, industrialist
ATTENTION: PHYSICIANS

As of May 2, 2017 an indication for antimicrobials with an Inpatient consult to Pharmacy is required

Rationale:
An indication is being implemented to assist in determining the most appropriate dose and target levels for vancomycin, gentamicin, amikacin, and tobramycin when Pharmacy is asked to assist with dosing. This workflow is similar to when an Inpatient consult to Pharmacy for warfarin is ordered.

Workflow:
1. Physician orders Inpatient consult to Pharmacy for vancomycin, gentamicin, amikacin, or tobramycin.
   a. An indication for the prescribed antimicrobial is selected.
   b. If the physician desires to provide a more specific indication the “Other (indicate in Comments field)” option can be selected as shown below.
Does Praxbind® (idarucizumab) Live Up to its Hype?

By Sherif Sharaby, PharmD, PGY1 Pharmacy Resident and Melissa Reger, PharmD, BCPS, Critical Care Clinical Pharmacy Specialist

Dabigatran (Pradaxa®) is an oral direct thrombin inhibitor that is approved by the U.S. Food and Drug Administration (FDA) to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation, to treat and reduce the risk of recurrence of deep venous thrombosis (DVT) and pulmonary embolism (PE), and to reduce the risk of DVT and PE following hip replacement surgery. Dabigatran offers many advantages compared to warfarin, the gold standard anticoagulant, including faster onset, shorter duration of action, and fewer drug-drug and food-drug interactions. However, management of serious bleeding in patients receiving dabigatran has traditionally been challenging due to the absence of a reversal agent. Previously, the only method of removal was hemodialysis, which is impractical in most clinical situations.

In October 2015, the FDA granted an accelerated approval for idarucizumab, the first direct oral anticoagulant reversal agent, for the reversal of the anticoagulant effects of dabigatran if needed for emergency/urgent surgery or procedure, or in life-threatening or uncontrolled bleeding.1 Idarucizumab is a humanized monoclonal antibody fragment that binds to dabigatran and its metabolites, thus neutralizing its anticoagulant effect. The binding affinity of idarucizumab to dabigatran is about 350 times the binding affinity of dabigatran to thrombin, and it binds to both free and thrombin-bound drug.2 Idarucizumab does not bind to other direct oral anticoagulants; therefore, it is only effective in reversal of dabigatran’s anticoagulant effect.

The FDA-accelerated approval of idarucizumab was based on results from three randomized, placebo-controlled trials that included a total of 283 healthy volunteers, as well as interim results available from the RE-VERSE AD trial (Study of the REVERSal Effects of idarucizumab in Patients on Active Dabigatran).3,4 In healthy volunteers, administration of idarucizumab reduced dabigatran to undetectable levels (less than 1 ng/ml), effectively reversed its anticoagulant effect, and was well tolerated.

The RE-VERSE AD trial is an ongoing phase III prospective cohort study that evaluates the efficacy and safety of idarucizumab in patients receiving dabigatran who have serious bleeding (group A) or need an urgent procedure (group B). The study has enrolled a total of 90 patients (51 patients in group A and 39 patients in group B) from June 2014 through February 2015. In these patients, most serious bleeds were due to gastrointestinal bleeding, intracranial hemorrhage, or trauma. Most patients had atrial fibrillation and were receiving dabigatran for stroke prophylaxis. Patients enrolled had a median age of 76.5 years, a median creatinine clearance of 58 ml/min, and a median time since last dose of dabigatran of 15.4 hours. All patients received 5g of intravenous idarucizumab, administered as two 50-ml bolus infusions containing 2.5g of idarucizumab each, 15 minutes or less apart. Interim analysis showed that idarucizumab completely reversed the anticoagulant effects of dabigatran within minutes as assessed by both the dilute thrombin time and the ecarin clotting time. However, bleeding cessation occurred after a median time of 11.4 hours. Because there was no control group, it is not clear whether this was faster than watchful waiting. Thrombotic events were reported in five patients who did not receive antithrombotic therapy, occurring 2-26 days after the administration of idarucizumab. A summary of outcomes, results, and adverse events is provided in Table 1. The study is expected to be completed before the end of 2017.

Evidence of idarucizumab’s clinical efficacy is limited to the interim analysis of the REVERSE-AD trial, which raises doubts about the effectiveness and safety of this reversal agent for several reasons. First, the RE-VERSE AD trial has several major limitations, including its lack of a control group, being underpowered, and possibly having a selection bias, as no information was given regarding how patients were screened for enrollment. The authors stated that it was unethical to perform a placebo-controlled trial in the setting of life-threatening bleeding. However, this stance assumes that idarucizumab is clinically effective and safe in a real world setting without ever being studied in this situation. The results with idarucizumab cannot be judged equal or superior to other existing recommendations, such as prothrombin complex concentrates. Second, a number of case reports documented failure to achieve clinical hemostasis with idarucizumab in patients with dabigatran-related bleeding.5,6 Furthermore, a limited number of patients in the RE-VERSE AD trial had re-elevated coagulation parameters (e.g. activated partial thromboplastin time) between 12-24 hours after administration of idarucizumab. This may suggest redistribution of dabigatran into the plasma, a finding that was reported when post-extracorporeal methods were used for dabigatran removal.7 The administration of a second dose of idarucizumab may be considered if a patient

See Pharmacy Corner on page 26
re-develops a clinically relevant bleed or requires a second emergent/urgent procedure and has elevated coagulation parameters.

Table 1. Summary of outcomes, results, and adverse events of the RE-VERSE AD trial

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Outcome</td>
<td>Maximum percentage reversal of the anticoagulant effect of dabigatran (assessed by measuring dilute thrombin time or ecarin clotting time)</td>
<td>▪ Median maximum percentage reversal of 100% (95CI;100-100)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Rapid and complete reversal of the anticoagulant effect of dabigatran in 88% to 98% of patients within minutes</td>
</tr>
<tr>
<td>Secondary Outcomes</td>
<td>Group A: Severity and hemodynamic stability</td>
<td>▪ Group A: 36 patients assessed, median investigator-reported time to the cessation of bleeding of 11.4 hours</td>
</tr>
<tr>
<td></td>
<td>Group B: Hemostasis during surgery (mild, moderate, or severely abnormal)</td>
<td>▪ Group B: 35 patients assessed, intraoperative hemostasis achieved in 92% of patients</td>
</tr>
<tr>
<td>Adverse Events</td>
<td>Adverse events with frequency greater than 5%</td>
<td>▪ Hypokalemia, delirium, constipation, pyrexia, and pneumonia</td>
</tr>
</tbody>
</table>

Use of idarucizumab should only be considered in patients receiving dabigatran with severe, uncontrolled bleeding or those who require an emergent procedure that requires hemostasis and cannot be delayed for at least 8 hours. The use of procoagulant agents such as fresh-frozen plasma or factor eight inhibitor bypassing activity (FEIBA®) in addition to idarucizumab may be considered in patients with severe or life-threatening bleeding. The doses, no more than 15 minutes apart. No dosage adjustment is needed in patients with renal impairment and it has not been studied in patients with hepatic impairment.

In conclusion, idarucizumab is a reversal agent for dabigatran that was granted an accelerated approval by the FDA. It rapidly normalizes abnormal coagulation parameters. However, there are limited data regarding its safety and clinical efficacy in achieving meaningful hemostasis.

References
As a student of history, I always search for historical references which can place popular culture into its proper context. Most of us can recount our childhood history lessons and tales of the Spanish Explorer, Ponce De Leon, and his quest to find the “Fountain of Youth” in North America in the 16th century. It turns out that the Greek historian Herodotus, The Father of History, wrote about such a fountain in the 5th century BC.

Our psyche is woven with the fabric of immortality or ever-lasting youth. My close attention to mortality was sparked after reading Atul Gawande's book, Being Mortal. It's a fantastic read on many levels but I was struck by his way of looking at mortality and its natural connection to our human experience.

We all sense connection to our bodies, our minds and the earth as we traverse the myriad paths of our lives. Survival is a primal instinct. The sun with its infinite power is the engine that moves and lights our planet, but it can also induce damage to our DNA, giving birth to certain life threatening cancers in individuals with too much exposure. Mortality and immortality by all accounts work in opposition to one another. But do they? Can our fear or refusal to accept mortality create irrational expectations on the medical profession? Somewhere a balance needs to be negotiated between the two concepts.

Occasionally it appears that modern medicine has cracked the code of mortality. Many advances in cancer care, life-extending medications, and interventions today allow individuals to live, when only fifty years ago the disease surely would have meant a more rapid end. Deepak Chopra, the American author and champion of "integrative or alternative" medicine, wrote the book, Ageless Body, Timeless Mind. In this book he writes about defying the aging process on a cellular level.

Our human experience bathes in the pool of immortality, whether it exists on the physical or metaphysical plane. I see individuals every day in the hospital who are facing their own mortality and asking the question, “How much time do I have left?” They are faced with an incurable riddle that medical science cannot solve. Many times the questions are less dramatic and involve probing the disease course, prognosis, and what can be done to slow down progression and lessen the physical and emotional burden. It's often a delicate conversation but one I take very seriously.

I recently met a middle-aged man in the hospital who was newly diagnosed with Stage 4 lung cancer. This is a terminal diagnosis. When I spoke with him he understood that he had lung cancer but was confident he could “beat it.” He brimmed with hope and relayed to me that he would be undergoing chemotherapy soon. I addressed the seriousness of his condition but he again assured me that he would “beat” the cancer. He had a bright and wide smile on his face, and I will admit it was difficult to have a forthright conversation with him but I did my best. However, I thought to myself that he has the right to maintain a maximal degree of hope that he would overcome this malady, despite my certainty that the disease would eventually claim his life. I closed in typical fashion by reassuring him that we would support him through his treatment on an outpatient basis and bid him farewell.

We were consulted to see him sometime later when he was again admitted to the hospital. He had received chemotherapy and was now gravely ill and septic. Vanished from his face was any smile or enthusiasm. As he lay there with tubes feverishly tunneling life-saving antibiotics into his veins, I wondered what he was thinking and feeling. The good news, there was some degree of tumor-slowing but the patient looked very sick. His voice struggled to produce a whisper. He had lost more weight and was unable to ambulate. He remembered having met me so the conversation naturally flowed as we discussed his goals. Although his spirit seemed on life support, his resolve to “beat” the cancer exuded with hope. He was looking forward to more chemotherapy and expected it would be soon. As I explained his condition, being septic and having no immune reserves to fight off even every-day microscopic invaders, his pupils began to enlarge, a sign the sympathetic nervous system is either excited or scared. For the first time I began to see some reality of his diagnosis and prognosis permeate his conscious mind. I asked him if we could meet with his family to discuss his goals of care. He agreed. Frankly, I had to be very blunt with him about the prognosis given his compromised functional status.

The patient remained in the hospital for over a month but was eventually discharged home with his sister on hospice care.

There is an element of culture shift that the field of medicine faces in today’s society. It involves the “taboo talk” about death and dying, about mortality. I have spoken to many individuals throughout my career about health, illness, and death. In all instances I have found that honesty is always appreciated. I am always thrilled when we have treatment options for patients. However, I am equally comforted

See Palliative Care on page 28
Palliative Care

Continued from page 27

knowing that options exist that offer hope and foster quality of life when the road of curative measures narrows. Telling a patient, “We have no more options” is never acceptable because we can always do something to alleviate the suffering of individuals even when extending life is no longer possible.

We are standing on the shoulders of history. Our culture constantly changes and adjusts to technology and the shifts in time. Mythology, dreams and spirituality shower us with reassurance that this life has meaning, much greater than the mundane noise of the modern world. Embracing mortality allows us to be at peace with ourselves and our world, along with whatever awaits us beyond our own dimensions.

CURES

CURES (Controlled Substance Utilization Review and Evaluation System) is California’s PDMP (prescription drug monitoring program). California Law required all licensed prescribers to register by July 1, 2016 but providers can still register, and are encouraged to use the database. If you have not done this already, please review the following:

Login website for clinical use (use once you have registered): CURES

Website Link to register:
https://cures.doj.ca.gov/registration/confirmEmailPnDRegistration.xhtml

Document with instructions on how to register:

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.

May 2017:
Calla Lily, Zantedeschia aethiopica
The elegant flowers of a Calla Lily are popular choices for bridal bouquets and cut flower arrangements. All parts of the plant are poisonous and biting or chewing the plant may cause irritation, burning, and stinging of the mouth, lips, and tongue. Vomiting and drooling have also been seen. Call Poison Control to help guide you to proper medical care.

Food Poisoning
Food poisoning can happen for a number of reasons: inadequate cooking time, improper food storage, or incomplete hand washing hygiene. All are preventable with a few simple steps! Food poisoning can cause nausea, vomiting, stomach pain, and diarrhea. Symptoms usually start a few hours after eating or drinking unsafe food, and multiple family members may be affected.
Investing in Healthier Futures

By Erin Kennedy, Senior Communications Specialist

The current edition of “Your Community at Work,” the Community Medical Centers corporate social responsibility report, highlights the record $214 million in “community benefit” our hospital network provided last fiscal year. The May-June edition outlines how community benefit dollars pay for the UCSF Fresno program to bring medical expertise to the Valley and attract physicians to stay and practice here. Community benefits also provide for our chaplain training program and outreach efforts to local elementary schools to encourage healthier habits.

“Your Community at Work” runs monthly in The Fresno Bee. It’s also published in the Business Journal and the California Advocate – and delivered to our patients in the hospital and mailed out to our donors. Its content also is available on www.CommunityMedical.org/Community-at-Work and through our social media.

Here’s a link to the Web page that contains the current report as well as previous editions. You can click through the “Your Community at Work” archive by year and by month to find printable PDF versions as well as the larger individual online stories.

Print readers: Go to Communitymedical.org > Community Involvement (on the top tab) > Your Community at Work (on the right side menu in the page)
Editor’s Note: We continue our presentation of important Choosing Wisely lists. This month we feature a list from The American College of Obstetricians and Gynecologists. The list addresses many clinically common Ob-Gyn situations and is highly recommended. We are grateful to UCSF-Fresno’s Holly Yuan M.D. for supplying our local expert commentary.

Don’t schedule elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks 0 days gestational age.

Delivery prior to 39 weeks 0 days has been shown to be associated with an increased risk of learning disabilities and a potential increase in morbidity and mortality. There are clear medical indications for delivery prior to 39 weeks 0 days based on maternal and/or fetal conditions. A mature fetal lung test, in the absence of appropriate clinical criteria, is not an indication for delivery.

Dr. Yuan: Unless there is a clear maternal or fetal indication, cesarean sections should be scheduled at 39 weeks 0 days or later. Even a pregnancy that is considered early term (between a gestational age of 37 weeks and 0 days to 38 weeks and 6 days) has a slightly increased risk for neonatal morbidity and mortality than an infant delivered after 39 weeks.

Don’t schedule elective, non-medically indicated inductions of labor between 39 weeks 0 days and 41 weeks 0 days unless the cervix is deemed favorable.

Ideally, labor should start on its own initiative whenever possible. Higher Cesarean delivery rates result from inductions of labor when the cervix is unfavorable. Health care practitioners should discuss the risks and benefits with their patients before considering inductions of labor without medical indications.

Dr. Yuan: Trying to induce labor in a patient whose cervix is “not ready” leads to unnecessary medical interventions which may then lead to increased risk for cesarean section. Of course every case must be individualized and patients will need to be counseled appropriately by their provider the risks and benefits of an elective induction.

Don’t perform routine annual cervical cytology screening (Pap tests) in women 30–65 years of age.

In average risk women, annual cervical cytology screening has been shown to offer no advantage over screening performed at 3-year intervals. However, a well-woman visit should occur annually for patients with their health care practitioner to discuss concerns and problems, and have appropriate screening with consideration of a pelvic examination.

Dr. Yuan: More recent studies have shown that women still receive early intervention for cervical dysplasia even if they were to be screened every 3 years, or even every 5 years if an HPV co-test is added. Eliminating annual cytology can cut down on medical costs and examinations on the cervix. Currently there is not enough evidence to either support or refute the recommendation for annual pelvic exams. Ideally patients should be involved in shared decision making to evaluate the need for the pelvic exam in the absence of symptoms.

Don’t treat patients who have mild dysplasia of less than two years in duration.

Mild dysplasia (Cervical Intraepithelial Neoplasia [CIN 1]) is associated with the presence of the human papillomavirus (HPV), which does not require treatment in average risk women. Most women with CIN 1 on biopsy have a transient HPV infection that will usually clear in less than 12 months and, therefore, does not require treatment.

Dr. Yuan: Up to 80% of sexually active women may contract HPV in their lifetime and sometimes that strain of HPV may cause cervical dysplasia. In general if a woman does not have a compromised immune system, they will usually clear mild dysplasia on their own. Close surveillance would be recommended decision making to evaluate the need for the pelvic exam in the absence of symptoms.
Encouraging these patients to ambulate periodically can help reduce risk for thrombosis without adversely affecting birth outcome.

Dr. Yuan: The thought of ovarian cancer is a scary one for female patients but the search for the perfect screening tool has yet to be found at this point in time. Obtaining a CA-125 is an option but there are many opportunities for false positives especially in premenopausal women which can then lead to unnecessary medical interventions and distress to the patient.

Avoid using robotic assisted laparoscopic surgery for benign gynecologic disease when it is feasible to use a conventional laparoscopic or vaginal approach.

Robotic-assisted and conventional laparoscopic techniques are comparable with respect to perioperative outcomes, intraoperative complications, length of hospital stay and rate of conversion to open surgery. However, evidence shows that robotic-assisted laparoscopic surgery has similar or longer operating times and higher associated costs.

Dr. Yuan: Robotic assisted laparoscopic surgery is a wonderful option in that it can decrease length of hospital stay for the patient, decrease overall blood loss from the procedure, and allow the surgeon to employ precise technique for what could otherwise be a difficult procedure. Based on overhead cost, surgeon experience and availability of resources and staff, the surgeon responsible for the patient’s care can decide whether robot assisted surgery is optimal for the patient vs laparoscopic vs vaginal vs open technique.

Don’t perform prenatal ultrasounds for non-medical purposes, for example, solely to create keepsake videos or photographs.

Prenatal ultrasounds are an integral part of a woman’s prenatal care. While obstetric ultrasound has an excellent safety record, the U.S. Food and Drug Administration considers keepsake imaging as an unapproved use of a medical device. The American Institute of Ultrasound in Medicine also discourages the non-medical use of ultrasound for entertainment purposes. Keepsake ultrasounds are not medical tests and should not replace a clinically performed sonogram.

Dr. Yuan: Unfortunately prenatal ultrasounds have now ventured outside the medically indicated scope to satisfy curiosities and to further capitalize on the pregnancy industry. Patients should understand that these ultrasounds cannot be part of their medical record.

Don’t routinely transfuse stable, asymptomatic hospitalized patients with a hemoglobin level greater than 7–8 grams.

Multiple factors need to be considered in transfusion decisions, including the patient’s clinical status and oxygen delivery ability. Arbitrary hemoglobin or hematocrit thresholds should not be used as the only criterion for transfusions of packed red blood cells.

Dr. Yuan: The decision to require blood transfusion should be based on multiple factors such as clinical symptoms, lab values, and risk for further bleeding to determine if the benefits of receiving blood outweigh the risk of receiving transfused blood.

Don’t perform pelvic ultrasound in average risk women to screen for ovarian cancer.

Although the mortality rate associated with ovarian cancer is high, the disease occurs infrequently in the general U.S. population, with an age-adjusted incidence of 13 cases per 100,000 women. As a result, the positive predictive value of screening for ovarian cancer is low, and most women with a positive screening test result will have a false-positive result. Annual screening with transvaginal ultrasonography in women does not reduce the number of ovarian cancer deaths.

Dr. Yuan: This point is similar to #5 in that it may create more unnecessary interventions and stress for the patient down the road.

Don’t routinely recommend activity restriction or bed rest during pregnancy for any indication.

Bed rest or activity restriction has been commonly recommended for a variety of conditions in pregnancy including multiple gestation, intrauterine growth restriction, preterm labor, premature rupture of membranes, vaginal bleeding and hypertensive disorders in pregnancy. However, information to date does not show an improvement in birth outcome with the use of bed rest or activity restriction, but does show an increase in loss of muscle conditioning and thromboembolic disease.

Dr. Yuan: We are trying to move away from recommending bed rest even in the setting for most of our high risk obstetric patients. Encouraging these patients to ambulate periodically can help reduce risk for thrombosis without adversely affecting birth outcome.

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician. Released February 21, 2013 (Items 1-5). Released March 14, 2016 (Items 6-10). Recommendation #6 revised August 24, 2016.
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 on April 4, 2017. If you identify that there is a problem please follow the procedure for corrective action. The appropriate form may be found on the FORUM: Departments>Joint Informatics Council>Submit a new CCT/JIC request. Thank You.

<table>
<thead>
<tr>
<th>Epic PRL#</th>
<th>Order Set Name</th>
<th>Description of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1367</td>
<td>Acute Ischemic Stroke TIA Orders</td>
<td>Change Request&lt;br&gt;• Neurology consult orders general versus stroke consults to populate into one system list for CRMC</td>
</tr>
<tr>
<td>1170</td>
<td>Acute Stroke Post tPA</td>
<td>Change Request&lt;br&gt;• Removed required hard stop for diagnostic procedures&lt;br&gt;• Consent to read removed&lt;br&gt;• Neurology consult orders general versus stroke consults to populate into one system list for CRMC</td>
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<tr>
<td>1683</td>
<td>Adult Insulin Pump Self-Management</td>
<td>Change Request&lt;br&gt;• Added orders to discontinue insulin pump and continuous glucose meter upon admission</td>
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<tr>
<td>1234</td>
<td>Adult Therapeutic Anticoagulation Therapy Order Set</td>
<td>Change Request&lt;br&gt;• Added new option for the High Intensity anticoagulation with anti-Xa monitoring&lt;br&gt;• Updated to include with or without PRN boluses for High Intensity with PTT and anti-Xa monitoring and the Low Intensity nomogram</td>
</tr>
<tr>
<td>7</td>
<td>Alteplase (t-PA) for Pulmonary Embolism</td>
<td>Biennial Review&lt;br&gt;• Decreased Neuro checks and vitals to hourly for 8 hours then every 2 hours for 8 hours&lt;br&gt;• Updated labs&lt;br&gt;• Added standard IV flush order</td>
</tr>
<tr>
<td>1637</td>
<td>Bariatric Evaluation (CEC)</td>
<td>Change Request&lt;br&gt;• Order set name changed to Bariatric Evaluation (previously ALSA Cardiac Evaluation Center)&lt;br&gt;• Removes Physicians name on blue print&lt;br&gt;• Updated code status</td>
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<tr>
<td>1550</td>
<td>Cardiovascular Surgery Discharge Orders</td>
<td>Change Request&lt;br&gt;• Modifications made to standardize contraindications for: Aspirin, Beta Blockers, Lipid’s, Thienopyridine/platelet inhibitors and Angiotensin-Converting Enzyme Inhibitors</td>
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<tr>
<td>303</td>
<td>Chest Pain High Risk Treatment ED</td>
<td>Biennial Review&lt;br&gt;• Added start IV orders&lt;br&gt;• Updated Oxygen Therapy orders</td>
</tr>
<tr>
<td>309</td>
<td>Comfort Care for the Dying Patient Z</td>
<td>Change Request&lt;br&gt;• Added drop down for 15-20-60 minutes for all infusion reassessments&lt;br&gt;• Updated Fentanyl dosing range&lt;br&gt;• Clarified MD notification order</td>
</tr>
<tr>
<td>1314</td>
<td>Gastrochisis Order Set</td>
<td>Change Request&lt;br&gt;• Clarified pre-procedure medication orders and fentanyl drip orders&lt;br&gt;• Updated post-procedure nursing communication orders</td>
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<td>1644</td>
<td>Heart Failure Module Z</td>
<td>Change Request&lt;br&gt;• Modifications made to standardize contraindications for: Aspirin, Beta Blockers, Lipid’s, Thienopyridine/platelet inhibitors and Angiotensin-Converting Enzyme Inhibitors</td>
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<tr>
<td>U925</td>
<td>High Intensity Nomogram UFH Anti-Factor Xa Monitoring</td>
<td>Change Request&lt;br&gt;• New nomogram added for High Intensity with Anti-Factor Xa monitoring</td>
</tr>
<tr>
<td>U576</td>
<td>High Intensity Nomogram UFH PTT Monitoring</td>
<td>Change Request&lt;br&gt;• Updated to include with or without PRN boluses for High Intensity with PTT monitoring nomogram</td>
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<td>1342</td>
<td>ICU Medical Admission Stroke Post tPA</td>
<td>Change Request&lt;br&gt;• Neurology consult orders general versus stroke consults to populate into one system list for CRMC</td>
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</tbody>
</table>

continued on page 33
<table>
<thead>
<tr>
<th>Epic PRL#</th>
<th>Order Set Name</th>
<th>Description of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>U578</td>
<td>Low Intensity Nomogram UFH</td>
<td>Change Request&lt;br&gt;• Updated to include with or without PRN boluses for Low Intensity nomogram</td>
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<tr>
<td>1412</td>
<td>NICU Discharge</td>
<td>Change Request&lt;br&gt;• Added “Referrals” to include Patient diagnosis&lt;br&gt;• Added appointment time to Clinic/Physician order&lt;br&gt;• Updated CRMC Neonatal ICU fax numbers</td>
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<tr>
<td>1302</td>
<td>NICU PICC Line</td>
<td>Change Request&lt;br&gt;• Added PICC line placement order</td>
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<td>1366</td>
<td>Non Invasive Ventilation BIPAP</td>
<td>Biennial Review&lt;br&gt;• Pre checked NON-INVASIVE VENTILATION (BIPAP)&lt;br&gt;• Added Arterial blood Gas (ABG)</td>
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<tr>
<td>1279</td>
<td>Oral Aspirin Desensitization</td>
<td>New Order Set&lt;br&gt;• Order set contains protocol when Oral Aspirin Desensitization is needed&lt;br&gt;• Contains Aspirin escalation doses, vital sign monitoring and PRN medications for any allergic response that may occur</td>
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<tr>
<td>1493</td>
<td>PICC Line Insertion Z</td>
<td>Biennial Review&lt;br&gt;• Updated PICC line verbiage to include “PICC Certified Nurse to insert PICC”&lt;br&gt;• Alteplase verbiage now includes repeat procedure “if no blood return after 120 minutes”</td>
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<td>1086</td>
<td>Post Cardiac Cath Orders</td>
<td>Change Request&lt;br&gt;• Modifications made to standardize contraindications for: Aspirin, Beta Blockers, Lipid’s, Thienopyridine/platelet inhibitors and Angiotensin-Converting-Enzyme Inhibitors</td>
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<tr>
<td>910</td>
<td>Post Op Breast Surgery</td>
<td>Change Request&lt;br&gt;• Added new BMAT to be consistent with philosophy of mobilizing patients to best of their ability</td>
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<tr>
<td>1387</td>
<td>Post Op Intervention Cardiology</td>
<td>Change Request&lt;br&gt;• Modifications made to standardize contraindications for: Aspirin, Beta Blockers, Lipid’s, Thienopyridine/platelet inhibitors and Angiotensin-Converting-Enzyme Inhibitors</td>
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<td>Post Op Pacemaker</td>
<td>Change Request&lt;br&gt;• Modifications made to standardize contraindications for: Aspirin, Beta Blockers, Lipid’s, Thienopyridine/platelet inhibitors and Angiotensin-Converting-Enzyme Inhibitors</td>
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<td>1401</td>
<td>Post Op Spine Orders</td>
<td>Change Request&lt;br&gt;• Added new BMAT to be consistent with philosophy of mobilizing patients to best of their ability</td>
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<tr>
<td>1376</td>
<td>Post Op Thoracic Surgery</td>
<td>Change Request&lt;br&gt;• Added new BMAT to be consistent with philosophy of mobilizing patients to best of their ability</td>
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<td>1363</td>
<td>Pre Admission Cardiothoracic Surgery</td>
<td>Change Request&lt;br&gt;• Modifications made to standardize contraindications for: Aspirin, Beta Blockers, Lipid’s, Thienopyridine/platelet inhibitors and Angiotensin-Converting-Enzyme Inhibitors</td>
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<td>1375</td>
<td>Pre Op Cardiothoracic Surgery</td>
<td>Change Request&lt;br&gt;• Modifications made to standardize contraindications for: Aspirin, Beta Blockers, Lipid’s, Thienopyridine/platelet inhibitors and Angiotensin-Converting-Enzyme Inhibitors</td>
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<tr>
<td>1585</td>
<td>Pre Op Short Stay Surgery - Inpatient</td>
<td>Change Request&lt;br&gt;• Removed orthopedic/podiatry antibiotic section from EPIC and kept the general antibiotics</td>
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<tr>
<td>1703</td>
<td>Pre-Admit Transesophageal Echo</td>
<td>Change Request: Break fix&lt;br&gt;• Capnography and ETCO2 monitoring for FHSH&lt;br&gt;• Added Day of Procedure for labs and diagnostics&lt;br&gt;• Pre-Selected Lidocaine and Hurricaine One Spray (TEE Only)&lt;br&gt;• Modified Fentanyl dose</td>
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</tbody>
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*continued on page 34*
Continued from page 33

<table>
<thead>
<tr>
<th>Epic PRL#</th>
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<tr>
<td>1335</td>
<td>Routine Cardiac Admission Orders</td>
<td>Change Request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Modifications made to standardize contraindications for: Aspirin, Beta Blockers, Lipid’s, Thienopyridine/platelet inhibitors and Angiotensin-Converting Enzyme Inhibitors</td>
</tr>
<tr>
<td>572</td>
<td>Subcutaneous Insulin for Non Pregnant Adult</td>
<td>Change Request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Build to be available at CCMC and FHSH Adjusted meal/prandial instructions for home dose</td>
</tr>
<tr>
<td>1639</td>
<td>Walk in Comprehensive Evaluation (CEC)</td>
<td>Change Request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Order set name changed to Walk in Comprehensive Evaluation (previously CEC Walk in Orders)</td>
</tr>
<tr>
<td>1487</td>
<td>Weakness/Dizziness/ Focal Neuro Deficit Treatment ED</td>
<td>Change Request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added “Select One” to the Antiemetic selection</td>
</tr>
</tbody>
</table>

**The following order set will be retired**

<table>
<thead>
<tr>
<th>Epic PRL#</th>
<th>Order Set Name</th>
<th>Reason for Retirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1500</td>
<td>Back Flank Pain Treatment ED</td>
<td>Biennial Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Zero usage within the past year</td>
</tr>
<tr>
<td>1503</td>
<td>ED Allergic Reaction Treatment</td>
<td>Biennial Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Zero usage within the past year</td>
</tr>
<tr>
<td>1502</td>
<td>ED Hyperglycemia Treatment</td>
<td>Biennial Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Zero usage within the past year</td>
</tr>
<tr>
<td>1505</td>
<td>ED Major Burn/Smoke Inhalation Treatment</td>
<td>Biennial Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Zero usage within the past year</td>
</tr>
<tr>
<td>1557</td>
<td>Fluid Conservation Protocol</td>
<td>Biennial Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Zero usage within the past year</td>
</tr>
<tr>
<td>1510</td>
<td>Trauma Treatment ED</td>
<td>Biennial Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Zero usage within the past year</td>
</tr>
</tbody>
</table>

MAY PHYSICIAN PHOTOGRAPHER
SCOTT AHLES M.D.
See page 2 for details
Please also see the enclosed individual flyers for more on these & other upcoming local CME activities to meet your CME needs.
HERE’S WHAT’S NEW

This monthly newsletter will provide you an overview of changes within Epic impacting various care team members.

Feel free to scan all items, or just focus on your ‘role’ section.

For more information, please feel free to reach out to your local Informatics Team

Quick Links for Changes on 5/2/17

For Providers

---Order Sets/Orders
---Other Items

For Care Teams

---General
---Women & Children’s

For Providers

Order Sets/Orders

Module Pain Order Set
Order set that presents pain medication choices based on pain score and route of administration; in response to TJC findings at all facilities

Inpatient Dialysis OS Changes
Changes to dialysate potassium elements and threshold statements

Diet Order Changes in OS
Removed ‘low bacteria restriction’ options on all order sets, removal of ‘Participate in On Call’ options

Post Biopsy Order Set Changes
Changes made to medication orders to significantly reduce duplications and warnings resulting from selected choices

Removal Donnatal from Order Panels
Donnatal has been removed from GI cocktail order panels and order sets due to expense, and limited usefulness

NICU ROP Laser Photocoagulation OS
Changes made to order set to update and match current practices

Blood Product OS for Oncology Patients
Specific order set to use when ordering blood products for Oncology patients, including product indications and thresholds for ordering.

Vascular Order Set Updates
Multiple changes made to order set to improve quality of care and informational instructions for nursing for this population.

New Neonatal and Pediatric CAUTI OS
New order sets created to minimize risk of CAUTI for neonatal and pediatric patients.

Oral Penicillin Desensitization OS revisions
Updates to OS to match changes to Antimicrobial Desensitization policy
BiPap Order Changes
BiPap order now written to include guideline verbiage for management, resulting from TJC survey

Other Items

Pediatric/Newborn Vital Signs
Reset ranges of Vitals signs for all L & D babies, PNU nursery and newborn unit infants across CMC; will eliminate flags being received currently based upon adult VS thresholds.

Updates to Tube Feedings/Oral Nutrition Supplements Formulary
Multiple changes to update formulary for enteral nutrition. Will facilitate selection of correct formula to be ordered/provided

Consolidation of Midline/Deep PIV documentation
When inserting midline IV, presented with single choice of ‘Midline’ for procedure documentation

HgAIC Point of Care Results Display
The Diabetic labs results view has been updated to include HgAIC from both lab and POC in same location, each labelled, for easy reference. Smart phrase to pull in both (all) results works as well.

NST Read/Interpretation Process
As patients complete NST’s, providers can log in from anywhere, review the fetal strip and provide an interpretation from within Epic, then close the encounter.

Haiku/Canto Password Re-entry Time Out
The need to re-enter your password every 24 hours with Haiku touch ID has now been extended to 30 days.

FOR CARE TEAMS

General

Wound LDA Documentation
Split of current wound LDA documentation into two-simple and complex to facilitate more accuracy and efficiency in documenting wounds.

External Catheter Documentation
Now have ability to document external catheter placement on male patients available on LDA documentation flowsheet

IV to PO Medication Patient List
Creation of patient list for all patients meeting IV to PO conversion criteria for specific medication classes for Pharmacy

Order Entry Enabled for Dieticians
Dieticians now able to place orders ‘per protocol’ when need to modify diet orders under physician direction.

Intervention documentation creation for Residents/Students-Pharmacy
Enables documentation of time spent on education activities for Pharmacy residents and students to facilitate improved CMS reimbursement

HgAIC Point of Care Results Display
The Diabetic labs results view has been updated to include HgAIC from both lab and POC in same location, each labelled, for easy reference. Smart phrase to pull in both (all) results works as well.
Patient Own Med Use BPA
When patients bring home medications for use in hospital, BPA will alert nursing to return medication to patient prior to discharge

Change to Default View-6W Rehab
The default view of the worklist for 6W will now display as ‘My Discipline with Meds’.

Women & Children’s

Electronic WIC Form
Form built within Epic captures required information already within record, to be printed out and handed to patients needing form.

Changes to Discharge Checklists
Changes made to maternal discharge checklist to ensure proper completion: syphilis screen is now a required field, Birth certificate info is now Birth Certificate Clerk only.

Admit Required Documentation Report-Infants
Report for infants to include necessary tasks for L & D as prepare patient for transfer to postpartum

Admit Required Documentation-Perinatal patients
Revision of items to include on Admit Required Documentation report for Perinatal Admissions

Family Interactions
Flowsheet built to capture necessary elements for NICU infants for compliance

Pediatric/Newborn Vital Signs
Reset ranges of Vitals signs for all L & D babies, PNU nursery and newborn unit infants across CMC; will eliminate flags being received currently based upon adult VS thresholds.

NST Read/Interpretation Process
As patients complete NST’s, providers can log in from anywhere, review the fetal strip and provide an interpretation from within Epic, then close the encounter.
C. diff Testing and Treatment for Practitioners

Repeat testing after treatment and resolution of signs/symptoms (s/s) is NOT indicated; repeat testing is not to be done as a test of cure.

- Testing only indicated in patients who have liquid stools and liquid stools are not a normal bowel pattern for the patient
- Testing only indicated once every 7 days unless patient’s signs and symptoms change [WBCs>15, acute rising creatinine, s/s of acute colitis]
- Testing should not be ordered until 24 hours after the last dose of laxative/bowel
- C. Diff testing generally not indicated in afebrile patients whose white blood cell count is within normal limits
- PCR alone does not indicate need for treatment. Clinically correlate with patient signs and symptoms in conjunction with EIA test results

### TOXIGENIC C. diff DETECTED

- Any inciting antimicrobials should be discontinued, if possible.
- Patients condition should improve in 7-10 days; if not consider alternate sources of infection

### TOXIGENIC C. diff TREATMENT MATRIX

<table>
<thead>
<tr>
<th>SEVERITY</th>
<th>CRITERIA</th>
<th>TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild to Moderate</td>
<td>WBC &lt; 15,000 AND CREAT &lt; 1.5 Base</td>
<td>Metronidazole 500 MG TID PO X 10-14 D</td>
</tr>
<tr>
<td>Severe</td>
<td>WBC &gt; 15,000 OR CREAT &gt; 1.5 Base</td>
<td>Vancomycin 125 MG QID PO X 10-14 D</td>
</tr>
<tr>
<td>Severe Complicated</td>
<td>Hypotension/shock, Ileus, Megacolon</td>
<td>Vancomycin 500 MG PO/NG QID AND Metronidazole 500 MG Q8H IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rectal Vancomycin per ID only for complicated Ileus</td>
</tr>
<tr>
<td>First Recurrence</td>
<td></td>
<td>Same as initial episode</td>
</tr>
<tr>
<td>Second Recurrence</td>
<td></td>
<td>Vancomycin in tapered or prolonged Rx</td>
</tr>
</tbody>
</table>

#0XXX09 - Infection Control Rev 0 - 11/17/2016
**ATTENTION: PHYSICIANS**

As of **May 2, 2017** an indication for antimicrobials with an **Inpatient consult to Pharmacy** is required

**Rationale:**
An indication is being implemented to assist in determining the most appropriate dose and target levels for vancomycin, gentamicin, amikacin, and tobramycin when Pharmacy is asked to assist with dosing. This workflow is similar to when an Inpatient consult to Pharmacy for warfarin is ordered.

**Workflow:**
1. Physician orders Inpatient consult to Pharmacy for vancomycin, gentamicin, amikacin, or tobramycin.
   a. An indication for the prescribed antimicrobial is selected.
   b. If the physician desires to provide a more specific indication the “Other (indicate in Comments field)” option can be selected as shown below.

![Image of Inpatient consult to Pharmacy workflow](image.png)
An Evening in Monte Carlo
PRESENTED BY SANTÉ HEALTH FOUNDATION
Saturday, May 13, 2017
6 O’clock PM
Clovis Community Medical Center Campus

Santé Health Foundation is preparing to launch our
2nd annual Spring Spectacular, a black-tie Evening in Monte Carlo,
benefitting the new Regional Cancer Treatment and Research Center
to be built on the Clovis Community Campus

There are many sponsorship and donation opportunities available!

Please contact Santé at (559) 228-4308 to receive a sponsorship packet
and to purchase a table

We would love for you to join us!

Santé Health Foundation. Improving The Health of The People in our Community.
23rd Annual Hispanic Medical Conference

Targeting Health Issues Affecting the Hispanic Community

SATURDAY, MAY 6, 2017
Veteran’s Memorial Auditorium
2425 Fresno Street
Fresno, CA 93721
7:30 am to 1:30 pm

A C C R E D I T A T I O N S T A T E M E N T
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.

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Community Medical Centers designates this live activity for a maximum of 5.0 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.

T A R G E T A U D I E N C E
This program is designed for Internist, Family Practice Attending Physicians, Residents, Medical Students, Physician Assistants, Nurses and Allied Healthcare Professionals.

P R O G R A M C H A I R
J. Luis Bautista, MD, Medical Director, Avance Home Health & Bautista Medical Group

C R E D I T
5 Hours of Category 1 Credit

F E E S
Free of Charge - Donations Welcomed

Please make check payable to:
Community Hospitals of Central California
CMC, c/o Avance Home Health, 1350 “O” Street, Suite 303, Fresno, CA 93721

Please call and register by phone or email:
(559) 266-8300 or hispmmedconf@avancehh.com
Program

Registration 7:30 A.M.
Welcome 8:00 A.M.
J. Luis Bautista, MD, Conference Director

Speakers 8:15 A.M.
Ulcerative Colitis
Ignacio Guzman, MD

9:00 A.M.
Multivitamins and OTC Supplements
Juan G. Bautista, MD

9:45 A.M.
Coronary Artery Bypass Graft Surgery (CABG): A Novel Approach
Pervaiz Chaudhry, MD (Special Guest)

Break 10:30 A.M.

Speakers 11:15 A.M.
Type 2 Diabetes
Carlos Santivanez, MD

12:00 P.M.
Health Law - An Overview of Laws Relevant to Medical Practice in California
Luis G. Bautista, MD, JD.

12:45 P.M.
Benign Prostatic Hyperplasia (BPH)
J. Luis Bautista, MD

Educational Objectives

Ulcerative Colitis
At the end of the session, the attendees will:
1. Be able to apply current guidelines to diagnosing Ulcerative Colitis in patient care
2. Increase awareness in causes of Ulcerative Colitis and treatment options and use this knowledge in practice
3. Learn how to better manage Ulcerative Colitis and recognize the impact of beliefs with various home remedies and learn to incorporate them in order to improve patient compliance and outcomes

Multivitamins and OTC Supplements
At the end of the session, the attendees will:
1. Have a better understanding on when the use of Multivitamins and OTC Supplements are appropriate
2. Learn that not all Multivitamins and OTC Supplements are equal
3. Have a better understanding of deceptive labeling, mineral potency, natural vs. synthetic and use this knowledge in practice
4. Be more proficient in disease prevention and/or nutrient deficiencies by using multivitamins and OTC supplements to improve patient outcomes

Coronary Artery Bypass Graft Surgery (CABG): A Novel Approach
At the end of the session, the attendees will:
1. Be able to apply current guidelines to diagnosing conditions that require CABG
2. Gain better understanding of CABG and its impact on improving patient outcomes
3. Have increased knowledge of the most common risks, complications and benefits and apply this competency to one’s practice

Type 2 Diabetes
At the end of the session, the attendees will:
1. Learn, better understand and incorporate into patient care the knowledge of Type 2 Diabetes
2. Identify and apply in practice the latest diagnostic and treatment strategies for Type 2 Diabetes, thus achieving better outcomes

Health Law – An Overview of Laws Relevant to Medical Practice in California
At the end of the session, the attendees will:
1. Increase physician recognition of laws relevant to medical practice in California and use that knowledge in practice
2. Apply in practice acquired changes of HIPAA for 2017, to learn key concepts and become familiar for better management strategies
3. Learn the key strategies to prevent and protect against malpractice suits and add this knowledge to one’s practice

J. Luis Bautista, MD: Benign Prostatic Hyperplasia (BPH)
At the end of the session, the attendees will:
1. Learn about the increased prevalence and causes of BPH and anticipate barriers that may adversely impact outcomes if not addressed
2. More proficiently manage and treat BPH and apply this knowledge to achieve better outcomes
3. Be more aware of indications and contraindications for BPH and add this competency to one’s practice
DISCLOSURES

- Dr. J. Luis Bautista has disclosed that he is on the Speakers Bureau for Auxilium, Boehringer Ingelheim Bristol Myers Squibb, Eli Lilly, Janssen, Merck, Novartis, Novo Nordisk, Proctor & Gamble, Sankyo-Forest, Sanofi-Aventis, and Takeda.
- Dr. Juan G. Bautista has listed no disclosures.
- Dr. Luis G. Bautista has listed no disclosures.
- Dr. Pervaiz Chaudhry has listed no disclosures.
- Dr. Ignacio Guzman listed no disclosures.
- Dr. Carlos Santivañez has disclosed that he is on the Speakers Bureau for Sanofi.
- Yolanda R. Cervantes, Program Coordinator, listed no disclosures.
- Potential conflicts for all speakers will be resolved prior to the conference.

VETERAN’S MEMORIAL AUDITORIUM
2425 FRESNO STREET (CORNER OF FRESNO & “O” STREETS)
FRESNO CA 93721

Please call (559) 266-8300
or email: hispmedconf@avancehh.com

Free of Charge - Donations Welcomed
Please make check payable to: Community Hospitals of Central California

Please mail donation to:
CMC, c/o Avance Home Health, 1350 “O” Street, Suite 303, Fresno, CA 93721
Department of Medicine
Grand Rounds

“Low Dose CT Screening for Early Diagnosis of Lung Cancer”

Kathryn Bilello, MD

Kathryn Bilello, MD, received her medical degree from New York University School of Medicine and completed her residency at University of Maryland in Baltimore and at William Beaumont Army Medical Center in El Paso, Texas. Her fellowship training was completed at Walter Reed Army Medical Center. Dr. Bilello is board certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine, and has special interest in lung Cancer, sepsis, ARDS and medical education.

Dr. Bilello joined the faculty at UCSF in 1998 and is currently a Clinical Professor serving as the Pulmonary Fellowship Program Director.

Dr. Bilello enjoys running, cycling, tennis and scuba diving.

Learning Objectives
Upon completion of this activity, participants will:

1. Learn, better understand and incorporate into patient care the rationale for lung cancer screening with low dose CT to improve diagnostic methods and patient outcomes.
2. Identify appropriate patients for screening in order to improve patient safety, satisfaction, understanding, compliance, etc.
3. Be more aware of risks and benefits of screening and use that knowledge in practice.
4. Know how to evaluate screen-detected nodules and will be able to add this competency to one’s practice.

Disclosures: Presenter Dr. Kathryn Bilello, Program Director Dr. Robert Libke, and Planner Sherrie Lewis have no relevant commercial relationships to disclose.

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For more information: (559) 459-2065 | slewis@fresno.ucsf.edu
Bi-annual Morbidity and Mortality conference. As such, this is a closed conference open only to faculty, residents, and invited guests.

Thursday, May 11, 2017
UCSF Fresno Center, Room 116 (Fresno St. and Divisadero)
4:00 P.M. – 5:00 P.M.

Target Audience: Psychiatry department faculty, residents & community mental health professionals

Objectives: After attending this lecture:

1. Attendees will gain competency in delivering patient care utilizing cutting edge clinical practices and educational techniques to use in patient practice.
2. Attendees will gain proficiency in interdisciplinary examination and collaboration in the care of a diverse population of patients.
3. Attendees will develop intellectual rigor and discipline in evaluating new treatments and techniques in order to achieve better outcomes when treating patients.
4. Attendees will be better able to apply current guidelines for practice based learning and improvement in patient care.

Program Director, Craig Campbell, MD and Planner Breana Contreras, have no relevant commercial relationships to disclose. Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians.

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

UCSF Fresno Department of Internal Medicine Presents

2017
12th Annual
Cardiology in the Valley Symposium

COURSE DIRECTOR: JOHN A. AMBROSE, MD, FACC

SATURDAY, MAY 13, 2017
7:00AM–1:30PM

UCSF Fresno Center for Medical Education and Research
155 N. Fresno Street
Fresno, CA 93701

CME: 4.5 (APPLIED FOR)
Category 1 Credits
Fees: $10

Continental breakfast & lunch will be provided

TOPICS:

• Heart Failure “Landscape”
  John A. Ambrose, MD, FACC, UCSF Professor of Medicine at UCSF Fresno

• Heart Failure with Preserved Ejection Fraction and Heart Failure with Recovered Ejection Fraction. How should we manage?
  Richard Kiel, MD

• Present & Future Management of Heart Failure with Reduced Ejection Fraction
  Richard Kiel, MD

• Atrial Fibrillation
  Chandrasekar Palaniswamy, MD

• Diagnosis of Management and Wide Complex Tachycardia
  Chandrasekar Palaniswamy, MD

TARGET AUDIENCE:
Cardiologists, hospitalists, family and internal medicine physicians, physician assistants, nurse practitioners, and allied healthcare professionals with an interest in cardiology.

DISCLAIMERS:
Presenters John A. Ambrose, Richard Kiel, Chandrasekar Palaniswamy and planners Monica Sozinho have no commercial disclosures to make. All potential contents of interest will be resolved prior to this event.

ACCREDITATION:
Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. Community Medical Centers designates this live activity for a maximum of 4.5 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

Pre-registration is required. Registration is on a first-come, first-served basis. Early registration is recommended, as seating is limited.

REGISTER ONLINE AT:
www.fresno.ucsf.edu/conferences/cardiology2017

Sponsored by

COMMUNITY MEDICAL CENTERS

MORE INFO: MONICA SOZINHO AT MSOZINHO@FRESNO.UCSF.EDU OR 559-499-6421
Perinatal M & M Presents:

“Zika Pregnancy and Beyond”

Wednesday, May 17, 2017 from 12:30pm – 1:30pm
UCSF – Fresno, Room: 136
155 N. Fresno Street, Fresno, CA  93701

Case Presentation
Obstetrics: Dr. Tiffany Pham
Neonatology: Dr. A Rajani

Principal Discussants
Obstetrics: Dr. David Abel
Neonatology: Dr. A Rajani

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

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

1) Apply to practice, current clinical evidence and guidelines relating to Risks of Reproductive Technology.
2) Gain insight into Risks of Reproductive Technology, 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.

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Community Medical Centers designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
This credit may also be applied to the CMA Certification in Continuing Medical Education.
PSYCHIATRY GRAND ROUNDS

“The Intersection of Palliative Care Boulevard and Psychiatry Lane”

Patrick J. Macmillan, MD
HS Associate Clinical Professor
Chief of Hospice and Palliative Care
UCSF Fresno Medical Education Program

Thursday, May 18, 2017
UCSF Fresno Center, Room 116 (Fresno St. and Divisadero)
4:00 P.M. – 5:00 P.M.

Target Audience: Psychiatry department faculty, residents & community mental health professionals

Objectives: After attending this lecture:
1. Attendees will gain competency in delivering patient care utilizing cutting edge clinical practices and educational techniques to use in patient practice.
2. Attendees will gain proficiency in interdisciplinary examination and collaboration in the care of a diverse population of patients.
3. Attendees will develop intellectual rigor and discipline in evaluating new treatments and techniques in order to achieve better outcomes when treating patients.
4. Attendees will be better able to apply current guidelines for practice based learning and improvement in patient care.

Patrick J. Macmillan, MD; Program Director, Craig Campbell, MD; and Planner, Breana Contreras, have no relevant commercial relationships to disclose.

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.
SPEAKERS:
Jim Davis, MD, Lois Blough, RN, Michael Allshouse, DO,
Alexander Eastman, MD, Patrick MacMillan, MD, Dan Lynch, EMS
Director, William Dominic, MD, Jason Davis, MD

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

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

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

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

To register online, visit:
https://centralcaliforniatraumasymposium.eventbrite.com

Coordinating Organizations

Thursday, May 25, 2017
7:00 AM - 5:00 PM
Fresno Convention Center
Exhibit Hall
848 M Street, Fresno CA

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

7 BRN and EMS credits provided

Community Medical Centers is accredited by the Institute
for Medical Quality/California Medical Association
(IMQ/CMA) to provide continuing medical education for
physicians. Community Medical Centers designates this
live activity for a maximum of 7 AMA PRA Category 1
Credit(s)™. Physicians should claim only the credit
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the activity. This credit may also be applied to the CMA
Certification in Continuing Medical Education

For more information, phone:
(559) 459-5130
AGENDA: SCHEDULE OF EVENTS

0700-0800  Registration/Breakfast/Vendor Booths
0800-0815  Welcome and Introduction
            Lois Blough, RN
0815-0915  Active Shooter
            Alexander L. Eastman, MD, MPH, FACS, DABEMS
0915-0930  Break/Vendor Booths
0930-1030  Trends in Trauma Care
            Jim Davis, MD, FACS
1030-1130  The Intersection of Palliative Care and Trauma Surgery
            Patrick Macmillan, MD, FACP
1130-1230  Lunch/Vendor Booths
1230-1330  911: Ride of Your Life
            Dan Lynch, Director CCEMSA
1330-1430  Important Lessons to be Learned From the Patient’s View
            William Dominic, MD, FACS
1430-1445  Break/Vendor Booths
            Raffle Drawing
1445-1545  Clearing the Pediatric C-Spine
            Michael Allshouse, DO, FACS, FAAP
1545-1645  Coordination of Care in Orthopaedic Trauma: Pre-hospital to the Operating Room
            Jason Davis, MD
1645-1700  Closing Remarks

DISCLOSURES
Speakers: Dr. James Davis, Dr. Alexander Eastman, Dr. Patrick Macmillan, Dan Lynch, Dr. William Dominic, Dr. Michael Allshouse, Dr. Jason Davis, and Lois Blough, RN have no commercial disclosures to make. Activity Director James Davis and Activity Planner Rachel Van Noy have no commercial disclosures to make.
PSYCHIATRY GRAND ROUNDS

“ADHD”

Christine Obata, MD
HS Assistant Clinical Professor
UCSF Fresno Medical Education Program

Thursday, May 25, 2017
UCSF Fresno Center, Room 116 (Fresno St. and Divisadero)
4:00 P.M. – 5:00 P.M.

Target Audience: Psychiatry department faculty, residents & community mental health professionals

Objectives: After attending this lecture:
1. Attendees will gain competency in delivering patient care utilizing cutting edge clinical practices and educational techniques to use in patient practice.
2. Attendees will gain proficiency in interdisciplinary examination and collaboration in the care of a diverse population of patients.
3. Attendees will develop intellectual rigor and discipline in evaluating new treatments and techniques in order to achieve better outcomes when treating patients.
4. Attendees will be better able to apply current guidelines for practice based learning and improvement in patient care.

Christine Obata, MD; Program Director, Craig Campbell, MD; and Planner, Breana Contreras, have no relevant commercial relationships to disclose.

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.
Department of Surgery
Vascular Surgery Conference
May 30th, 2017
7:30a.m, Dept. of Surgery Conf. Rm, 1st Floor

Yan Cho, MD
Topic TBD

Target Audience: CMC surgical faculty, resident and internationalist in radiology and cardiology

Objectives:

**Learn and better understand the pathophysiology of disease processes and incorporate into improved patient care, including health disparities present within our patient population.

**Will more proficiently diagnose endovascular and open surgical management of said disease processes.

**Apply in practice current clinical evidence based medicine for objective and better management of patient care, improved outcomes and efficient use of resources.

Program Director Kamell Eckroth-Bernard, MD, and Program Planner Milena Ooon have no relevant commercial relationships to disclose.

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PosterMyWall.com
Thursday, June 1, 2017
8:00-9:00 a.m.

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

Principal Discussant
Dr. Alok Kumar Neonatologist
Dr. Athira Nair, Pediatric Cardiologist

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 in identifying and treating blue babies
2) Gain insight into the physiologic changes that occur with blue babies
3) Learn key concepts of strategies in caring for blue babies

1 CME will be offered
Provider approved by the California Board of Registered Nursing, Provider Number 00091 for 1 Contact Hour
RSVP is not required and Breakfast will be provided

Program Director Dr. A. Kumar and Program Planner Rebecca Avila have no relevant commercial relationships to disclose.

This is an activity offered by Community Medical Centers, a CMA-accredited provider.
Records of attendance are based on sign-in registration and are maintained only for Community Medical Centers staff members who are credentialed as an MD, DO, CNM, NP, or PA.

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**GI UPDATE**

**“Therapeutic Endoscopic Ultrasound”**

**Shreyas Saligram, MD**

Dr. Shreyas Saligram, M.D., MRCP, graduated from Sri Devaraj Urs Medical School in India. Thereafter, he moved to England and completed his residency in Internal Medicine from Royal Liverpool University Hospital. During his sub specialization training in Gastroenterology from Poole Hospital of Wessex Deanery, he received his membership from the prestigious Royal College of Physicians (MRCP). Thereafter Dr. Saligram moved to USA and underwent training in Internal Medicine from University of Pittsburgh Medical Center. He completed his sub specialization in Gastroenterology from Kansas University Medical Center and Advanced Endoscopy Training from Moffitt Cancer Center – University of South Florida.

Dr. Saligram joined VA Central California Healthcare System and is a faculty of UCSF Fresno. He is currently an Assistant Professor of Clinical Medicine in the Department of Medicine specializing in Interventional Gastroenterology. He has presented in various international conferences and has several published articles.

**Learning Objectives**

Upon completion of this activity, participants will:

1) Learn the indications for therapeutic EUS and apply this knowledge to one’s practice
2) Describe the existing techniques and utility of therapeutic EUS treatment options to improve delivery of patient care
3) Review the emerging techniques in therapeutic EUS towards achieving better patient outcomes

**Disclosures:** Presenter Dr. Shreyas Saligram, Program Director Dr. Robert Libke, and Planner Debbie Wagner have no relevant commercial relationships to disclose.

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For more information: (559) 459-3821 | dwagner@fresno.ucsf.edu
San Joaquin Valley
Geriatrics Interdisciplinary Group

ACHY BREAKY BONES;
BRACE YOURSELF FOR OLD BACKS!

Enhancing the prevention and treatment of Osteoporosis and pain sequela by maximizing function while minimizing risk

Wednesday, June 14, 2017
Marcus Radin Conference Room at Clovis Community Medical Center
5:30 pm: Dinner and Socializing
6 pm - 8 pm: Keynote Speaker & Interdisciplinary Group Discussion

Keynote Speaker: Joseph Hawkins, MD

Interdisciplinary Panel: Jonathan Grossman, MD
Deborah Walker, PT, DPT, OCS, GCS, CEEAA
Christopher Foley, PharmD

Moderators: Alex Sherriffs, MD, UCSF Fresno, Alzheimer’s & Memory Center
Adriana Padilla, MD, Family and Community Medicine, UCSF Fresno
Eliana Troncale, Injury Prevention Specialist-Trauma Program CRMC

Objectives:
• Describe and Apply appropriate screening tests for Osteoporosis to patients at risk
• Educate patients about prevention tools for Osteoporosis across the lifespan
• Improve treatment options for pain management from the sequela of Osteoporosis

RSVP: Call (559) 459-4450 or email etroncale@communitymedical.org

Accreditation: Community Medical Centers is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians.
Community Medical Centers designates this live activity for a maximum of 2.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
This credit may also be applied to the CMA Certification in Continuing Medical Education. Certificates available upon signing in.

Disclosures: Activity Directors, Adriana Padilla and Eliana Troncale have no disclosures; Moderator, Alex Sherriffs, MD has no disclosures; Speaker Joseph Hawkins, MD has no disclosures; Interdisciplinary Panel, Jonathan Grossman, MD, Deborah Walker, PT and Christopher Foley, PharmD has no disclosures.
Community Regional Medical Center’s
Lung Nodule Program Presents:
THE 6TH ANNUAL LUNG SYMPOSIUM
DIAGNOSTIC REFORM
IN LUNG NODULES

Diagnostic Dilemma:
CT Screening and Management of Lung Nodules

SATURDAY, SEPTEMBER 23, 2017 | 8 a.m. to 1:30 p.m.
Registration and breakfast at 7:30 a.m. | Interactive lunch at noon

UCSF Fresno Center for Medical Education & Research | Auditorium
155 N. Fresno Street – corner of Fresno and Divisadero streets

For more information or to RSVP call 559.451.3660 or email
gdeleon2@CommunityMedical.org

TOPICS:
• Advances in Rapid Diagnosis of Lung Cancer and Lung Cancer Survivorship
• Diagnostic Complexity in Coccidioidomycosis Lung Nodules
• Echo-Endoscopic Lymph Node Biopsies and Lung Cancer Staging
• Low Dose CT Screening for Early Diagnosis of Lung Cancer
• Minimally Invasive Video-Assisted Thoracoscopic Surgery for Lung Cancer
• CyberKnife: A Newer Treatment Options in Lung Cancer
• Advances and Newer Treatment Options in Lung Cancer
May 2017

May 4
No Grand Rounds – Resident Open Meeting

May 11
M&M Presentation

May 18
“The Intersection of Palliative Care Boulevard and Psychiatry Lane”
Patrick J, Macmillan, MD
HS Associate Clinical Professor
Chief of Hospice and Palliative Care
UCSF Fresno Medical Education Program

May 25
TBD
Chris Obata, MD
HS Assistant Clinical Professor
UCSF Fresno Medical Education Program

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The Department of Surgery
SURGICAL GRAND ROUNDS
May 2017

May 5, 2017   TBA
Dr. Yan Cho

May 12, 2017   Ethics III
Lynn Burnett PhD

May 19, 2017   Clinical Reasoning Workshop
Dr. Kenny Banh
(Mock Orals- PGY4-5)

May 26, 2017   Dr. Alexander Eastman- Trauma
Dr. Karipineni - Endocrinology

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

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

Objectives: At the end of the session the attendees will be able to:
• Demonstrate a commitment to carry out professional responsibilities while adhering to ethical principles
• Achieve increased competency and performance using newly integrated surgical techniques
• Improve the performance and competency of the faculty in teaching and increase the knowledge of resident trainees

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

Community Medical Centers is accredited by the Institute of 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)™.
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Department of Surgery
Critical Care/Trauma Conference

May 2017

Thursday - 12:00 p.m. – 1:00 p.m.
(2nd Thursday/Combined ED/Surgery Conference)
CRMC Sequoia East Conference Room

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Speaker</th>
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<tr>
<td>5/4/17</td>
<td>TBD</td>
<td>Melissa Reger, PharmD</td>
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<tr>
<td>5/11/17</td>
<td>Combined ED/Surgery Conference</td>
<td>Rachel Caiafa, MD - Video review</td>
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<td>5/18/17</td>
<td>TBD</td>
<td>Rachel Caiafa, MD</td>
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<tr>
<td>5/25/17</td>
<td>TBD</td>
<td>Victoria Sharp, DO</td>
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</tbody>
</table>

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

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

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

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.
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<tr>
<td>6:30-7:15 am</td>
<td>Ortho Surg.-Foot/Ankle/Hand SPOC</td>
<td>Orthopaedic X-Ray GR</td>
<td>Ortho Surg-Adult Recon GR</td>
<td>Chest Conference</td>
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<td>7:00-8:00 am</td>
<td>Ortho Surgery Conf. Rm.</td>
<td>7:00-8:00 am</td>
<td>Ortho Surgery Conf. Rm.</td>
<td>UCSF # 116</td>
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<tr>
<td>8:00-8:30 am</td>
<td>Medicine Grand Rounds</td>
<td>Cancer Conference</td>
<td>HPB Planning Conf.</td>
<td>Surgical Grand Rounds</td>
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<td>9:00-9:30 am</td>
<td>UCSF Fresno Auditorium</td>
<td>CRMC-Sequoia West Conf. Rm.</td>
<td>CRMC-Sequoia West Conf. Rm</td>
<td>CRMC-Sequoia West Conf. Rm</td>
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<tr>
<td>12:00-1:00 pm</td>
<td>Neurovascular Conference</td>
<td>Cardiac Cath &amp; Intervention</td>
<td>Emergency Medicine</td>
<td>Surgery Clinical Case Rev.</td>
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<tr>
<td>12:30-1:30 pm</td>
<td>CRMC</td>
<td>Brain Tumor/Cyberknife Conf.</td>
<td>Critical Care/Trauma</td>
<td>CRMC-Sequoia East Conf Rm</td>
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<td>CRMC-Sequoia West Conf. Rm</td>
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This credit may also be applied to the CMA Certification in Continuing Medical Education. Email: Ismith@communitymedical.org P: 559-459-1777 F: 559-459-1999
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<tr>
<td>22</td>
<td>6:30 - 7:15 am Ortho Surg.- Foot/Ankle/Hand SPOC</td>
<td>7:00 - 8:00 am Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>7:30 - 8:30 am Chest Conference UCSF # 116</td>
<td>7:00 - 8:00 am Orthopaedic GR UCSF Rm. 136</td>
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<td>7:30-8:30 am Vascular Surgery Conference CRMC-Surgery Conf. Rm.</td>
<td>7:30 - 8:30 am Cancer Conference CRMC-Sequoia West Conf. Rm</td>
<td>7:30 - 8:30 am HPB Planning Conf. CRMC-Sequoia West Conf. Rm</td>
<td>7:30 - 8:30 am Surgical Grand Rounds CRMC Sequoia West Conf. Rm</td>
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<tr>
<td>23</td>
<td>8:00 - 9:00 am Medicine Grand Rounds UCSF Fresno Auditorium</td>
<td>7:30 - 8:30 am Cardiac Cath &amp; Intervention Cath Lab (7 West)</td>
<td>8:00 - 12:00 pm Emergency Medicine UCSF Rm 136</td>
<td>8:30 - 9:30 am Surgery Clinical Case Rev. CRMC- Sequoia West Conf. Rm</td>
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<td>24</td>
<td>12:00 - 1:00 pm Neurovascular Conference CRMC-Sequoia East Conf Rm</td>
<td>12:00 - 1:00 pm Brain Tumor/Cyberknife Conf- CRMC- Sequoia West Conf. Rm</td>
<td>12:00 - 1:00 pm Critical Care/Trauma CRMC- Sequoia East Conf Rm</td>
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<td>25</td>
<td>12:30 - 1:30 pm Cardiology Grand Rounds CRMC-Sequoia West Conf Rm</td>
<td>12:00 - 1:00 pm Neuroscience Grand Rounds UCSF Rm 137</td>
<td>12:00 - 1:30 pm QPSC-CCMC CCMMC Palm Room</td>
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<td>26</td>
<td>4:00 - 5:00 pm Psychiatry GR UCSF Rm 116</td>
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<td>7:00 - 8:00 am Orthopaedic X-Ray GR Ortho Surgery Conf. Rm.</td>
<td>7:00 - 8:00 am Ortho Surg-Adult Recon GR Ortho Surgery Conf. Rm</td>
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<td>7:30-8:30 am Vascular Surgery Conference CRMC-Surgery Conf. Rm.</td>
<td>7:30 - 8:30 am Cancer Conference CRMC-Sequoia West Conf. Rm</td>
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<td>CRMC 4W NICU Conference Room</td>
<td>CCMC Emergency Medicine Committee</td>
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<td>9:00am</td>
<td>CCMC Outpatient Conference Room</td>
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<td>CRMC Sequoia East Room</td>
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<td>12:00pm</td>
<td>Neo/Peds Cross-Facility Peer Review</td>
<td>Neo/Peds Cross-Facility Peer Review</td>
<td>CRMC Sequoia East Room</td>
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<td>4:00pm</td>
<td>Blood Management Steering Committee</td>
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<td>CRMC Facility Executive Committee</td>
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<td>CRMC Robotic Steering Committee</td>
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<td>East Medical Plaza – Suite 210</td>
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<td>CCMC Medicine/Family Medicine/Psychiatry/Psychology/Physical Med &amp; Rehab</td>
<td>12:30pm</td>
<td>CRMC Pediatrics</td>
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<td>CRMC Pediatrics</td>
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<td>7:30am</td>
<td>CRMC Family Medicine</td>
<td>4:45pm</td>
<td>Quality Council</td>
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<td>UCSF Fresno 329</td>
<td>FHS Hockey Medical</td>
<td>CRMC Sequoia East Room</td>
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<td>7:30am</td>
<td>Pediatric Surgery Section</td>
<td>FHS Hockey Medical</td>
<td>Medical Executive Committee</td>
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<td>FHS Hockey Medical</td>
<td>CRMC Sequoia West Room</td>
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<td>12:30pm</td>
<td>Credentials Committee</td>
<td>6:00pm</td>
<td>FHSH Quality Practice Bariatric</td>
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<td>CRMC Lab Conference Room</td>
<td>CCMC Surgery</td>
<td>FHS Riverpark Conf A&amp;B</td>
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<td>12:30pm</td>
<td>FHS Hockey Medical</td>
<td>CRMC Surgery</td>
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<td>FHS Hockey Medical</td>
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<td>6:00pm</td>
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<td>MRCC Palm Room</td>
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<td>15</td>
<td>12:30pm</td>
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<td>6:00pm</td>
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<td>CCMC Multi Specialty Peer Review</td>
<td>East Medical Plaza – Suite 210</td>
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<td>9:00am</td>
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<td>East Medical Plaza – Suite 210</td>
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As of 4/25/17
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As of 4/25/17
Women in Medicine

Save the Date
Thursday, May 25, 2017
5 pm - 7:30 pm - Fort Washington Golf & Country Club
For more information 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

Limited cabins available for 3rd and 4th guest in the same stateroom – call to inquire
Nephrology Symposium 2017
Fresno Madera Medical Society
Clovis Veterans Memorial Auditorium - Clovis, CA
Saturday, June 3, 2017 - 8 am to 1 pm

SAVE THE DATE

Topics:
- Chronic Kidney Disease
- Inpatient Nephrology
- Hypertension and Management
- Drug Induced Kidney Failure
- Pediatric Nephrology Update
- Pregnancy and Kidney Failure
- Acid Base Electrolytes Update
- Diabetic/Diabetes Advances in Management
- Kidney Transplant

Speakers:
- Gabriel M. Danovitch, MD
- Hemant Dhingra, MD
- Ramanath Dukkipati, MD
- Richard Glassock, MD, MACP
- Apurv Khanna, MD

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 4 hours AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.