Applications Previously Approved
March 15, 2015 to April 14, 2015

**Internet CME - Enduring Materials**
Advances in Antithrombotic Therapy: Update on NOACs (1 Cat. 1)
Medical Errors: Promoting a Culture of Patient Safety (2 Cat. 1) [RENEWAL]

**Regularly Scheduled Series (RSS)**
The Golden Hour Initiative - Patient Safety Simulation (1.5 Cat. 1)

**Live CME**
04.09.15  Cardiovascular Conference Series: Vascular Medicine for Practicing Cardiologists: Peripheral Arterial Disease and Pulmonary Embolism (1 Cat. 1)
04.27.15  SMH Emergency Department Conference Series: Evaluating and Managing Pediatric Emergencies (1 Cat. 1)
04.28.15  Dentistry and Medicine Conference Series: "Digitally Driven Dentistry" - Utilizing Advancements in Science and Technology to Deliver Restorative Excellence (1 Cat. 1)
05.04.15  Bundle Up for Sepsis: A System Approach to Early Treatment and Management (2 Cat. 1)
05.05.15  Ninth Annual José “Pepe” Alvarez, Jr., M.D. Memorial Lecture on Vascular Disease: The New MCVI and the Future of Healthcare: The Good, the Bad and the Ugly (1 Cat. 1)
05.06.15  NICU Conference Series: The Tiny Preemie NICU Environment: A New Model of Care that Significantly Improves Outcomes (1.5 Cat. 1)
05.07.15  PSA Screening: Who, What, Why and When? (1 Cat. 1)
05.13.15  Conversations in Ethics: Ethical Concerns With the Critically Ill Disabled Patient (2 cat. 1)
05.19.15  Surgery Conference Series: Periampullary Pathology Diagnosis and Treatment (1 Cat 1)
05.26.15  ICD-10-CM: Change on the Horizon- What I Need to Know ( 1 Cat. 1/ each)
05.28.15  Stroke and PFO: To Close or Not to Close? (1 Cat. 1)
05.28.15  Cardiovascular Conference: Endovascular Treatment of Acute Stroke and Brain Aneurysms (1 Cat. 1)
09.18.15  Third Annual Foot and Ankle Symposium (4 Cat. 1)
10.09.15  Ob Gyn Conference Series: Breast Cancer Screening Guidelines (1 Cat. 1)
CME ACTIVITY TITLE: Advances in Antithrombotic Therapy: Update on NOACs

RECORDED: Thursday, March 5, 2015 TIME: 12 noon – 1 p.m. ONLINE COURSE
Valid Until: March 2017

CONFERENCE DIRECTOR: Marcus St. John, M.D. CREDIT HOUR(S) APPLIED FOR: _1_ Category 1

AMA/PRA LEARNING FORMAT:
- Live activity
- Enduring material
- Journal-based CME activity
- Test-item writing activity
- Manuscript review activity
- Internet point-of-care activity
- PI CME activity

TARGET AUDIENCE: Cardiologists, Interventional Cardiologists, Interventional Radiologists, General Internists, Primary Care Physicians, Intensivist, Pulmonologists, General Surgeons, Orthopedic Surgeons, Urologists, Gynecologists, Anesthesiologists, Emergency Medicine Physicians, Hospitalists, Nurses, Radiologic Technologists, Pharmacists and other interested healthcare providers.

Describe how the content of the activity is aligned with the target learners' current or potential scope of practice (C4). This activity addresses professional practice gaps relevant to physicians in the practice of cardiology. In addition, physicians that identify conditions and refer patients to a cardiologist, and those specialists to whom a cardiologist might refer for further evaluation or treatment, are also included in the target audience, as are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 40-50 CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5).
- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- Other (specify)_________

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check and explain.)
- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review
- Other (Specify): _____________________________

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)
Patient: ☑ Non-compliance ☑ Lifestyle ☑ Resistance-to-change ☑ Financial/Lack of Insurance
Physician: ☑ Non-compliance ☑ Resistance-to-change ☑ Communication Skills ☑ Financial
Resources: ☑ Institutional Capabilities ☑ Physician Practice Limitations ☑ Community Service Limitations
State of Science: ☑ Limited or No Treatment Modalities ☑ Limited or No Diagnostic Modalities
Other: ________________________________________________

PROFESSIONAL PRACTICE GAP (C2)
The difference between current practice (or performance) and optimal practice that we want to address with this education.

Provide reference(s) in this section that support the current practice, the optimal practice and/or the practice gap(s).

WHAT IS THE CURRENT PRACTICE? (What are doctors not doing or doing that needs to change?)
Current physician practice does not show consistent use of new anticoagulants in the prevention and treatment of DVT and management of acute coronary syndromes.

WHAT IS THE OPTIMAL PRACTICE? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
Physicians consistently include Factor Xa and DTIs in the prevention and treatment of DVT and management of acute coronary syndromes.

WHAT IS THE REASON FOR THIS GAP? (Educational needs.) (C2) What kind of gap is causing this deviation from optimal practice? Is this a ☑ Knowledge Gap? -or- ☑ Competence Gap? -or- ☑ Performance Gap? (Check one or more.)
REFERENCES
Published estimates of the incidence of diagnosing DVT in the United States range from 130,000 to 550,000 cases per year. Assuming that 42% of suspected DVT patients actually have the diagnosis, between 300,000 and 1,300,000 people undergo tests to diagnose DVT each year in the United States. (http://www.medscape.com).

Disadvantages with traditional anticoagulants (vitamin K antagonists and heparinoids) have led to the development on non-vitamin K antagonist oral anticoagulants (NOACs). These agents are set to replace the traditional anticoagulants in situations such as following orthopaedic surgery, in atrial fibrillation, and in the prevention and treatment of venous thromboembolism. Although superior to vitamin K antagonists and heparinoids in several aspects, NOACs retain the ability to cause haemorrhage and, despite claims to the contrary, may need monitoring. http://www.ncbi.nlm.nih.gov/pubmed/25562993

National Patient Safety Goal requirement 3E, which states "reduce the likelihood of patient harm associated with the use of anticoagulation therapy," requires prescriber education on anticoagulants. (http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/08_npsg_facts.htm) The Joint Commission has mandated educational programming to address this safety goal.

The precise number of people affected by DVT/PE is unknown, but estimates range from 300,000 to 600,000 (1 to 2 per 1,000, and in those over 80 years of age, as high as 1 in 100) each year in the United States. (http://www.cdc.gov/ncbddd/dvt/data.html)

The U.S. Food and Drug Administration today expanded the approved use of Xarelto (rivaroxaban) to include treating deep vein thrombosis (DVT) or pulmonary embolism (PE), and to reduce the risk of recurrent DVT and PE following initial treatment. (http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm326654.htm)

Traditional anticoagulant drugs, including unfractionated heparin and warfarin, have several limitations. Until now, vitamin K antagonists, such as warfarin, are the only clinically available oral anticoagulants. Chronic anticoagulation, however, is often cumbersome. Not only does the effect of warfarin differ among patients, it also varies over time in the same individual. Also, various intercurrent illnesses, drugs, and food can influence the level of anticoagulation. Therefore, repeated monitoring of the anticoagulant effect and careful adjustments of warfarin dosage is necessary. In spite of these adjustments oral anticoagulation is associated with an increased risk of bleeding complications. These caveats explain in part why over 40% of patients with AF do not receive anticoagulant treatment, and why physicians are reluctant to give prolonged anticoagulant treatment after ACS. (http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1768393)

DESIRE OUTCOMES (GOAL): Will this result in a change in ☐ Competence? -or- ☐ Performance? -or- ☐ Patient Outcomes**? (C3) *(NOTE: Do not select 'patient outcomes' unless there is an achievable measurement plan.) What is this CME Activity designed to change? What are the desired or expected outcomes?

Educational Objectives: Describe what doctors will be able to do after they leave the classroom. What is the "take-away" that they can put into practice. What new strategies, tools, treatment plans, approaches, etc. will they be able to implement, utilize, do, etc. as a result of attending this CME activity?

Upon completion of this conference, participants should be better able to:

- Analyze clinical studies of non-vitamin K antagonist oral anticoagulants (NOACs) and their impact on prevention and treatment of venous thromboembolism (VTE).
- Implement strategies for the proper management and reversal of NOACs.

Competencies: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

☐ Patient Care ☐ Medical Knowledge ☐ Interpersonal and Communications Skills
☐ Professionalism ☐ Systems-based Practice ☐ Practice-based Learning and Improvement

Evaluation Method(s): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) Planned method(s):

☒ Baptist Health CME Evaluation Form (post-Conference) ☐ Follow-up Survey
☐ Review of Hospital, Health System or Other Data ☐ Other

Outcomes Measurement: (List strategy measurement questions and/or other measurement plans.) (C11)

☒ As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?
If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: __________________________

FACULTY:
Alexander G. G. Turpie, M.D., FRCP, FACP, FACC, FRCPC
Professor of Medicine
McMaster University
Hamilton, Ontario, Canada

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
Yes ☐ No ☐ Medical Education Dept. Leadership and Staff ☐ Medical Education Committee ☐ Conference Director (see above) ☐ Others (i.e.: Conference Coordinator, Planning Group etc.) ☐

COMMERCIAL SUPPORT: The Baptist Health Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. Please indicate here (X) if support will come from the Foundation general medical education fund. ☐

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners? ☐ Yes ☐ No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? ☐ Yes ☐ No If yes, please describe the related CME program change. ________________.
And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (MedEd or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
☐ Process redesign or new protocol ☐ Reminders (Posters, mailings, email blasts) ☐ New order sheets ☐ Other tools or tactics Explain: In celebration of the Annual DVT Awareness Month, the VTE* Committee is sponsoring a VTE Prevention Fair on Wednesday, March 17 from 10:00a to 7:00p in the 5BCVI Conference Room- Side A. We will have stations set up with experts to answer questions, provide demos, forms, facts, and data.

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)
☐ Yes ☐ No Are we partnering with other organizations in a purposeful manner to achieve common interests?
☐ Yes ☐ No Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.
This lecture is part of the Anticoagulation ACT initiative which focuses on treatment of deep vein thrombosis (DVT) or other diagnoses that are best treated with anticoagulants. National Patient Safety Goal requirement 3E, which states "reduce the likelihood of patient harm associated with the use of anticoagulation therapy," requires prescriber education on anticoagulants. (http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/08_npsg_facts.htm) The Joint Commission has mandated educational programming to address this safety goal.
It is also in support of our Baptist Health Coumadin Clinic.

DATE REVIEWED: March 13, 2015 REVIEWED BY: ☒ Executive Committee ☐ Chairman

APPROVED: ☐YES ☐NO  ■ Credits: AMA/PRA Category 1 Credits: # 1
Continuing Psychology Education Credits: # ☐ N/A  ■ Continuing Dental Education Credits: # ☐ N/A

Test Questions

1. Factor Xa inhibitors include:
   a) rivaroxaban
   b) apixaban
   c) edoxaban
   d) betrixaban
2. The following FXa inhibitors are approved for stroke reduction in atrial fibrillation (AF):
   a) rivaroxaban
   b) apixaban
   c) edoxaban
   d) betrixaban
   e) all of the above
   f) a, b, and c

3. Factor Xa inhibitors inhibit:
   a) thrombin action
   b) thrombin generation
   c) contact activation
   d) fibrinolysis

4. Dabigatran is a(n):
   a) indirect thrombin inhibitor
   b) direct thrombin inhibitor
   c) a vitamin K antagonist
   d) a platelet inhibitor

5. NOACs (non-vitamin K oral anticoagulants) have:
   a) rapid onset of action
   b) short half lives
   c) renal excretion
   d) hepatic metabolism
   e) all of the above

6. NOACs are approved in the U.S. for:
   a) VTE prophylaxis in hip and knee replacement surgery
   b) treatment of acute VTE
   c) stroke reduction in AF
   d) treatment of ACS
   e) b and c
   f) a, b and c
   g) all of the above
March 2016- Online Course

CREDIT HOURS APPLIED FOR: Physician Course: 2 Cat. 1 Psychology Course: 2 Cat. 1

TARGET AUDIENCE: Physicians, Psychologists & Podiatrists licensed in the State of Florida. This activity addresses professional practice gaps relevant to physicians and psychologist who practice medicine in the State of Florida.

EXPECTED NUMBER OF ATTENDEES: 200+ CHARGE: No charge

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5).

- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED?

- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review
- Other (Explain): Florida Board of Medicine, Florida Board of Psychology, and Florida Board of Osteopathic Medicine & Florida Board of Podiatry relicensure requirements.

PROFESSIONAL PRACTICE GAP (C2)


WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is in physician:

- Knowledge? (They do not know that they need to be doing something.)
- Competence? (They do not know how to do it)
- Performance? (They know how to do it but are non-compliant - or are not doing it properly)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)

Will this result in a change in ☒ Competence? -or- ☒ Performance? -or- ☐ Patient Outcomes”? (Check all that apply.)

*(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

► On June 20, 2006 Governor Bush signed HB 699 into law. It takes effect on July 1, 2006. The new law provides that physicians (MDs and DOs) will now only be required to complete one (1) credit in HIV/AIDS - this must be done prior to the first renewal of the license, but once the physician has taken one (1) credit, he or she does not ever have to take it again. Most Florida physicians have already met this requirement and will not need to take the course again. The new law provides that physicians (MDs and DOs) will now only be required to complete two (2) credits in Domestic Violence every third biennial renewal, beginning with renewals following July 1, 2006. The HIV/AIDs and Domestic Violence courses will no longer be required prior to initial licensure. For initial licensure, the only requirement will be two (2) credits in Prevention of Medical Errors. The biennial requirement for Prevention of Medical Errors also remains the same – MDs and DOs must complete two (2) credits during each two-year licensure cycle. End of life and palliative care courses can no longer be used in lieu of the HIV/AIDS course or Domestic Violence course.

EDUCATIONAL OBJECTIVES: SEE ATTACHED
FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)

Patient: ☐ Non-compliance ☐ Lifestyle ☐ Resistance-to-change ☐ Financial/Lack of Insurance

Physician: ☒ Non-compliance ☒ Resistance-to-change ☒ Communication Skills ☐ Financial

Resources: ☒ Institutional Capabilities ☒ Physician Practice Limitations ☐ Community Service Limitations

State of Science: ☐ Limited or No Treatment Modalities ☐ Limited or No Diagnostic Modalities

Other: ____________________________

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

☐ Patient Care ☒ Medical Knowledge ☒ Interpersonal and Communications Skills

☐ Professionalism ☒ Systems-based Practice ☒ Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

☐ Baptist Health CME Evaluation Form (post-Conference) ☐ Follow-up Survey

☐ Review of Hospital, Health System or Other Data ☒ Other Post-test and evaluation

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)

► As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice? _______________________________________________________________________

► If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: _______________________________________________________________________

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State)

See attached.

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).

Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)

☐ Yes ☐ No ☐ Medical Education Dept. Leadership and Staff ☐ Medical Education Committee

☐ Conference Director (see above) ☐ Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. ☐ Indicate here if support will come from the Foundation general medical education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners? ☐ Yes ☒ No ☐ If ‘yes’, list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission?

☐ Yes ☒ No If yes, please describe the related CME program change. ____________________________

And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (MedEd or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.

☐ Process redesign or new protocol ☐ Reminders (Posters, mailings, email blasts) ☐ New order sheets

☐ Other tools or tactics

Explain: _______________________________________________________________________________

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)

☐ Yes ☒ No Are we partnering with other organizations in a purposeful manner to achieve common interests?

☐ Yes ☒ No Are we collaborating with internal departments in a purposeful manner to achieve common interests?

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. ____________________________________________________________________________

DATE REVIEWED: March 24, 2015 REVIEWED BY: ☒ EXECUTIVE COMMITTEE ☐ CHAIRMAN

APPROVED: ☐ YES ☒ NO 2.0 Category 1 each

Patient Safety: Prevention of Medical Errors
Online & DVD Courses

FACULTY

Paul A. Gluck, M.D.
Obstetrician/Gynecologist
Baptist and South Miami Hospitals
Chair of the Board, National Patient Safety Foundation
Past Chair, Quality Improvement and Patient Safety Committee
American College of Obstetricians and Gynecologists
Associate Clinical Professor of Medicine
Department of Obstetrics & Gynecology
University of Miami Miller School of Medicine
Miami, Florida

Barry M. Crown, Ph.D., J.D.
Psychologist, Baptist, Doctors, Homestead and South Miami Hospitals

Yvonne Zawodny, RN, LHRM, CPHRM
Corporate Assistant Vice President, Risk Management

Physician Course Learning Objectives & Outline

Upon completion of this conference, participants should be better able to:

• Describe the incidence of medical errors and the effect on patient safety.
• Identify the most commonly misdiagnosed conditions during the previous biennium.
• Identify processes to reduce and prevent errors.
• Recognize error-prone situations/processes.
• Identify factors that impact the occurrence of errors.
• Define the process and benefit of multicausal analysis (root causes).
• Delineate Baptist Health policies and procedures for reporting medical errors.
• Identify safety needs of special populations.
• Discuss how we can partner with patients/families to prevent medical errors.
• Explain what each of us can do to protect patients and ourselves from accidental injury.
• Explain the role of the Institutes of Medicine (IOM) task forces on improving the quality of healthcare in America.
• Identify 3 strategies to reduce medication errors.

Outline

I. Introduction
   A. The program and our mission
   B. Florida Department of Health Requirements
      a. Five Most Misdiagnosed Conditions Previous Biennium:
         The five most misdiagnosed conditions during the previous biennium
         1. Cancer
         2. Neurological conditions
         3. Acute abdomen related conditions
         4. Timely diagnosis of surgical complications
         5. Diagnosis of pregnancy related conditions
      (Information accurate as of July 30, 2013)

II. Prevalence of Errors in Medicine

III. Reasons for Medical Errors

IV. Safe Systems

V. Principles for Safety & Patient Engagement

VI. Medication Safety

VII. Risk Management

Psychologist Course

Learning Objectives and Course Outline

CE-BROKER Approved Course Number: 20-374418

Florida Board of Psychology approved the course content in 2/04/2013. According to Florida Board of Psychology regulations the approved course content can not be altered. Any alterations to the following will require the course to be resubmitted to the Board for approval.

Upon completion of this conference, participants should be better able to:
Describe the incidence of medical errors and the effect on patient safety.

Explain the role of the Institutes of Medicine (IOM) task forces on Improving the Quality of Healthcare in America.

Recognize error-prone situations, processes and factors, and create a culture of safety in order to reduce errors.

Identify processes to approach error reduction and prevention in order to improve patient outcomes.

Define the process and benefit of root cause analysis.

Delineate Baptist Health policies and procedures for reporting medical errors.

Identify safety needs of special populations.

Discuss areas within the mental health practice that carry the potential for “medical” errors including improper diagnosis; failure to comply with abuse reporting laws; inadequate assessment of potential for violence; failure to detect medical conditions presenting as a psychological/psychiatric disorder.

Introduction /Module: Introduction
A. The program and our mission
B. An interactive approach
C. Legal and corrective approaches

I. The Problem (NEW MODULE)/Module: Prevalence of Errors in Medicine
A. What is a medical error?
B. Magnitude of the problem
C. Institute of Medicine (IOM) task forces
D. Impact of IOM on healthcare delivery

III. Types of Errors/ Module: Reasons for Medical Errors
A. Human errors and system errors
B. How errors happen
C. Prevention and risk analysis
D. TJC standards

IV. Patient Safety Myths (+Addendum)/ Module: Myths

V. Putting Safety First – Reduction of Error /Module: Principles of Safety & Patient Engagement
A. Creating a culture of safety and concern
B. Putting the puzzle together
C. Building in change and its monitoring
D. Patient engagement & Health literacy (Addendum)

VI. Safety Needs of Special Populations /Module: Mental Health Concerns
A. Those with psychological/psychiatric needs

VII. Patients with Psychological, Psychiatric or Behavioral Problems/Module Mental Health Concerns
A. Assessing suicide and homicide risk
B. Child abuse and its reporting
C. Domestic violence and abuse
D. Elder abuse
E. Alcohol abuse
F. Substance abuse

VIII. Interventions and Confidentiality/Module: Mental Health Concerns
A. The duty to warn
B. Florida’s Baker Act
C. Special situations in the general medical hospital

IX. Errors in the Office /Module: Mental Health Concerns
A. Medication problems
B. Practice management issues
C. Treatment issues and concerns

X. Improving Outcomes /Module: Medication Safety
A. Reducing risk
B. Medication errors
C. Surgical errors
D. Psychodiagnostic errors
E. Psychotherapy/counseling/relationship errors
F. Falls
G. Restraints
H. Infections
I. Equipment problems
J. Delays in the delivery of care
K. Keeping the care team informed
L. Improving performance

XI. Root Cause Analysis – Identifying Error Risk Situations/Module: Risk Management
A. Risk management in the hospital setting
B. Mandatory reporting situations
C. Response Mechanisms
Online Course Module Outline

Outline should be used for course planning purposes only. Above approved content is covered in these Modules. Please only use above outline when documentation for course content is requested.

Introduction
Prevalence of Errors in Medicine
Reasons for Medical Errors
Myths
Principles of Safety
Mental Health Concerns
Medication Safety
Risk Management
Conclusion

Applicable Credits: AMA Category 1 ☒ • Continuing Psychology Education ☐ • Continuing Dental Education ☐

CME ACTIVITY TITLE: The Golden Hour Initiative

DATE: April 2015 to April 2017

TIME: Courses scheduled through PSSL, 786-596-1493 or Simulation@BaptistHealth.net

LOCATION: Patient Safety Simulation Lab, Baptist Hospital
CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1 each

CONFERENCE DIRECTOR: William Smalling, M.D.

CONFERENCE COORDINATOR: Karen P. Baez, BS-HSA, R.N., CEN

AMA/PRA LEARNING FORMAT:
☒ Live activity ☐ Test-item writing activity ☐ Internet point-of-care activity
☐ Enduring material ☐ Manuscript review activity
☐ Journal-based CME activity ☐ PI CME activity

TARGET AUDIENCE: Neonatologists, Obstetricians, Labor and Delivery Nurses and NICU Nurses

EXPECTED NUMBER OF ATTENDEES: 80-90 CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
☒ Live ☐ Question & Answer ☐ Enduring Material
☐ Didactic Lecture ☐ Case Studies ☐ Internet-Home Study
☐ ARS ☐ Panel ☐ Other: Simulation Lab Training

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
☒ Best practice parameters ☒ Consensus of experts
☒ Joint Commission initiatives ☒ Mortality/morbidity statistics
☒ National Pt Safety Goals ☒ National/regional data
☒ Other (Explain): _____________________________

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18)

Patient: ☐ Non-compliance ☒ Lifestyle ☒ Resistance-to-change ☐ Financial/Lack of Insurance
Physician: ☒ Non-compliance ☒ Resistance-to-change ☒ Communication Skills ☒ Financial
Resources: ☐ Institutional Capabilities ☒ Physician Practice Limitations ☐ Community Service Limitations
State of Science: ☐ Limited or No Treatment Modalities ☒ Limited or No Diagnostic Modalities
Other: _____________________________

PROFESSIONAL PRACTICE GAP (C2)
The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
► There is a current nationwide “Golden Hour” initiative regarding the care of extremely premature births. This push for standardizing the care, equipment and even the communication of the team when handling low birth weight babies at birth will improve patient outcomes. Healthcare teams at Baptist Health need to learn to implement the Golden Hour strategy during a crisis while performing the technical skills needed to provide effective resuscitation for a newborn.

WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like'?)
► The interdisciplinary healthcare team works cohesively to implement the golden hour intervention to improve quality of care in extremely low birth weight infants.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
☐ Knowledge (Doctors do not know that they need to be doing something.)
☒ Competence (Doctors do not know how to do it)
☒ Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☒ Competence? -or- ☒ Performance? -or- ☐ Patient Outcomes**? (Check all that apply.) *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)*
► Healthcare teams communicate effectively during a crisis and successfully implement golden hour strategy to improve quality of care of the extremely low birth weight infants.
The "Golden Hour," the first 60 minutes following the birth of an extremely premature infant, are perhaps the most important of his or her life. Specific attention to respiratory management, temperature regulation, and vascular access, undertaken via a standardized approach may have immeasurable long-term benefits, and make the difference between life and death. (The Neonatal Golden Hour – intervention to improve quality of care of the extremely low birth weight infant. Reuter S. S D Med. 2014. Oct; 67(10):397-403.)

The impact of implementation of a Golden Hour Protocol in a level III neonatal intensive care unit (NICU) for infants delivered at less than 28 weeks gestation was examined, with a focus on admission temperature, admission glucose, and time to the initiation of an intravenous glucose and amino acid administration. As part of a quality initiative project, data were collected before and after the implementation of the Golden Hour Protocol for infants born at less than 28 weeks gestational age from May 2008 through December 2011. Desired outcomes were admission axillary temperature within a range of 36.5°C to 37.4°C, admission glucose more than 50 mg/dL, and the initiation of a glucose and amino acid infusion within 1 hour of birth. Key components of the Golden Hour included the use of a protocolized script, which clearly defined the roles of the delivery room personnel, placing the infant in a polyethylene bag to prevent heat loss, the application of the isolette skin temperature probe within 10 minutes of age, and insertion of umbilical catheters before moving the infant from the resuscitation area to the NICU. Data were collected on 225 infants born less than 28 weeks gestation: 106 in the preprotocol group and 119 in the postprotocol group. Differences between the 2 groups were not statistically significant for birth weight and gestational age. There was a statistically significant difference in the number of infants with an admission temperature in-range (36.5°C-37.4°C) between the preprotocol and postprotocol infants (28.3% vs 49.6%; P = .002). There was a statistically significant difference in the incidence of admission glucose greater than 50 mg/dL between the pre- and postprotocol groups (55.7% vs 72%; P = .012). There was a highly statistically significant difference in the number of post-Golden Hour Protocol infants who received an intravenous administration of glucose and amino acids within 1 hour of life compared with the preprotocol group (61.3% vs 7%; P = 0.001). Our results suggest that the implementation of the Golden Hour Protocol can significantly improve the stabilization of infants delivered less than 28 weeks gestation. (Initial Resuscitation and Stabilization of the periviable neonate: the Golden Hour approach. Wyckoff MH. Semin Perinatol. 2014 Feb; 38(1):12-16.)


The Golden Hour. Giving high risk neonates the best possible start. Dunn MS. AAP Perinatal section website.


EDUCATIONAL OBJECTIVES
Upon completion of this conference, participants should be better able to:

- Identify the target population for implementation of the Golden Hour strategy.
- Explain the key elements of Golden Hour and how this strategy can improve outcomes.
- Demonstrate correct techniques for temperature regulation, ventilation and oxygenation saturation monitoring.
- Utilize effective teamwork and communication to manage a premature infant.

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

- Patient Care
- Medical Knowledge
- Interpersonal and Communications Skills
- Professionalism
- Systems-based Practice
- Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

- Baptist Health CME Evaluation Form (post-Conference)
- Follow-up Survey
- Review of Hospital, Health System or Other Data
- Other______________________

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)

- As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?
- If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so:

COURSE FACILITATORS & DEBRIEFERS
Maria Victoria Lopez-Beecham, M.D.
Medical Director, Baptist Health Patient Safety Simulation Lab

Karen P. Baez, BS-HSA, R.N., CEN
Manager, Patient Safety Simulation Lab

William Smalling, M.D.
Faculty, Baptist Health Patient Safety Simulation Lab

Margarita Hernandez, M.D.
Faculty, Baptist Health Patient Safety Simulation Lab

Ernesto Valdes, M.D.
Faculty, Baptist Health Patient Safety Simulation Lab

COURSE ASSISTANTS: Individuals that assist as confederates play a role in a scenario and assist with debriefing but are not full certified as faculty/debriefers.
To be determined.

CONTENT AREAS/SCENARIOS/TARGET AUDIENCE
SPECIALTIES: Neonatology
Scenarios: Golden Hour
Target Audience: Neonatologists, Obstetricians, Labor and Delivery Nurses and NICU Nurses

FORMAT AND SCENARIOS:
B: Introduction & Orientation (30 Minutes): Participants will be given a brief didactic on Crisis Resource Management principles and why they are important to patient safety. This is followed by an orientation of the simulation room layout and location of supplies. Participants will be asked to sign a confidentiality agreement stipulating they will not disclose and information regarding the scenarios presented.
B. Case Scenario: Participants will participate in one simulation scenarios that will take about fifteen to twenty minutes to complete.
C. Debriefing: A forty-five minute debriefing session will follow each scenario during which participants will review their performance with a course facilitator.
D. Handouts: Participants will be given a communication tools that reinforcnes SBAR and CUS techniques. These materials have helpful visual reminders regarding these patient safety techniques.

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).

- Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
- Yes See below- Non-clinical content
- No
- Non-clinical content (See below)
Non-clinical content: All activities that are considered non-clinical must be vetted by the Department Director. If there is no opportunity to affect the content of CME concerning the products or services of a commercial interest, then there can be no relevant financial relationships or conflicts of interest. Both the following statements must apply. Reference SOP “Disclosures for Activities with Non-Clinical Content” for further instructions and necessary steps to ensure compliance.

- CME Activity content is not related to products or services of commercial interests.
- CME Activity content is non-clinical.

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners? Yes No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? Yes No If yes, please describe the related CME program change. And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.

- Process redesign or new protocol
- Reminders (Posters, mailings, email blasts)
- New order sheets
- Other tools or tactics

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)

- Yes No Are we partnering with other organizations in a purposeful manner to achieve common interests?
- Yes No Are we collaborating with internal departments in a purposeful manner to achieve common interests?

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.

This meeting is planned in collaboration with the Neonatology Intensive Care Unit at Baptist Hospital to implement the Golden Hour protocol.

DATE REVIEWED: April 10, 2015 REVIEWED BY: Executive Committee Chairman
APPROVED: Yes No
Credits: AMA/PRA Category 1 Credits: # 1
Continuing Psychology Education Credits: # N/A
Continuing Dental Education Credits: # N/A

Applicable Credits: AMA Category 1 Continuing Psychology Education Continuing Dental Education
CME ACTIVITY TITLE: ICD-10-CM: Change on the Horizon- What I Need to Know

DATE/TIME/LOCATION: 5:30-7 p.m.  
Tuesday May 12th (BHM) – Lee Shimano presenter- 5MCVI →WEBEX  
Tuesday May 26th (BHM) – Debby Enfield presenter – Auditorium  
Tuesday June 9th (BHM) – Lee Shimano presenter - MCVI

CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 each

CONFERENCE DIRECTOR: Arturo Fridman, M.D.

AMA/PRA LEARNING FORMAT:
- Live activity
- Enduring material
- Journal-based CME activity
- Test-item writing activity
- Manuscript review activity
- PI CME activity
- Internet point-of-care activity

TARGET AUDIENCE: All Medical Staff

EXPECTED NUMBER OF ATTENDEES: 40-45 per session  
CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- Live
- Didactic Lecture
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- Other (Explain): National Conversion to ICD:10

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18)
- Patient: Non-compliance, Lifestyle, Resistance-to-change, Financial/Lack of Insurance
- Physician: Non-compliance, Resistance-to-change, Communication Skills, Financial
- Resources: Institutional Capabilities, Physician Practice Limitations, Community Service Limitations
- State of Science: Limited or No Treatment Modalities, Limited or No Diagnostic Modalities
- Other: The national transition from International Classification of Diseases, 9th Revision (ICD-9) to International Classification of Diseases, 10th Revision (ICD-10) has a significant impact on physicians daily inpatient practice and affects documentation for all procedures.

PROFESSIONAL PRACTICE GAP (C2)
The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap. ► Beginning October 1, 2015, the U.S. Department of Health and Human Services (HHS) will use a new coding system, the International Classification of Diseases, 10th Revision (ICD-10). The new codes will be required for inpatient claims. Physicians are not familiar with impact coding changes will have to their documentation for inpatient care.

WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?) ► Practitioners appreciate the impact of new ICD-10 coding system changes and implement improvements to their documentation which will lead to enhanced disease management.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
- Knowledge (Doctors do not know that they need to be doing something.)
- Competence (Doctors do not know how to do it)
- Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in □ Competence? -or- □ Performance? -or- □ Patient Outcomes*? *(Check all that apply.)

► Physicians implement documentation changes for inpatient care for enhanced disease management.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

► Everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition to ICD-10. The transition will impact Baptist Health's clinical, financial and operational areas and require business and system changes. The new coding system will bring greater clinical detail and specificity to describing diagnoses and procedures, an increased number of codes and a different organization, structure and code composition.

The new coding system will improve data used to measure quality and safety and give healthcare organizations a better understanding of medical conditions and outcomes. ICD-10 also will help organizations operate more efficiently, design better payment systems and improve how insurance claims are processed.

EDUCATIONAL OBJECTIVES

Upon completion of this conference, participants should be better able to:

- Explain how the new coding system will improve data used to measure quality and safety and give healthcare organizations a better understanding of medical conditions and outcomes.
- Discuss how ICD-10-CM will help organizations operate more efficiently, design better payment systems and improve how insurance claims are processed.

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

- Patient Care
- Medical Knowledge
- Interpersonal and Communications Skills
- Professionalism
- Systems-based Practice
- Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

- Baptist Health CME Evaluation Form (post-Conference)
- Follow-up Survey
- Review of Hospital, Health System or Other Data
- Other ____________________________

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)

► As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?

► If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: ________________________________

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

Litriana Shimano, CPC, CMDP, CCP, PCS
AHIMA Approved ICD-10-CM/PCS Trainer
HIM Education Consultant, ICD-10 & Industry-Driven Solutions
Optum360

OR- See dates above which indicate who will be speaking.

Debby Enfield
Senior Consultant, ICD-10 & Industry-Driven Solutions
Optum360

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).

Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)

- Yes □ No □ CME Dept. Leadership and Staff □ CME Committee
- Conference Director (see above) □ Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. □ Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners? □ Yes □ No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.
OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission?

☐ Yes  ☒ No  If yes, please describe the related CME program change. _________________________

And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.

☐ Process redesign or new protocol  ☐ Reminders (Posters, mailings, email blasts)  ☐ New order sheets

☐ Other tools or tactics

Explain: _______________________________________________________________________________

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)

☐ Yes  ☒ No  Are we partnering with other organizations in a purposeful manner to achieve common interests?

☒ Yes  ☐ No  Are we collaborating with internal departments in a purposeful manner to achieve common interests?

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. This meeting is planned in collaboration with the Health Information Management Department.

DATE REVIEWED:  March 19, 2015  REVIEWED BY:  ☐ Executive Committee  ☐ Chairman

APPROVED:  ☐ YES  ☒ NO  □ Credits: AMA/PRA Category 1 Credits: # 1

Continuing Psychology Education Credits: #  □ N/A  □ Continuing Dental Education Credits: #  □ N/A

Applicable Credits: AMA Category 1  □  □ Continuing Psychology Education  □  □ Continuing Dental Education  □

CME ACTIVITY TITLE: Cardiovascular Conference Series: Vascular Medicine for Practicing Cardiologists: Peripheral Arterial Disease and Pulmonary Embolism

DATE:  Thursday, April 9, 2015  TIME:  12 noon – 1 p.m.
LOCATION:  BHM, 5MCVI  
VC to SMH MCVI 2nd Floor Conf Room, HH Mango Room and WKBH Cl 4&5  
And Live Webcast

CONFERENCE DIRECTOR:  Marcus St. John, M.D.

AMA/PRA LEARNING FORMAT:
- Live activity
- Enduring material
- Journal-based CME activity
- Test-item writing activity
- Manuscript review activity
- Internet point-of-care activity
- PI CME activity

TARGET AUDIENCE:
Cardiologists, Interventional Cardiologists, Interventional Radiologists, General Internists, Primary Care Physicians, Intensivist, Pulmonologists, General Surgeons, Orthopedic Surgeons, Urologists, Gynecologists, Anesthesiologists, Emergency Medicine Physicians, Hospitalists, Nurses, Radiologic Technologists Pharmacists and other interested healthcare providers.

Describe how the content of the activity is aligned with the target learners' current or potential scope of practice (C4). This activity addresses professional practice gaps relevant to physicians in the practice of cardiology. In addition, physicians that identify conditions and refer patients to a cardiologist, and those specialists to whom a cardiologist might refer for further evaluation or treatment, are also included in the target audience, as are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES:  40-60  
CHARGE:  0

TYPE OF MEETING (FORMAT):  Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED?  (Check all that apply and explain in professional practice gap.)
- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- Other (Explain): _____________________________

FACTORs OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)

Patient:  
- Non-compliance
- Lifestyle
- Resistance-to-change
- Financial/Lack of Insurance

Physician:  
- Non-compliance
- Resistance-to-change
- Communication Skills
- Financial

Resources:  
- Institutional Capabilities
- Physician Practice Limitations
- Community Service Limitations

State of Science:  
- Limited or No Treatment Modalities
- Limited or No Diagnostic Modalities

Other: _____________________________

PROFESSIONAL PRACTICE GAP (C2)
The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**?  What are physicians doing (or not doing) that needs to change? Describe the practice gap.
- Physicians do not consistently apply evidence-based recommendations for the evaluation and management of diseases of the thoracic aorta.

WHAT IS THE OPTIMAL PRACTICE**?  (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
- Physicians apply evidence-based recommendations for the evaluation of PAD and initiate appropriate treatment.

WHAT IS THE REASON FOR THIS GAP?  Indicate if the gap is related to either/or:
- Knowledge (Doctors do not know that they need to be doing something.)
- Competence (Doctors do not know how to do it)
- Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)
**EDUCATIONAL OBJECTIVES**

Upon completion of this conference, participants should be better able to:

- Implement evidence-based recommendations for the diagnosis and management of peripheral arterial disease.
- Effectively identify cases of peripheral arterial disease, review diagnostic and initiate appropriate treatment.
- Implement evidence-based risk-stratification of patients presenting with acute pulmonary embolism, and initiate appropriate treatment.

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**COMPETENCIES:** *What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)*

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Medical Knowledge</th>
<th>Interpersonal and Communications Skills</th>
<th>Professionalism</th>
<th>Systems-based Practice</th>
<th>Practice-based Learning and Improvement</th>
</tr>
</thead>
</table>

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**EVALUATION METHOD(S):** Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11)

- Baptist Health CME Evaluation Form (post-Conference)
- Follow-up Survey
- Review of Hospital, Health System or Other Data
- Other

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**OUTCOMES MEASUREMENT:** (List strategy measurement questions and/or other measurement plans.) (C11)

- As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?

- If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so.
FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)
Ian Del Conde Pozzi, M.D.
Cardiologist
Baptist, Doctors and Homestead Hospitals

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).
Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
☐ Yes ☐ No ☑ CME Dept. Leadership and Staff ☑ CME Committee
☐ Conference Director (see above) ☐ Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. ☑ Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on ‘overcoming, addressing, or removing barriers to physician change’ applicable to our learners? ☐ Yes ☑ No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? ☐ Yes ☑ No If yes, please describe the related CME program change. ____________________________________________
And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
☐ Process redesign or new protocol ☑ Reminders (Posters, mailings, email blasts) ☐ New order sheets
☐ Other tools or tactics Explain: ______________________________________________________________

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)
☐ Yes ☑ No Are we partnering with other organizations in a purposeful manner to achieve common interests?
☐ Yes ☑ No Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. This activity was planned in collaboration with the Miami Cardiac & Vascular Institute.

DATE REVIEWED: March 24, 2015 REVIEWED BY: ☑ Executive Committee ☐ Chairman
APPROVED: ☐ YES ☐ NO  Credits: AMA/PRA Category 1 Credits: # 1
Continuing Psychology Education Credits: # N/A  Continuing Dental Education Credits: # N/A

DATE: Tuesday, April 28, 2015  TIME: 6:30 p.m. – 7:30 p.m.
LOCATION: Miami Cardiac and Vascular Institute  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 and 1 Dental CE

CONFERENCE DIRECTOR:  Fred Pedroletti, DMD

AMA/PRA LEARNING FORMAT:
☒ Live activity
☐ Test-item writing activity
☐ Internet point-of-care activity
☐ Enduring material
☐ Manuscript review activity
☐ PI CME activity
☐ Journal-based CME activity

TARGET AUDIENCE: Dentists, dental specialists, pain management, neurologists, ENT, family medicine, pediatrics, and other healthcare practitioners.

In addition, describe how the content of the activity is aligned with the target learners’ current or potential scope of practice (C4). This activity addresses professional practice gaps relevant to physicians in the practice of dentistry. In addition, physicians that identify conditions and refer patients to Oral & Maxillofacial Surgeons, and those specialists to whom a dentist might refer for further evaluation or treatment, are also included in the target audience, as are related members of the hospital care team.

EXPECTED NUMBER OF ATTENDEES: 20-30 CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
☒ Live
☒ Didactic Lecture
☒ Question & Answer
☐ ARS
☒ Case Studies
☐ Panel
☐ Enduring Material
☐ Internet-Home Study
☐ Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
☒ Best practice parameters
☒ Consensus of experts
☐ Joint Commission initiatives
☐ Mortality/morbidity statistics
☐ National Pt Safety Goals
☐ National/regional data
☐ Other (Explain): _____________________________
☒ New or updated policy/protocol
☐ Patient care data
☐ Peer review data
☒ Process improvement initiatives (C16 & 21)
☒ Research/literature review

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18)
Patient: ☐ Non-compliance ☑ Lifestyle ☑ Resistance-to-change ☐ Financial/Lack of Insurance
Physician: ☘ Non-compliance ☒ Resistance-to-change ☒ Communication Skills ☒ Financial
Resources: ☒ Institutional Capabilities ☒ Physician Practice Limitations ☐ Community Service Limitations
State of Science: ☐ Limited or No TreatmentModalities ☐ Limited or No Diagnostic Modalities
Other: ____________________________________________________________________________

PROFESSIONAL PRACTICE GAP (C2)
The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
▶ Dentists use inefficient and time-consuming conventional methodologies to diagnose and treat patients. Dentists treating the edentulate patient may not consistently consider and/or clearly discuss all available options including newer technologies for treatment.

WHAT IS THE OPTIMAL PRACTICE**? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
▶ Dentists treating the edentulate patient consider and discuss all available options including newer technologies clearly outlining the advantages and disadvantages.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
☒ Knowledge (Doctors do not know that they need to be doing something.)
☒ Competence (Doctors do not know how to do it)
☒ Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or
improve as a result of this CME activity? (C3)
And will this result in a change in ☐ Competence? -or- ☐ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.) *(NOTE: If 'patient outcomes' is selected, there must be an achievable measurement plan.)
▶ Physicians and dentists will be better able to assess options and discuss recommendations with the edentulate patient so both can consider all available options for treatment. Physicians and dentists will be better able to explain the full spectrum of treatments – from complete denture therapy to mandibular implants – and outline the advantages and disadvantages.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
▶ Over the last 100 years, techniques and materials for restoring compromised teeth have evolved dramatically. Nowhere has this been more pronounced than in the field of implant dentistry. Clinicians now can provide patients with highly esthetic restorations, often in a significantly compressed time frame. Computer-aided design and computer-aided manufacturing (CAD/CAM) techniques have been transforming the dental field in parallel with these developments. Introduced to dentists in 1971, CAD/CAM techniques were used to create the first dental prototype in 1983, and the first crown was milled and installed in a mouth without any laboratory involvement in 1985. By 1998, customized implant abutments were being created with CAD/CAM technology. Because these are patient-specific, such abutments, like cast custom abutments, have the potential to provide improved peri-implant soft-tissue support, essential to achieving an optimal esthetic result. The CAD/CAM process moreover eliminates the inherent dimensional inaccuracies of waxing. http://www.readcube.com/articles/10.1111%2Fj.1708-8240.2011.00481.x?r3_referer=wol&tracking_action=preview_click&show_checkout=1&purchase_referrer=onlinelibrary.wiley.com&purchase_site_license=LICENSE_DENIED

The accuracy of conventional impression materials and stone dies has been a consistent challenge for clinicians. As an alternative, intraoral scanning technology has the potential to resolve this problem. This clinical report describes the step-by-step technique necessary to scan digitally coded healing abutments with an intraoral scanner and generate implant abutments and cement-retained restorations without the use of impression materials, dental stone, or implant impression copings and analogs. http://www.sciencedirect.com/science/article/pii/S0022391313000735

From treatment planning to design of definitive restorations, computers are changing the processes used to treat patients. Nobel Clinician, in conjunction with Nobel Procera, allows dentists to use these newer technologies to make treatment protocols more efficient and less time consuming, especially for complex implant single-tooth therapies. This suite of state of the art concepts allow for the easiest way to deliver restorative excellence to our patients. (From Dr. Rawal)

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:

- Recognize the importance of thorough diagnosis and treatment planning.
- Discuss and implement guidelines for proper patient selection, treatment planning, indications/contraindications and diagnosis with the end prosthetic result in mind.
- Assess the correct approach for provisional restoration.
- Review latest advancements in science and technology available for dental restoration.

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)
☑ Patient Care ☑ Medical Knowledge ☑ Interpersonal and Communications Skills
☐ Professionalism ☐ Systems-based Practice ☐ Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:
☐ Baptist Health CME Evaluation Form (post-Conference) ☐ Follow-up Survey
☐ Review of Hospital, Health System or Other Data ☐ Other______________________

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)
▶ As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?
▶ If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: ____________________________________________

FACULTY:
Sundeep R. Rawal, DMD
Raj M. Rawal, BDS, P.A. & Sundeep R. Rawal, DMD
Prosthodontist
Merritt Island, Florida

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).
Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
☐ Yes ☐ No ☐ CME Dept. Leadership and Staff ☐ CME Committee
☐ Conference Director (see above) ☐ Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. ☐ Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on ‘overcoming, addressing, or removing barriers to physician change’ applicable to our learners? ☐ Yes ☐ No ☐ If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? ☐ Yes ☐ No ☐ If yes, please describe the related CME program change.__________________________
And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
☐ Process redesign or new protocol ☐ Reminders (Posters, mailings, email blasts) ☐ New order sheets
☐ Other tools or tactics
Explain: ______________________________________________________________________________

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)
☐ Yes ☐ No ☐ Are we partnering with other organizations in a purposeful manner to achieve common interests?
☐ Yes ☐ No ☐ Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.

DATE REVIEWED: March 10, 2015 REVIEWED BY: ☒ Executive Committee ☐ Chairman
APPROVED: ☒ YES ☐ NO ☐ Credits: AMA/PRA Category 1 Credits: __1__
Continuing Psychology Education Credits: ___ ☐ N/A ☐ Continuing Dental Education Credits: ___1__ ☐ N/A

CME ACTIVITY TITLE: SMH Emergency Department Conference Series: Evaluating and Managing Pediatric Emergencies

DATE: Monday, April 27, 2015 TIME: 8-9 a.m.

LOCATION: SMH: E.R. Conference Room A & B CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTOR: John Baldino, M.D.

AMA/PRA LEARNING FORMAT:
☒ Live activity ☐ Test-item writing activity ☐ Internet point-of-care activity
☐ Enduring material ☐ Manuscript review activity
☐ Journal-based CME activity ☐ PI CME activity
TARGET AUDIENCE: Hospitalists, Pediatricians, General Internists, Family Practitioners, Emergency Medicine and Urgent Care Physicians, and other interested healthcare providers, nurses and physical therapists.

EXPECTED NUMBER OF ATTENDEES: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- Other (Explain): _____________________________
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18)
Patient: ☒ Non-compliance ☒ Lifestyle ☒ Resistance-to-change ☒ Financial/Lack of Insurance
Physician: ☒ Non-compliance ☒ Resistance-to-change ☒ Communication Skills ☒ Financial
Resources: ☒ Institutional Capabilities ☒ Physician Practice Limitations ☒ Community Service Limitations
State of Science: ☒ Limited or No Treatment Modalities ☒ Limited or No Diagnostic Modalities
Other: __________________________________________

PROFESSIONAL PRACTICE GAP (C2)
The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP*? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
► Despite the important decisions made based on triage assessment in a pediatric emergency department (ED), there is wide variability in the parameters assessed and the methodology used. Because of the varying physiological and developmental stages in children, the taking of vital signs and other assessments at triage in an ED can be challenging.

WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
► Physicians properly triage, diagnose and treat children presenting to the emergency department.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
- Knowledge (Doctors do not know that they need to be doing something.)
- Competence (Doctors do not know how to do it)
- Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESired OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☐ Competence? -or- ☐ Performance? -or- ☐ Patient Outcomes**? (Check all that apply.)
*(NOTE: If 'patient outcomes' is selected, there must be an achievable measurement plan.)
► Pediatricians engage in targeted training and interventions to prevent diagnostic errors when treating children in the emergency department.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Because of the varying physiological and developmental stages in children, the taking of vital signs and other assessments at triage in an emergency department (ED) can be challenging.

When asked what assessments are done on all patients at triage, all EDs (100%) obtain pulse rate and respiratory rate, 92% measure temperature, 60% measure blood pressure, 41% measure pulse oximetry, and 13% assess Glasgow Coma Scale. The methods used to measure temperature were widely variable. Multiple methods are used to assess pain: for those aged 0 to 2 years, 44% use a Wong FACES Scale and 48% use a behavioral scale; at 2 to 4 years, most (80%) use the Wong FACES Scale, but in older 10- to 18-year-old patients, most (81%) use a numerical scale. The use of standing orders at triage is variable.
Despite the important decisions made based on triage assessment in a pediatric ED, there is wide variability in the parameters assessed and the methodology used.

http://ovidsp.tx.ovid.com/sp-3.15.1b/ovidweb.cgi?&S=APEKFPDPJADDEPDCNCKPALBAAEHAA00&Complete+Reference=S.sh.54%7c3%7c1

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:

- Accurately assess common pediatric illnesses presenting in the emergency department.
- Identify prominent factors to assist in diagnosing pediatric patients.
- Promptly implement appropriate treatment plans upon diagnosis.

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

☑ Patient Care ☑ Medical Knowledge ☐ Interpersonal and Communications Skills
☑ Professionalism ☐ Systems-based Practice ☑ Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

☑ Baptist Health CME Evaluation Form (post-Conference) ☐ Follow-up Survey
☐ Review of Hospital, Health System or Other Data ☐ Other

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)

- As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice? _____________________________________________________________________________
- If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: _______________________________________________________________________

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

Francisco A. Medina, M.D.
Medical Director
Pediatric Department
Homestead Hospital

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).
Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)

☑ Yes ☐ No ☐ CME Dept. Leadership and Staff ☐ CME Committee
☐ Conference Director (see above) ☐ Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. ☐ Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners? ☑ Yes ☐ No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission?

☑ Yes ☐ Nolf yes, please describe the related CME program change. _________________________
And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.

☐ Process redesign or new protocol ☐ Reminders (Posters, mailings, email blasts) ☐ New order sheets
COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)

☐ Yes  ☑No  Are we partnering with other organizations in a purposeful manner to achieve common interests?

☐ Yes  ☑No  Are we collaborating with internal departments in a purposeful manner to achieve common interests?

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.

DATE REVIEWED: 03.23.15
REVIEWED BY: ☐ Executive Committee  ☑ Chairman
APPROVED: ☑YES  ☐NO  ☐ Credits: AMA/PRA Category 1 Credits: # 1
Continuing Psychology Education Credits: # ☑N/A  ☐ Continuing Dental Education Credits: # ☑N/A

CME ACTIVITY TITLE: Bundle Up for Sepsis: A System Approach to Early Treatment and Management

DATE: Monday, May 4, 2015  TIME: 5:30-7:30 p.m.

LOCATION: 5 MCVI Conference Room  CREDIT HOUR(S) APPLIED FOR: 2.0 Cat. 1

Videoconference:
HH – Executive Office, Center Conference Room
MH – Executive Conference Room
SMH – Dube Executive Boardroom
WKBH – Auditorium

CONFERENCE DIRECTOR: Justin Polga, M.D.

AMA/PRA LEARNING FORMAT:

EXPECTED NUMBER OF ATTENDEES: 80  CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.

- [ ] Live
- [ ] Didactic Lecture
- [ ] ARS
- [ ] Question & Answer
- [ ] Case Studies
- [ ] Panel
- [ ] Enduring Material
- [ ] Internet-Home Study
- [ ] Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)

- [ ] Best practice parameters
- [ ] Consensus of experts
- [ ] Joint Commission initiatives
- [ ] Mortality/morbidity statistics
- [ ] National Pt Safety Goals
- [ ] National/regional data
- [ ] New or updated policy/protocol
- [ ] Patient care data
- [ ] Peer review data
- [ ] Process improvement initiatives (C16 & 21)
- [ ] Research/literature review
- [ ] Other (Explain): _____________________________

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18)

Patient:  [ ] Non-compliance  [ ] Lifestyle  [ ] Resistance-to-change  [ ] Financial/Lack of Insurance
Physician:  [ ] Non-compliance  [ ] Resistance-to-change  [ ] Communication Skills  [ ] Financial
Resources:  [ ] Institutional Capabilities  [ ] Physician Practice Limitations  [ ] Community Service Limitations
State of Science:  [ ] Limited or No Treatment Modalities  [ ] Limited or No Diagnostic Modalities
Other:  _____________________________

PROFESSIONAL PRACTICE GAP (C2)

The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.► Sepsis is the 10th leading cause of death in the United States. Early sepsis identification and rapid treatment modalities remain the most effective ways to properly manage septic patients. Linking early sepsis recognition with pathogen identification allows for practitioners to effectively administer proper antibiotic therapy more rapidly, hence decreasing morbidity and mortality. In a collaborative approach to improve the increasing rate of sepsis and severe sepsis, health care providers have formulated different methods to not only rapidly identify sepsis but also treat it. Despite multiple approaches much confusion still remains on the management of septic patients.

WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)► Multiple recommendations and approaches have been put in place to improve patient outcomes during the management of sepsis. Some interventions include: implementation of screening tools; implementation of sepsis bundles in ICU, ED, medical-surgical units and pediatrics; implementation of sepsis task force; implementation of sepsis protocols such as lactic acid order sets: development of code sepsis in E.D.; implementation of different research studies analyzing sepsis data and initiative Collaboration with advanced technology tools for data collection such as Truven Analytics, Care Discovery, etc. More recently, an International guideline for management of severe sepsis and septic shock, with evidence-based recommendations, has been proposed and updated and constitutes the backbone for the Surviving Sepsis Campaign.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:

- [ ] Knowledge (Doctors do not know that they need to be doing something.)
- [ ] Competence (Doctors do not know how to do it)
- [ ] Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)
**DESIRED OUTCOMES (GOAL):** What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in □ Competence? -or- □ Performance? -or- □ Patient Outcomes*? (Check all that apply.)
*(NOTE: If 'patient outcomes' is selected, there must be an achievable measurement plan.)*
► Physicians will implement and monitor sepsis protocols and interventions, improving quality outcomes in the ICU.

**REFERENCES** supporting the current practice and/or the optimal practice and/or practice gap:
► As the Surviving Sepsis Campaign was assessing patient-level data over multiple countries, we sought to evaluate the use of a pragmatic and parsimonious severity-of-illness scoring system for patients with sepsis in an attempt to provide appropriate comparisons with practical application.


http://ovidsp.tx.ovid.com/sp-3.14.0b/ovidweb.cgi?WebLinkFrameset=1&S=FEOGFDPOMIDDJAFPNCLKPAJCBIEAA00&returnUrl=ovidweb.cgi%3f%26Fu%2bText%3d%253DL%25257cS%25257csh.23.44%25257c0%25257c00003246-201409000-00001%25257c3%25257cFEOGFDPOMIDDJAFPNCLKPAJCBIEAA00&directlink=http%3a%2f%2fgraphics.tx.ovid.com%2fovftpdfs%2fFPDDNCJCPAFPM00%2fsso47%2f2ovft%2f5live%2f2vq024%2f00003246%2f00003246-201409000-00001.pdf&filename=Sepsis+Severity+Score%3a++An+Internationally+Derived+Scoring+System+From+the+Surviving+Sepsis+Campaign+Database%2a.&pdf_key=FPDDNCJCPAFPM00&pdf_index=/fs047/ovft/live/gv024/00003246/00003246-201409000-00001&D=medf

**EDUCATIONAL OBJECTIVES:**
Upon completion of this conference, participants should be better able to:
- Examine the studies that led to “The Surviving Sepsis Campaign” international guidelines for the management of patients with sepsis and septic shock.
- Implement innovative strategies to improve patient outcomes.
- Recognize barriers to the implementation of appropriate sepsis protocols, and employ evidence-based solutions.
- Explain the future of sepsis management strategies.

**COMPETENCIES:** What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)
□ Patient Care □ Medical Knowledge □ Interpersonal and Communications Skills
□ Professionalism □ Systems-based Practice □ Practice-based Learning and Improvement

**EVALUATION METHOD(S):** Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11)
List the planned method(s) of evaluation:
□ Baptist Health CME Evaluation Form (post-Conference) □ Follow-up Survey
□ Review of Hospital, Health System or Other Data □ Other______________________

**OUTCOMES MEASUREMENT:** (List strategy measurement questions and/or other measurement plans.) (C11)
► As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice? _________________________________________________________________________
► If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: _______________________________________________________________________

**FACULTY:** (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)
Please see below.

**RELEVANT FINANCIAL RELATIONSHIPS:** List individuals in control of the content of this CME activity (other than faculty).
Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
□ Yes □ No □ CME Dept. Leadership and Staff □ CME Committee
□ Conference Director (see above) □ Others (i.e.: Conference Coordinator, Planning Group etc.)

**COMMERCIAL SUPPORT:** The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. □ Indicate here if support will come from the Foundation general Continuing Medical Education fund.

**BARRIERS TO PHYSICIAN CHANGE:** (C19) Is this activity focused on ‘overcoming, addressing, or removing barriers to physician change’ applicable to our learners? □ Yes □ No If 'yes', list the barrier(s) identified and include relevant data
OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? □ Yes  □ No  If yes, please describe the related CME program change. _____________________________
And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
□ Process redesign or new protocol  □ Reminders (Posters, mailings, email blasts)  □ New order sheets
☒ Other tools or tactics
Explain: Brochure outlining sepsis protocol will be created and provided as a take-away.

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)
□ Yes  □ No  Are we partnering with other organizations in a purposeful manner to achieve common interests?
□ Yes  □ No  Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. _____________________________
This conference is planned in collaboration with the Sepsis Accelerated Change Team (ACT). The ACT Team leader, Jill Szymanski, MSN, AVP of PI, also a member of the committee.

DATE REVIEWED: March 17, 2015 REVIEWED BY: □ Executive Committee  □ Chairman
APPROVED: □ YES  □ NO  □ Credits: AMA/PRA Category 1 Credits: # 2
Continuing Psychology Education Credits: # N/A  □ Continuing Dental Education Credits: # N/A

Agenda
5 p.m.  Dinner and Registration
5:30 p.m.  Welcome and Introductions
Jill Szymanski, MSN, R.N., MBA, FACHE, CPHQ
5:40 p.m.  Bundle Up for Sepsis: A System Approach to Early Treatment and Management.
Carlos Torres Viera, M.D., MPH
6:30 p.m.  BHSF Sepsis Care: Implementations and Outcomes
Donna Lee Armaignac, Ph.D., RN-CNS, CCNS, CCRN
Jorge Hirigoyen, ARNP
7 p.m.  A Multidisciplinary Perspective Approach on Sepsis
Moderator: Dr. Torres Viera
Abby Marrero, Pharm. D., Fernando Mendoza, M.D., Justin Polga, M.D., Joseph Scott, M.D.
7:30 p.m.  Adjourn

Faculty
Donna Lee Armaignac, Ph.D., RN-CNS, CCNS, CCRN
Director of Best Practices, Sepsis ACT Member

Jorge Hirigoyen, ARNP
Sepsis ACT Member, BHM Sepsis Collaborative

Abby Marrero, Pharm. D.
Supervisor of Pharmacy Operations, Sepsis ACT Member

Fernando Mendoza, M.D.
Baptist Children’s Hospital Sepsis Champion

Justin Polga, M.D.
Sepsis ACT Member, Sepsis Champion

Joseph Scott, M.D.
Sepsis ACT Member
NICU Conference Series: The Tiny Preemie NICU Environment: A New Model of Care that Significantly Improves Outcomes

DATE: Wednesday, May 6, 2015
TIME: 6:00 - 7:30 p.m.
LOCATION: BHM, 5 MCVI
CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1

CONFERENCE DIRECTOR: Andrew Kairalla, M.D.

TARGET AUDIENCE: Neonatologists, Obstetricians, Pediatricians, Pediatric Neurologists, NICU, Labor and Delivery and Nurse Midwives and other interested healthcare professionals.

EXPECTED NUMBER OF ATTENDEES: 50-60
CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- [x] Live
- [x] Didactic Lecture
- [ ] ARS
- [x] Question & Answer
- [ ] Case Studies
- [ ] Panel
- [ ] Enduring Material
- [ ] Internet-Home Study
- [ ] Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in
Facility: Baptist. (Andrew Kairalla, M.D., Medical Director, BHM NICU).

Cost of care. A number of us heard her speak in Chicago, and proposed the idea of trying to recreate her work here at Baptist. (Andrew Kairalla, M.D., Medical Director, BHM NICU).

The environment of care in this special unit is much different than the typical NICU, with private rooms and with low light and noise levels. It is staffed by specially trained and motivated neonatal nurses and therapists. NICU leaders are exploring the possibility of implementing this model at the Baptist Hospital NICU.

WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)

► Physicians as well as the multidisciplinary team will implement follow standardized guidelines and strategies in the NICU practices to improve health outcomes with decreased morbidity and mortality while advancing the health care quality of extremely low-birth weight infants.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:

☐ Knowledge (Doctors do not know that they need to be doing something.)
☐ Competence (Doctors do not know how to do it)
☐ Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)

And will this result in a change in ☑ Competence? -or- ☑ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.)

*(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)

► The NICU team will identify components of this model that could be implemented in existing NICU departments, and ultimately they will formulate a plan to create a care environment and specially trained multidisciplinary care team based on the model presented.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

Dr Mindy Morris is a neonatal nurse practitioner and Doctor of Nursing Practice from Children’s Hospital of Orange County in California. She is the head of their Extremely Low birth Weight Program there. Her doctoral thesis dealt with creating a specialized separate NICU environment of care that is much different than the typical NICU, with private rooms and with low light and noise levels. Mindy gave a talk a recent Vermont Oxford meeting on this project in Chicago last October. After 18 months of operation, they were able to show vastly improved outcomes for these patients, and marked reductions in labs, x-rays and cost of care. A number of us heard her speak in Chicago, and proposed the idea of trying to recreate her work here at Baptist. (Andrew Kairalla, M.D., Medical Director, BHM NICU).

► Reductions in sound levels can be achieved in an entire NICU or in an individual patient room by architectural remodelling. Intervention strategies include education of caregivers and parents to achieve behavioural changes to decrease sound levels. Sound levels can be monitored and electronically recorded for long periods of time using a sound level meter with computing and data storage capabilities (dosimeter). As sound levels vary by location and over 24 hours in a NICU, it is important that the monitoring is ongoing in various locations of the NICU, including inside the incubators. Environmental changes in the NICU aimed at reducing the sound levels might even increase decibel levels as described by Brandon et al after installation of...
motion-sensing motorized paper towel dispensers and the introduction of a new communication system. It is of note that two centers, using primarily human behavior noise reduction strategies, were unable to demonstrate measurable improvements in sound levels within the occupied open-unit design NICU.  http://www.update-software.com/BCP/WileyPDF/EN/CD010333.pdf
► The better outcomes observed in VLBW infants in recognition nursing Excellence (RNE) hospitals may reflect higher-quality NICU and obstetric care. Perhaps RNE hospitals have a broad, long-standing commitment to quality care that is reflected in other aspects of care, such as excellent physician care, respiratory care, or infection control, that are not directly related to RNE but that may independently contribute to better outcomes for VLBW infants. Thus, RNE status may serve as a marker for an institution-wide commitment to optimizing outcomes. Recognition for nursing excellence status has been included as a criterion for a high-quality institution by the national groups US News & World Report Best Hospitals (since 2004) and Leapfrog. http://jama.jamanetwork.com/article.aspx?articleid=1148194

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:

- Examine a new model of care for the tiny preemie patient that has vastly improved outcomes.
- Discuss key components of the care environment of this non-traditional model.
- Identify components of this model that could be implemented in existing NICU departments.
- Formulate a plan to create a care environment and specially trained multidisciplinary care team based on the model presented.

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

- Patient Care
- Medical Knowledge
- Interpersonal and Communications Skills –
- Professionalism
- Systems-based Practice
- Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

- Baptist Health CME Evaluation Form (post-Conference)
- Follow-up Survey
- Review of Hospital, Health System or Other Data
- Other

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)
► As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?
► If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so:

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

Mindy Morris, DNP, NNP-BC, CNS
Neonatal Nurse Practitioner
Extremely Low Birth Weight Program Coordinator
Children’s Hospital of Orange County
Orange County, California

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).
Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
- Yes ☑No ☑ CME Dept. Leadership and Staff ☑ CME Committee
- Conference Director (see above) Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program’s commitment to be independent and free of the influence of commercial interests. Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on ‘overcoming, addressing, or removing barriers to physician change’ applicable to our learners?
- Yes ☑ No ☑ If ‘yes’, list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission?
- Yes ☑ No ☑ If yes, please describe the related CME program change.
And describe how the impact of the related program improvement will be measured and documented? (C15)
NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
- Process redesign or new protocol
- Reminders (Posters, mailings, email blasts)
- New order sheets
- Other tools or tactics

Explain: _______________________________________________________________________________

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)
- Yes
- No

Are we partnering with other organizations in a purposeful manner to achieve common interests?
- Yes
- No

Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.

Baptist Children’s Hospital NICU Department

DATE REVIEWED: March 27, 2015 REVIEWED BY: Executive Committee Chairman
APPROVED: Yes No

Credits: AMA/PRA Category 1 Credits: #1 Continuing Psychology Education Credits: # N/A Continuing Dental Education Credits: # N/A


DATE: Tuesday, May 5, 2015 TIME: 6:30-7:30 p.m. (6 p.m. Registration)

LOCATION: BHM, 5MCVI CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

AMA/PRA LEARNING FORMAT:
- Live activity
- Enduring material
- Journal-based CME activity
- Test-item writing activity
- Manuscript review activity
- Internet point-of-care activity
- PI CME activity

CONFERENCE DIRECTORS: Barry T. Katzen, M.D. and Howard Katzman, M.D.

Planning Committee Members
James Benenati, M.D. Ignacio Rua, M.D.
Barry Katzen, M.D. Mrs. Cristina Alvarez
Howard Katzman, M.D. Sean Kramer

TARGET AUDIENCE: Cardiologists, Vascular Surgeons, Interventional Radiologists, Interventional Cardiologists, Primary Care Physicians, Emergency Medicine Physicians, General Internists, Nurses and other interested healthcare providers.

Describe how the content of the activity is aligned with the target learners' current or potential scope of practice (C4). This activity addresses professional practice gaps relevant to physicians in the practice of vascular surgery. In addition, physicians that identify conditions and refer patients to a vascular surgeon, and those specialists to whom a vascular surgeon...
might refer for further evaluation or treatment, are also included in the target audience, as are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 90-100    CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.

- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Internet-Home Study
- Enduring Material
- Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)

- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- Other (Explain): _____________________________

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)

- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)

Patient:  
- Non-compliance
- Lifestyle
- Resistance-to-change
- Financial/Lack of Insurance

Physician:  
- Non-compliance
- Resistance-to-change
- Communication Skills
- Financial

Resources:  
- Institutional Capabilities
- Physician Practice Limitations
- Community Service Limitations

State of Science:  
- Limited or No Treatment Modalities
- Limited or No Diagnostic Modalities

Other: ______________________________________

PROFESSIONAL PRACTICE GAP (C2)

The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.

Local physicians may not be aware of the research conducted through MCVI, and future programs that will be offered with the expansion program, which influences implementation of new interventional therapies poised to impact cardiac and vascular patients.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)

Physicians consider current research that may influence recommendations for interventional therapies for the endovascular patient.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to physician:

- Knowledge (They do not know that they need to be doing something.)
- Competence (They do not know how to do it)
- Performance (They know how to do it but are non-compliant - or are not doing it properly)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)

And will this result in a change in ☑ Competence? -or- ☐ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.) *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)

- Physicians will consider all available interventional therapies and incorporate current research recommendations when developing treatment options plans for their vascular patient.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

- The future for interventional therapists continues to evolve. These doctors are continuously improving upon minimally invasive procedures to treat common medical conditions. Even with improved medical therapy for atherosclerotic vascular disease, which may negate the need for some interventional procedures, the population is aging and there will be enormous numbers of patients needing care for coronary artery disease and carotid atherosclerosis, along with other less common conditions. http://www.intarchmed.com/content/2/1/27

- Federal investments in research and development, coupled with private firms’ innovative research and product development, have led to the robust broadband ecosystem users enjoy today. The private sector continues to invest in high-speed networks, as revealed in several recent announcements during the course of the National Broadband Plan proceeding. Cisco Systems is deploying a telemedicine pilot solution to 15 medical sites in California to spur e-health application development.
All of these efforts aim to accelerate the pace of innovation by placing next-generation technology in the hands of individuals and entrepreneurs, and allowing them to discover the best uses for it. Very fast networks may lead to unanticipated discoveries that will change how people connect, work, learn, play and contribute online. [http://www.broadband.gov/plan/7-research-and-development/](http://www.broadband.gov/plan/7-research-and-development/)

### EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
- Review the historic advances in cardiac and vascular diseases at Miami Cardiac & Vascular Institute (MCVI.)
- Assess how the new programs being developed at MCVI will impact the future of interventional medicine and improve patient outcomes.

### COMPETENCIES:
*What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)*
- Patient Care
- Medical Knowledge
- Interpersonal and Communications Skills
- Professionalism
- Systems-based Practice
- Practice-based Learning and Improvement

### EVALUATION METHOD(S):
Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11)
- Baptist Health CME Evaluation Form (post-Conference)
- Follow-up Survey
- Review of Hospital, Health System or Other Data
- Other__________________________

### OUTCOMES MEASUREMENT:
(List strategy measurement questions and/or other measurement plans.) (C11)
1. As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice? _____________________________________________
2. If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: _____________________________________________

### FACULTY:
(Name, Specialty and/or Title(s), Institution(s), City, State)
Brian Keeley
President and CEO
Baptist Health South Florida

### RELEVANT FINANCIAL RELATIONSHIPS:
List individuals in control of the content of this CME activity (other than faculty).
*Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)*
- Yes
- No
- Medical Education Dept. Leadership and Staff
- Medical Education Committee
- Conference Director (see above)
- Others (i.e.: Conference Coordinator, Planning Group etc.)

### COMMERCIAL SUPPORT:
The Baptist Health Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests.  Indicate here if support will come from the Foundation general medical education fund.

### BARRIERS TO PHYSICIAN CHANGE: (C19)
Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners?  Yes  ☐ No  ☐ If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.  

### OVERALL PROGRAM CHANGES:
Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission?
- Yes
- No
- If yes, please describe the related CME program change. ____________________________________________
- And describe how the impact of the related program improvement will be measured and documented? (C15)

### NON-EDUCATION STRATEGIES:
Explain what we are doing (MedEd or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
- Process redesign or new protocol
- Reminders (Posters, mailings, email blasts)
- New order sheets
- Other tools or tactics
- Explain: ____________________________________________

### COLLABORATION:
Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)
- Yes
- No
- Are we partnering with other organizations in a purposeful manner to achieve common interests?
- Yes
- No
- Are we collaborating with internal departments in a purposeful manner to achieve common interests?
- Yes
- No
- If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. This activity was
planned in collaboration with the Miami Cardiac & Vascular Institute

DATE REVIEWED: April 7, 2015 REVIEWED BY: EXECUTIVE COMMITTEE

APPROVED: YES NO

Category 1 Credits: 1

Continuing Psychology Education Credits: N/A

Schedule:
6:00 pm  Registration and Refreshments
6:20 p.m.  Welcome Remarks
  Cristina Alvarez, Barry Katzen, M.D. and Howard Katzman, M.D.
6:30 p.m.  The New MCVI and the Future of Healthcare: The Good, the Bad and the Ugly
  Brian Keeley
7:30 p.m.  Adjourn

Applicable Credits: AMA Category 1  ■ Continuation Psychology Education  ■ Continuation Dental Education

CME ACTIVITY TITLE: PSA Screening: Who, What, Why and When?

DATE: Thursday, May 7, 2015  TIME: 6-7 p.m.

LOCATION: BHM Classroom 5  CREDIT HOUR(S) APPLIED FOR: 1  Cat. 1

CONFERENCE DIRECTOR: Hanif Williams, M.D.

AMA/PRA LEARNING FORMAT:
  Live activity  Test-item writing activity  Internet point-of-care activity
  Enduring material  Manuscript review activity
  Journal-based CME activity  PI CME activity

TARGET AUDIENCE: Hospitalists, General Internists, Family Practitioners, Nurses and other interested healthcare providers.

EXPECTED NUMBER OF ATTENDEES: 20-25  CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
  Live  Question & Answer  Enduring Material
  Didactic Lecture  Case Studies  Internet-Home Study
  ARS  Panel  Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
  Best practice parameters  Consensus of experts
PROFESSIONAL PRACTICE GAP (C2)

The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP*? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
► PSA screening for prostate cancer is controversial. Conflicting views exist regarding whether men should undergo PSA screening and, if they do, when to stop. Furthermore, patient selection for PSA screening is challenging and providers struggle to identify those who will benefit from a PSA blood test. PSA screening is not a 'one-size fits all' approach and this practice needs to be changed. Interpretation of PSA results is challenging, and there are further tests available to help determine who should undergo a biopsy. In addition, there are several new tests available to further risk stratify patients based on PSA and their risk of prostate cancer. Providers should be aware of the new tests coming down the pipeline and how to order and interpret them.

WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice ‘look like’?)
► Prostate cancer will be detected at an early stage so treatment may be offered with curative intent, while reducing the number of negative or unnecessary biopsies. Providers are aware of evidence and tools available to determine who should be screened and at what age. They interpret PSA results and when indicated, they utilize further tests to risk stratify patients based on PSA and their risk of prostate cancer and to help determine who should undergo a biopsy. Providers are aware of the new tests coming down the pipeline, and they know how to order and interpret them.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
► Knowledge (Doctors do not know that they need to be doing something.)
► Competence (Doctors do not know how to do it)
► Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in □ Competence? -or- □ Performance? -or- □ Patient Outcomes*? (Check all that apply.) *(NOTE: If 'patient outcomes' is selected, there must be an achievable measurement plan.)
► Physicians will follow best-practice selection criteria for PSA screening; implement appropriate PSA screening tools; accurately interpret results; and determine when to refer appropriate patients to specialists.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Many men are diagnosed with indolent disease not requiring treatment. Although there is evidence of a survival benefit from screening, the numbers needed to screen and treat remain high. There is risk of exposing men to the side effects of treatment for nonthreatening disease. A screening test is needed with sufficiently good performance characteristics to detect disease at an early stage so treatment may be offered with curative intent, while reducing the number of negative or unnecessary biopsies.

http://ovidsp.tx.ovid.com/sp-3.15.0a/ovidweb.cgi?&S=FINBFPHJADDGPLDNCKKLBOEAJHAA00&Complete+Reference=S_sh.51%7c3%7c1

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
► Determine when to initiate PSA testing based on identifiable risk factors and symptoms, not excluding age and race.
Implement appropriate PSA screening tools and identify which patients would benefit from additional testing.

List additional tests available to assess patients at risk of prostate cancer.

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

- Patient Care
- Medical Knowledge
- Interpersonal and Communications Skills
- Professionalism
- Systems-based Practice
- Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

- Baptist Health CME Evaluation Form (post-Conference)
- Follow-up Survey
- Review of Hospital, Health System or Other Data
- Other

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)

- As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?
- If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so:

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

Chad R. Ritch, M.D., MBA
Urologic Oncologist
Assistant Professor of Urology
University of Miami, Miller School of Medicine
Miami, Florida

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).

Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)

- Yes
- No
- CME Dept. Leadership and Staff
- CME Committee
- Conference Director (see above)
- Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners?

- Yes
- No

If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission?

- Yes
- No

If yes, please describe the related CME program change. And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.

- Process redesign or new protocol
- Reminders (Posters, mailings, email blasts)
- New order sheets
- Other tools or tactics

Explain:

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)

- Yes
- No

Are we partnering with other organizations in a purposeful manner to achieve common interests?

- Yes
- No

Are we collaborating with internal departments in a purposeful manner to achieve common interests?

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.
CME ACTIVITY TITLE: Conversations in Ethics: Ethical Concerns With the Critically Ill Disabled Patient

DATE: Wednesday, May 13, 2015  TIME: 6:00 p.m. – 8:00 p.m.

LOCATION: 5 MCVI Conference Room  CREDIT HOUR(S) APPLIED FOR: 2.0

Videoconferenced to: MH Exec Conf Room, & WKBH CL 4 & 5, SMH CL F

CONFERENCE DIRECTOR: Raúl de Velasco, M.D., FACP, Chairman, Baptist Health Bioethics Department

CONFERENCE COORDINATOR: Rose Allen, R.N., M.S.M./H.M., CHPN, Director, Bioethics & Palliative Care

AMA/PRA LEARNING FORMAT:

- Live activity
- Enduring material
- Journal-based CME activity
- Test-item writing activity
- Manuscript review activity
- Internet point-of-care activity
- PI CME activity

TARGET AUDIENCE: Physicians, Psychologists, Nurses, Social Workers, Respiratory Therapists, Clergy, Pharmacists, Medical Students, Dietitians and other interested healthcare professionals.

EXPECTED NUMBER OF ATTENDEES: 50-60  CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.

- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
Best practice parameters  ☑ Consensus of experts  ☑ Joint Commission initiatives  ☑ Mortality/morbidity statistics  ☑ National Pt Safety Goals  ☑ National/regional data  ☑ Other (Explain): National Guidelines; Bioethics Committee Request

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)

Patient:  ☑ Non-compliance  ☑ Lifestyle  ☑ Resistance-to-change  ☑ Financial/Lack of Insurance
Physician:  ☑ Non-compliance  ☑ Resistance-to-change  ☑ Communication Skills  ☑ Financial
Resources:  ☑ Institutional Capabilities  ☑ Physician Practice Limitations  ☑ Community Service Limitations
State of Science:  ☑ Limited or No Treatment Modalities  ☑ Limited or No Diagnostic Modalities
Other: ____________________________________________

PROFESSIONAL PRACTICE GAP (C2)

The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.

Care decisions regarding disabled individuals are oftentimes managed differently that those for non-disabled patients in same situation.

WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)

► Patients with disabilities are treated as individuals, their wishes are respected and followed, and there is no disparity when compared to care given to non-disabled patients.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:

☑ Knowledge (Doctors do not know that they need to be doing something.)
☑ Competence (Doctors do not know how to do it)
☑ Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)

And will this result in a change in ☑ Competence? -or- ☐ Performance? -or- ☑ Patient Outcomes*? (Check all that apply.)

*(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)

► Physicians are knowledgeable of and employ ethical guidance consistent with national practice guidelines and standards of care when providing care for patients with disabilities.
Healthcare providers and patient advocates will acknowledge and remove disparities of care affecting patients with disabilities.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

► Health status is critically important to experiencing quality of life, self-sufficiency, and full participation in society. For the 54 million Americans with disabilities, maintaining health and wellness is especially important to reduce the impact of impairment on functioning in these critical life areas. Yet, people with disabilities may be the largest underserved subpopulation demonstrating health status disparities that stem from preventable secondary conditions. Healthy People 2010, the nation’s blueprint for improved health, addresses this problem in its objectives. In 2002 and 2005, the U.S. Surgeon General asked for public health efforts to improve the health and wellness of persons with disabilities. This article examines the concepts of health and wellness, summarizes currently available information documenting disparities in health for people with disabilities, and provides a framework for policy recommendations to reduce health disparities among people with disabilities. C. E. Drum et al. / Californian Journal of Health Promotion 2005, Volume 3, Issue 3, 29-42

► Conclusion- Responding to Disparities Eliminating health discrepancies in people with disabilities requires changes in access to medical care, improvements in the delivery of health promotion, increased prevention strategies implemented for secondary conditions, and removal of environmental barriers. Responding to these health disparities requires a comprehensive, multi-level approach that involves persons with disabilities, health care and other service providers, and policy makers. Available data indicate that having a disability puts one at substantially higher risk for experiencing poorer
health status than the general population. Disparities appear related to both differences in access to medical care and to health promotion services. These disparities need to be addressed at the level of the person with the disability, the professionals who provide services, and importantly, the policies that impede or facilitate better access to medical care and health promotion. Four categories of policy change are recommended along with key examples of needed policy reform:

- **Legal and Regulatory Reforms** that enforce the ADA to address accessibility in conjunction with broader definitions of medical necessity to address habilitation needs, simplification of regulations to make maneuvering the health care system easier, tax incentives that support persons with disabilities in purchasing equipment or making home modifications to increase access to the community, and increased physical accessibility of medical and fitness facilities and equipment (e.g., mammography machines, athletic equipment).
- **Health Plan Benefits** that ensure access to needed specialty care, habilitative and rehabilitative services, care coordinated "defragmentation", and coverage for prescription medications and durable medical equipment.
- **Communication Enhancement** that includes interpreter services for non-English speakers, sign language interpreters, health information materials in alternative formats (e.g., large print, electronic copies for screen readers), adequate time for medical care appointments, and use of "plain language" to promote comprehension by all, but particularly people with cognitive disabilities.
- **Health Promotion Programs** that include access to generic health promotion programs like smoking cessation, weight management, drug and alcohol treatment, complementary and alternative medicine, and accommodation of facilities and staff to allow equitable participation by people with disabilities.

With the changing demographics of America, the proportion of persons experiencing disabilities will increase. Public health has a significant role to play in addressing and ameliorating the health disparities experienced by people with disabilities. C. E. Drum et al. / Californian Journal of Health Promotion 2005, Volume 3, Issue 3, 29-42

**EDUCATIONAL OBJECTIVES**

Upon completion of this conference, participants should be better able to:

- Recognize that people with disabilities are people first and that having a disability is not the same as being sick.
- Commit to treating the critically ill patient with disabilities as a competent adult or emancipated minor by asking and following the patient’s wishes regarding his/her own medical care prior to consulting with her/his companion(s).
- Increase awareness, challenge and change the preconceived notions that many nondisabled folks have about the quality of life experienced by people with disabilities and their own fears of what "being disabled" may mean for themselves.

**COMPETENCIES:** What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

- Patient Care
- Medical Knowledge
- Interpersonal and Communications Skills
- Professionalism
- Systems-based Practice
- Practice-based Learning and Improvement

**EVALUATION METHOD(S):** Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

- Baptist Health CME Evaluation Form (post-Conference)
- Review of Hospital, Health System or Other Data
- Follow-up Survey
- Other ________________

**OUTCOMES MEASUREMENT:** (List strategy measurement questions and/or other measurement plans.) (C11)

- ▶ As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?
  - If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so:

**FACULTY:** (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

Mary Jo Iozzio, Ph.D.
Professor of Moral Theology
Boston College
School of Theology and Ministry
Boston, Massachusetts

**RELEVANT FINANCIAL RELATIONSHIPS:** List individuals in control of the content of this CME activity (other than faculty).

- □ Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
  - Yes
  - No
  - CME Dept. Leadership and Staff
  - CME Committee
  - Conference Director (see above)
  - Others (i.e.: Conference Coordinator, Planning Group etc.)

**COMMERCIAL SUPPORT:** The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. □ Indicate here if support will come from the Foundation general Continuing Medical Education fund.
BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners? □ Yes ☒ No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? □ Yes ☒ No If yes, please describe the related CME program change. __________________________ And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
□ Process redesign or new protocol □ Reminders (Posters, mailings, email blasts) □ New order sheets
□ Other tools or tactics
Explain: ______________________________________________________________________________

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)
□ Yes ☒ No Are we partnering with other organizations in a purposeful manner to achieve common interests?
□ Yes ☒ No Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.

DATE REVIEWED: March 27, 2015 REVIEWED BY: □ Executive Committee □ Chairman

APPROVED: ☒ YES ☒ NO □ Credits: AMA/PRA Category 1 Credits: # __2
Continuing Psychology Education Credits: # __2 N/A □ Continuing Dental Education Credits: # ___ N/A

Script:
As more people with disabilities participate in many different settings, from which they might have once been excluded, nondisabled folks have become more accustomed to both casual and commercial interactions with them. Yet, many of these same people may question the general and critical healthcare needs that people with disabilities will have from time to time including whether or not they should receive extraordinary levels of medical care in times of crisis. The subtext of this thinking may be, "Aren't they better off dead?" Are the standards of care for people with disabilities different than for the nondisabled? Whose quality of life is at stake in these cases?
Applicable Credits: AMA Category 1 ☒ ■ Continuing Psychology Education ☐ ■ Continuing Dental Education ☒

CME ACTIVITY TITLE: Surgery Conference Series: Periampullary Pathology Diagnosis and Treatment

DATE: Tuesday, May 19, 2015 TIME: 6:00 p.m. – 7:30 p.m.

LOCATION: Baptist Hospital of Miami Auditorium CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1 Credit

CONFERENCE DIRECTOR: Arturo Fridman, M.D.

AMA/PRA LEARNING FORMAT:
☒ Live activity ☐ Test-item writing activity ☐ Internet point-of-care activity
☐ Enduring material ☐ Manuscript review activity
☐ Journal-based CME activity ☐ PI CME activity

TARGET AUDIENCE: General Surgeons, Anesthesiologists, Oncologists, Pathologists, Family Physicians, Gastroenterologists, Hospitalists, Pharmacists, Nurses and other interested healthcare providers.

EXPECTED NUMBER OF ATTENDEES: 50-70 CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
☒ Live ☒ Didactic Lecture ☐ Case Studies
☒ ARS ☐ Question & Answer ☐ Internet-Home Study
☐ Panel ☐ Enduring Material ☐ Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
☒ Best practice parameters ☐ New or updated policy/protocol
☒ Consensus of experts ☐ Patient care data
☐ Joint Commission initiatives ☐ Peer review data
☐ Mortality/morbidity statistics ☐ Process improvement initiatives (C16 & 21)
☐ National Pt Safety Goals ☐ Research/literature review
☐ National/regional data ☐ Other (Specify): _____________________________

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)
Patient: ☐ Non-compliance ☐ Lifestyle ☐ Resistance-to-change ☐ Financial/Lack of Insurance
<table>
<thead>
<tr>
<th>Physician:</th>
<th>☑ Non-compliance</th>
<th>☑ Resistance-to-change</th>
<th>☐ Communication Skills</th>
<th>☐ Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources:</td>
<td>☐ Institutional Capabilities</td>
<td>☐ Physician Practice Limitations</td>
<td>☐ Community Service Limitations</td>
<td></td>
</tr>
<tr>
<td>State of Science:</td>
<td>☐ Limited or No Treatment Modalities</td>
<td>☐ Limited or No Diagnostic Modalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

**PROFESSIONAL PRACTICE GAP (C2)**

*The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.*

**WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.

► The unique diagnosis of borderline resectable pancreatic ductal adenocarcinoma (BLPDAC) is such that surgeons and other diagnosticians may not know the full spectrum of periampullary pathology diagnosis and treatment. Though certain criteria exist for defining BLPDAC, subjectivity in determining resectability creates some ambiguity in the diagnoses of BLPDAC. This may cause delayed treatment and potentially decrease potential for optimal outcomes.

**WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)

► Surgeons accurately assess and diagnose patients presenting with periampullary disease and determine if periampullary pathology is benign or malignant with clinical presentations and whether it is mild or life threatening in order to provide the best treatment for optimal patient outcomes.

**WHAT IS THE REASON FOR THIS GAP?** Indicate if the gap is related to either/or:

☑ Knowledge (Doctors do not know that they need to be doing something.)

☑ Competence (Doctors do not know how to do it)

☐ Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

**DESIRED OUTCOMES (GOAL):** What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)

And will this result in a change in ☑ Competence? -or- ☑ Performance? -or- ☑ Patient Outcomes*? *(Check all that apply.)*

*NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)*

► Surgeons will understand the full spectrum of periampullary pathology diagnosis and treatment and recognize existence of ambiguity in the diagnoses of BLPDAC. They will determine if periampullary pathology is benign or malignant with clinical presentations and whether it is mild or life threatening, and they will establish whether pathology is biliary colic or obstruction and extreme necrotizing pancreatitis. In the absence of these competencies, physicians will refer to a specialist for timely assessment and best practice intervention.

**REFERENCES** supporting the current practice and/or the optimal practice and/or practice gap:

► Each year, approximately 5,000 patients are diagnosed with borderline resectable pancreatic ductal adenocarcinoma (BLPDAC). This unique stage encompasses localized primary pancreatic cancer with limited involvement of the superior mesenteric vein (SMV), portal vein (PV), superior mesenteric artery (SMA), common hepatic artery (HA), or celiac axis (CA). Though certain criteria exist for defining BL-PDAC, subjectivity in determining resectability creates some ambiguity in the diagnoses of BL-PDAC. Regardless of the classification system used, BL-PDAC patients are more likely to require a highly challenging surgery leading to increased risk of complications, positive resection margins following a surgery-first approach, and early systemic metastases given the more advanced stage of primary tumors.


► Most PNETs are diagnosed incidentally as a part of the workup for non-specific abdominal pain or mass effect leading to biliary or bowel obstruction. General presenting symptoms include abdominal pain, weight loss, palpable mass and jaundice. With lesions in the head of pancreas, there can be gastrointestinal bleeding secondary to erosion in the duodenum, as well as gastric or biliary outlet obstruction. The patient presented with many of these symptoms including abdominal pain, weight loss, biliary obstruction and gastrointestinal bleeding.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3030725/

► As initial imaging, transabdominal ultrasound may be done. It is relatively inexpensive and widely available, but has a reported sensitivity of only 9%-64%. Therefore, further imaging modalities may still be necessary. CT scanning also may be done as initial imaging to localize and stage the disease. It also can be used to assess liver metastases and pancreatic lymph node involvement. Magnetic resonance imaging (MRI) also is helpful to evaluate metastatic disease, and to delineate the mass in relation to the pancreatic duct and major vessels. MRI has been shown to be generally effective at detecting lesions > 1 cm, with 50% effectiveness in detecting lesions between 1 and 2 cm. Somatostatin receptor scintigraphy or octreotide scanning has been deemed to be the most sensitive imaging modality because it can effectively localize and stage disease by
EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
- Review full spectrum of periampullary pathology diagnosis and treatment.
- Determine if periampullary pathology is benign or malignant with clinical presentations and whether it is mild or life threatening.
- Establish whether pathology is biliary colic or obstruction and extreme necrotizing pancreatitis.

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

- [x] Patient Care
- [x] Medical Knowledge
- [ ] Interpersonal and Communications Skills
- [x] Professionalism
- [x] Systems-based Practice
- [ ] Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11)

- [x] Baptist Health CME Evaluation Form (post-Conference)
- [ ] Follow-up Survey
- [ ] Review of Hospital, Health System or Other Data
- [x] Other _______________________

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)

- As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice? ___________________________________________________________________________
- If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: ___________________________________________________________________________

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

Joe U. Levi, M.D.
Professor of Surgery
Chief, Division of General Surgery
University of Miami Health System
Miami, Florida

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).

Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)

- [x] Yes
- [ ] No
- [ ] CME Dept. Leadership and Staff
- [ ] CME Committee
- [ ] Conference Director (see above)
- [ ] Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on ‘overcoming, addressing, or removing barriers to physician change’ applicable to our learners? [ ] Yes  [ ] No  If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? [ ] Yes  [x] No  If yes, please describe the related CME program change. _______________________

And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.

- [ ] Process redesign or new protocol
- [ ] Reminders (Posters, mailings, email blasts)
- [ ] New order sheets
- [ ] Other tools or tactics

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)

- [ ] Yes  [ ] No  Are we partnering with other organizations in a purposeful manner to achieve common interests?
- [x] Yes  [ ] No  Are we collaborating with internal departments in a purposeful manner to achieve common interests?

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.

DATE REVIEWED: April 3, 2015 REVIEWED BY: [x] Executive Committee  [ ] Chairman
CME ACTIVITY TITLE: ICD-10-CM: Change on the Horizon- What I Need to Know

DATE/TIME/LOCATION: 5:30-7 p.m.

- Tuesday May 12th (BHM) – Lee Shimano presenter- 5MCVI → WEBEX
- Tuesday May 26th (BHM) – Debby Enfield presenter– Auditorium
- Tuesday June 9th (BHM) – Lee Shimano presenter - MCVI

CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 each

CONFERENCE DIRECTOR: Arturo Fridman, M.D.

AMA/PRA LEARNING FORMAT:
- Live activity
- Enduring material
- Journal-based CME activity
- Test-item writing activity
- Manuscript review activity
- PI CME activity
- Internet point-of-care activity

TARGET AUDIENCE: All Medical Staff

EXPECTED NUMBER OF ATTENDEES: 40-45 per session CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.

- Live
- Didactic Lecture
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)

- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)
The national transition from International Classification of Diseases, 9th Revision (ICD-9) to International Classification of Diseases, 10th Revision (ICD-10) has a significant impact on physicians daily inpatient practice and affects documentation for all procedures.

PROFESSIONAL PRACTICE GAP (C2)

The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap. ► Beginning October 1, 2015, the U.S. Department of Health and Human Services (HHS) will use a new coding system, the International Classification of Diseases, 10th Revision (ICD-10). The new codes will be required for inpatient claims. Physicians are not familiar with impact coding changes will have to their documentation for inpatient care.

WHAT IS THE OPTIMAL PRACTICE**? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?) ► Practitioners appreciate the impact of new ICD-10 coding system changes and implement improvements to their documentation which will lead to enhanced disease management.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
☒ Knowledge (Doctors do not know that they need to be doing something.)
☒ Competence (Doctors do not know how to do it)
☐ Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESIRE OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3) And will this result in a change in ☑ Competence? -or- ☑ Performance? -or- ☑ Patient Outcomes*? (Check all that apply.) *NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)
► Physicians implement documentation changes for inpatient care for enhanced disease management.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition to ICD-10. The transition will impact Baptist Health's clinical, financial and operational areas and require business and system changes. The new coding system will bring greater clinical detail and specificity to describing diagnoses and procedures, an increased number of codes and a different organization, structure and code composition.

The new coding system will improve data used to measure quality and safety and give healthcare organizations a better understanding of medical conditions and outcomes. ICD-10 also will help organizations operate more efficiently, design better payment systems and improve how insurance claims are processed.

EDUCATIONAL OBJECTIVES

Upon completion of this conference, participants should be better able to:

- Explain how the new coding system will improve data used to measure quality and safety and give healthcare organizations a better understanding of medical conditions and outcomes.
- Discuss how ICD-10- CM will help organizations operate more efficiently, design better payment systems and improve how insurance claims are processed.

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)
☐ Patient Care ☒ Medical Knowledge ☒ Interpersonal and Communications Skills
☐ Professionalism ☒ Systems-based Practice ☒ Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:
☒ Baptist Health CME Evaluation Form (post-Conference)
☐ Follow-up Survey
☐ Review of Hospital, Health System or Other Data ☒ Other________________________
OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)
► As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?
► If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so:

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)
Litriana Shimano, CPC, CMDP, CCP, PCS
AHIMA Approved ICD-10-CM/PCS Trainer
HIM Education Consultant, ICD-10 & Industry-Driven Solutions
Optum360

OR- See dates above which indicate who will be speaking.

Debby Enfield
Senior Consultant, ICD-10 & Industry-Driven Solutions
Optum360

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).
Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
☑ Yes ☐ No ☐ CME Dept. Leadership and Staff ☐ CME Committee
☐ Conference Director (see above) ☐ Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. ☐ Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on ‘overcoming, addressing, or removing barriers to physician change’ applicable to our learners? ☐ Yes ☑ No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? ☐ Yes ☑ No If yes, please describe the related CME program change.
And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
☐ Process redesign or new protocol ☑ Reminders (Posters, mailings, email blasts) ☐ New order sheets
☐ Other tools or tactics
Explain: ____________________________________________________________

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)
☑ Yes ☐ No Are we partnering with other organizations in a purposeful manner to achieve common interests?
☒ Yes ☐ No Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. This meeting is planned in collaboration with the Health Information Management Department.

DATE REVIEWED: March 19, 2015 REVIEWED BY: ☐ Executive Committee ☐ Chairman
APPROVED: ☑ YES ☐ NO ■ Credits: AMA/PRA Category 1 Credits: # 1
Continuing Psychology Education Credits: # ☐ N/A ■ Continuing Dental Education Credits: # ☐ N/A
CME ACTIVITY TITLE: Cardiovascular Conference: Endovascular Treatment of Acute Stroke and Brain Aneurysms

DATE: Thursday, May 28, 2015

TIME: 12 noon – 1 p.m.

LOCATION: BHM, 5MCVI

CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

VC to HH Phys' Lounge, WKBH Classrooms 4&5; SMH, MCVI 2nd Floor Conference Room

Live Webcast

CONFERENCE DIRECTOR: Marcus St. John, M.D.

AMA/PRA LEARNING FORMAT:

- Live activity
- Enduring material
- Journal-based CME activity
- Test-item writing activity
- Manuscript review activity
- PI CME activity
- Internet point-of-care activity

TARGET AUDIENCE: Cardiologists, Interventional Cardiologists, Interventional Radiologists, Internists, Emergency Medicine Physicians, Family Physicians, Hospitalists, Nurses, Radiation Technologists, Pharmacists, and all other interested healthcare providers.

Describe how the content of the activity is aligned with the target learners' current or potential scope of practice (C4).

This activity addresses professional practice gaps relevant to physicians in the practice of cardiology. In addition, physicians that identify conditions and refer patients to a cardiologist, and those specialists to whom a cardiologist might refer for further evaluation or treatment, are also included in the target audience, as are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 40-40

CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.

- Live
- Didactic Lecture
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)

- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient


outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18)

Patient:  □ Non-compliance  □ Lifestyle  ✓ Resistance-to-change  □ Financial/Lack of Insurance
Physician:  ✓ Non-compliance  ✓ Resistance-to-change  □ Communication Skills  □ Financial
Resources:  □ Institutional Capabilities  □ Physician Practice Limitations  □ Community Service Limitations
State of Science:  □ Limited or No Treatment Modalities  □ Limited or No Diagnostic Modalities
Other:  

PROFESSIONAL PRACTICE GAP (C2)
The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
Physicians do not consistently assess patients with ischemic stroke according to current practice guidelines and don’t consistently consider indications for interventional treatment when managing patients with acute ischemic stroke.

WHAT IS THE OPTIMAL PRACTICE***? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like’?)
Physicians implement current treatment guidelines and utilize indications for interventional treatment when managing patients with acute ischemic stroke.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to physician:
✓ Knowledge (They do not know that they need to be doing something.)
✓ Competence (They do not know how to do it)
□ Performance (They know how to do it but are non-compliant - or are not doing it properly)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ✓ Competence? -or- ✓ Performance? -or- □ Patient Outcomes***? (Check all that apply.) *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)
► Physicians familiarize themselves with evidence-based treatment guidelines and the indications for interventional treatment of acute stroke and implement recommendations in a timely manner to improve patient care.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Stroke remains the third leading cause of death and leading cause of long-term disability among Americans; approximately 700,000 individuals suffer a new or recurrent strike each year.
The goals in the initial phase include: Ensuring medical stability, Quickly reversing any conditions that are contributing to the patient's problem, Moving toward uncovering the pathophysiologic basis of the patient's neurologic symptoms, Screening for potential contraindications to thrombolysis in acute ischemic stroke patients.
Mounting evidence suggests that patients with acute stroke have better outcomes when admitted to a hospital unit that is specialized for the care of patients with all types of acute stroke, including ischemic, intracerebral hemorrhage, and subarachnoid hemorrhage. Lowering the systemic blood pressure in patients with acute ischemic stroke has been associated with clinical deterioration. Observational studies from several different groups have found an adverse effect of reducing blood pressure in the first 24 hours after stroke onset.
In the evaluation of the acute stroke patient, imaging studies are necessary to exclude hemorrhage as a cause of the deficit, and they are useful to assess the degree of brain injury and to identify the vascular lesion responsible for the ischemic deficit. Some advanced CT and MRI technologies are able to distinguish between brain tissue that is irreversibly infarcted and that which is potentially salvageable, thereby allowing better selection of patients who are likely to benefit from therapy. This topic is discussed separately.
Appropriate and timely use of these therapies should be considered as soon as ischemic stroke is recognized. Utilization of these interventions may be improved by the use of standardized stroke care orders or critical pathways beginning with hospital admission through discharge.  http://www.uptodate.com/contents/initial-assessment-and-management-of-acute-stroke

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
• Describe the etiology of acute stroke due to large vessel occlusion and brain aneurysms, and assess clinical indicators to determine if interventional treatment should be considered.
• Apply evidence-based treatment guidelines in the management of acute ischemic stroke.
COMPETENCIES: What desirable physician attributes (e.g., professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

- Patient Care
- Medical Knowledge
- Interpersonal and Communications Skills
- Professionalism
- Systems-based Practice
- Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

- Baptist Health CME Evaluation Form (post-Conference)
- Follow-up Survey
- Review of Hospital, Health System or Other Data
- Other _______________________

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)

- As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice? ____________________________________________
- If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: ____________________________________________

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State) (If necessary, attach a list.)

Guilherme Dabus, M.D.
Director, Fellowship Program in Neurolnterventional Surgery
Miami Cardiac & Vascular Institute
Associate Professor
Florida International University Herbert Wertheim College of Medicine
Miami, Florida

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).

Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
- Yes  ☒  No
- CME Dept. Leadership and Staff
- CME Committee
- Conference Director (see above)
- Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners? ☐ Yes  ☒  No  If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? ☐ Yes  ☒  No  If yes, please describe the related CME program change. ____________________________________________

And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.

- Process redesign or new protocol
- Reminders (Posters, mailings, email blasts)
- New order sheets
- Other tools or tactics

Explain: ____________________________________________

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)

- Yes  ☒  No  Are we partnering with other organizations in a purposeful manner to achieve common interests?
- Yes  ☒  No  Are we collaborating with internal departments in a purposeful manner to achieve common interests?

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. ________________________

BHM Neuroscience Center and Baptist Cardiac & Vascular Institute

DATE REVIEWED: April 9, 2015  REVIEWED BY: ☒ Executive Committee  ☐ Chairman

APPROVED: ☐ YES  ☒ NO  Credits: AMA/PRA Category 1 Credits: # 1
CME ACTIVITY TITLE: Stroke and PFO: To Close or Not to Close?

DATE: Thursday, May 28, 2015  
TIME: 6:30 – 7:30 p.m.  6-7 p.m.

LOCATION: BHM – Auditorium  
CREDIT HOUR(S) APPLIED FOR: 1.0 Cat. 1

CONFERENCE DIRECTOR: Sergio Gonzalez-Arias, M.D.

AMA/PRA LEARNING FORMAT:
- Live activity
- Test-item writing activity
- Internet point-of-care activity
- Enduring material
- Manuscript review activity
- Journal-based CME activity
- PI CME activity


EXPECTED NUMBER OF ATTENDEES: 80  
CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- Live
- Didactic Lecture
- Question & Answer
- Panel
- Enduring Material
- Case Studies
- Internet-Home Study
- Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- Other (Explain): __________________________________________
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)

Patient:  
- Non-compliance
- Lifestyle
- Resistance-to-change
- Financial/Lack of Insurance

Physician:  
- Non-compliance
- Resistance-to-change
- Communication Skills
- Financial

Resources:  
- Institutional Capabilities
- Physician Practice Limitations
- Community Service Limitations

State of Science:  
- Limited or No Treatment Modalities
- Limited or No Diagnostic Modalities
PROFESSIONAL PRACTICE GAP (C2)

_The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity._

**WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.

► At present, there is significant variability on how patients with PFO are evaluated and managed. Adequate risk stratification in these patients is rarely done. Many clinicians are not familiar with the anatomical and physiological features that are associated with PFOs as a source of paradoxical embolism and stroke. The possibility of paroxysmal atrial fibrillation must be specifically excluded.

**WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)

► Patients with cryptogenic stroke should be evaluated for cardiac sources of embolism, including PFO. The presence of an intra atrial septal aneurysm and right to left shunt at rest, and with valsala, should be specifically addressed. The degree of leftward shunting is best assessed with transcranial doppler with bubble injection. The decision of whether to treat a patient with cryptogenic stroke with antiplatelet therapy, anticoagulation, or PFO closure depends on a global assessment that includes bleeding risk, age, and specific features of the PFO. Prior to PFO closure, patients should be assessed with prolonged monitoring with Holter or implanted loop recorder to exclude paroxysmal atrial fibrillation as the source of stroke.

**WHAT IS THE REASON FOR THIS GAP**? Indicate if the gap is related to either/or:
- Knowledge (Doctors do not know that they need to be doing something.)
- Competence (Doctors do not know how to do it)
- Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

**DESIGNED OUTCOMES (GOAL):** What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)

And will this result in a change in ☐ Competence? -or- ☐ Performance? -or- ☐ Patient Outcomes? (Check all that apply.)

*(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)*

► Physicians identify and assess patients with PFO’s at risk of a cryptogenic stroke and implement the most appropriate treatment plans.

*REFERENCES* supporting the current practice and/or the optimal practice and/or practice gap:

► Patent foramen ovale (PFO) is a common finding in healthy subjects and has not been associated with increased risk of ischemic stroke in population-based cohort studies. Nevertheless, case-control studies have consistently shown an increased prevalence of PFO in cryptogenic stroke, suggesting that PFO might be a cause of stroke. The risk of stroke recurrence in patients with cryptogenic stroke and PFO is low under aspirin therapy but may be substantially higher in patients with an associated atrial septal aneurysm (ASA). The mechanisms of stroke associated with PFO or ASA are uncertain. Paradoxical embolism through the PFO is rarely documented. The optimal treatment for secondary prevention in patients with cryptogenic stroke and PFO is still uncertain and debated. A randomized controlled trial failed to demonstrate the superiority of transcatheter PFO closure over medical therapy. Whether anticoagulation is superior to aspirin should be tested in a randomized controlled trial.


http://ovidsp.tx.ovid.com/sp-3.15.1b/ovidweb.cgi?&S=GGODFPBJELDDPFFNCKKPBJCABKMA00&Complete+Reference=S.sh.48%7c9%7c1

**EDUCATIONAL OBJECTIVES:**

Upon completion of this conference, participants should be better able to:
- Describe the epidemiology, anatomy and pathological implications of Patient Foramen Ovale (PFO).
- Implement evidence-based evaluation methods to assess patients with PFO’s.
- Examine and compare the relationship between a PFO and cryptogenic stroke.
- Assess and identify stroke patients who may benefit from PFO closure.

**COMPETENCIES:** What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

- ☑ Patient Care
- ☑ Medical Knowledge
- ☑ Interpersonal and Communications Skills
- ☑ Professionalism
- ☑ Systems-based Practice
- ☑ Practice-based Learning and Improvement
EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:
- ☑ Baptist Health CME Evaluation Form (post-Conference)
- ☑ Follow-up Survey
- ☑ Review of Hospital, Health System or Other Data
- ☑ Other_____________________

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)
- ▶ As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?
- ▶ If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so:_________________________

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

Ian del Conde Pozzi, M.D.
Cardiovascular Disease and Vascular Medicine Specialist
Miami Cardiac & Vascular Institute and Baptist, Doctors, Homestead and West Kendall Baptist Hospitals
Miami, Florida

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).

Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
- ☑ Yes  ☐ No
- ☑ CME Dept. Leadership and Staff
- ☐ CME Committee
- ☑ Conference Director (see above)
- ☑ Others (i.e.: Conference Coordinator, Planning Group etc.)

COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. ☐ Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners?  ☐ Yes  ☑ No  If 'yes', list the barrier(s) identified and include relevant data and information about the barriers:

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission?  ☐ Yes  ☑ No  If yes, please describe the related CME program change:______________________________

And describe how the impact of the related program improvement will be measured and documented? (C15)

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
- ☑ Process redesign or new protocol
- ☑ Reminders (Posters, mailings, email blasts)
- ☑ New order sheets
- ☐ Other tools or tactics

Explain:____________________________________________________________________________

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)
- ☑ Yes  ☐ No
- Are we partnering with other organizations in a purposeful manner to achieve common interests?
- ☑ Yes  ☐ No
- Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.________________________________________

This series is planned in collaboration with the Baptist Hospital Neuroscience Center, a Stroke-accredited Center, which also includes the Neuro-critical care and Spine Surgery departments.

DATE REVIEWED: _____03.31.2015_______ REVIEWED BY: ☐ Executive Committee  ☑ Chairman

APPROVED: ☑ YES  ☐ NO  ■ Credits: AMA/PRA Category 1 Credits: # 1
Continuing Psychology Education Credits: # 1 ☐ N/A  ■ Continuing Dental Education Credits: # _____ ☐ N/A
CME ACTIVITY TITLE: Third Annual Foot and Ankle Symposium

DATE: Friday, September 18, 2015  
TIME: 12:30 p.m. - 5:20 p.m.

LOCATION: The Ritz-Carlton Coconut Grove, Miami  
CREDIT HOUR(S) APPLIED FOR: 4 Cat. 1

CONFERENCE DIRECTOR: Jason Hanft, DPM

AMA/PRA LEARNING FORMAT:
- Live activity
- Enduring material
- Journal-based CME activity
- Test-item writing activity
- Manuscript review activity
- PI CME activity
- Internet point-of-care activity

TARGET AUDIENCE: Podiatrists, Surgeons, Surgical Nurses and Physical Therapists.

EXPECTED NUMBER OF ATTENDEES: 80-85

SYMPOSIUM RATES: See below.

<table>
<thead>
<tr>
<th></th>
<th>Third Annual Foot &amp; Ankle (Friday, September 18) (4 CME/CE)</th>
<th>10th Annual Wound Care Symposium (Saturday, September 19) (6 CME/CE)</th>
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<tbody>
<tr>
<td>Physician Rate</td>
<td>$135 Foot &amp; Ankle Only</td>
<td>$215 Wound Care Only</td>
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<tr>
<td>COMBO</td>
<td>Discounted Combined Registration (10% discount)</td>
<td>$315</td>
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**Physicians Group Rates**  
(Groups of 3 or more that register at the same time only)

<table>
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<tr>
<th></th>
<th>Group Rate for Both Meetings</th>
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<td>GROUP DAILY RATE</td>
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<td>$125</td>
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Nurses & Allied Health Professionals

<table>
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<tr>
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<th>$115 Foot &amp; Ankle Only</th>
<th>$175 Wound Care Only</th>
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</thead>
<tbody>
<tr>
<td>COMBO</td>
<td>Discounted Combined Registration (10% discount)</td>
<td>$260</td>
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</table>

**Nurses & Allied Health Professionals Group Rates**  
(Groups of 3 or more that register at the same time only)

<table>
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<tbody>
<tr>
<td>GROUP DAILY RATE</td>
<td>$95</td>
<td>$100</td>
<td></td>
</tr>
</tbody>
</table>

Baptist Health Employees

|                | $25                          | $35                                     |

Students

|                | $25                          | $35                                     |
TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- Other (specify)

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review
- Other (Explain): _____________________________
FACTORs OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18)

Patient: □ Non-compliance □ Lifestyle □ Resistance-to-change □ Financial/Lack of Insurance

Physician: □ Non-compliance □ Resistance-to-change □ Communication Skills □ Financial

Resources: □ Institutional Capabilities □ Physician Practice Limitations □ Community Service Limitations

State of Science: □ Limited or No Treatment Modalities □ Limited or No Diagnostic Modalities

Other: ____________________________

PROFESSIONAL PRACTICE GAP (C2)

The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP*? What are physicians doing (or not doing) that needs to change? Describe the practice gap.

► Podiatrists may not be familiar with the current, evidence-based, best practice recommendations for common podiatric problems and may not recognize as well as when to escalate treatment interventions and consider surgical interventions.

WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)

► Podiatrists implement current, evidence-based, best practice recommendations for common podiatric problems and provide timely escalation of care when surgical interventions are recommended.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:

□ Knowledge (Doctors do not know that they need to be doing something.)

□ Competence (Doctors do not know how to do it)

□ Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)

And will this result in a change in □ Competence? -or- □ Performance? -or- □ Patient Outcomes*? (Check all that apply.)

*(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)

► Podiatrists will implement evidence-based, best practice recommendations in their approaches to the management of the podiatric patient.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

► See attached.

EDUCATIONAL OBJECTIVES

Upon completion of this conference, participants should be better able to:

See attached.

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

□ Patient Care □ Medical Knowledge □ Interpersonal and Communications Skills

□ Professionalism □ Systems-based Practice □ Practice-based Learning and Improvement

EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

□ Baptist Health CME Evaluation Form (post-Conference) □ Follow-up Survey

□ Review of Hospital, Health System or Other Data □ Other

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)

► As a result of what you learned at this symposium what do you intend to do differently? What new strategies will you apply to your practice?

► If you do not plan to implement any new strategies learned at this symposium, please list any barriers or obstacles that might keep you from doing so: ____________________________

FACULTY: See attached.

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).

Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)

□ Yes □ No □ CME Dept. Leadership and Staff □ CME Committee

□ Conference Director (see above) □ Others (i.e.: Conference Coordinator, Planning Group etc.)
COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. □ Indicate here if support will come from the Foundation general Continuing Medical Education fund.

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners? □ Yes □ No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
□ Process redesign or new protocol □ Reminders (Posters, mailings, email blasts) □ New order sheets
□ Other tools or tactics
Explain: ________________________

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)
□ Yes □ No Are we partnering with other organizations in a purposeful manner to achieve common interests?
□ Yes □ No Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.
This symposium has been planned in collaboration with the Podiatry Residency Program at South Miami Hospital.

DATE REVIEWED: ____________ REVIEWED BY: ❑ Executive Committee ❑ Chairman
APPROVED: □ YES □ NO □ Credits: AMA/PRA Category 1 Credits: # 4
Continuing Psychology Education Credits: # N/A □ Continuing Podiatry Education Credits: # N/A

FACULTY:

Jason R. Hanft, DPM, FACFAS
Podiatrist, Baptist, Doctors and South Miami Hospitals
Director of Podiatric Education and Director of Research, Podiatry Residency Program, South Miami Hospital
Adjunct Professor, Rosalind Franklin University, Temple University and Barry University
Diplomate, American Board of Podiatric Surgery
Chief Science Officer, Doctors Research Network, South Miami, Florida
South Miami, Florida

Adam Landsman, DPM, Ph.D.
Assistant Professor of Surgery
Harvard Medical School
Chief, Division of Podiatric Surgery
Cambridge Health Alliance
Cambridge, Massachusetts

John S. Steinberg, DPM FACFAS
Associate Professor, Department of Plastic Surgery, Georgetown University School of Medicine
Program Director, MedStar Washington Hospital Center Podiatric Residency
Co-Director, Center for Wound Healing, MedStar Georgetown University Hospital
Washington, D.C.
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>12:30 p.m.</td>
<td>Registration, Snack and Exhibits</td>
</tr>
<tr>
<td>1 p.m.</td>
<td>Welcome and Introductions</td>
</tr>
<tr>
<td></td>
<td>Jason R. Hanft, DPM, FACFAS</td>
</tr>
<tr>
<td>1:10 p.m.</td>
<td>Onychomycosis: Reality vs. Fiction</td>
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<td></td>
<td>Adam Landsman, DPM, Ph.D.</td>
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<tr>
<td>2:00 p.m.</td>
<td>Charcot Foot: Treatment &amp; Reconstruction</td>
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<tr>
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<td>John S. Steinberg, DPM, FACFAS</td>
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<tr>
<td>2:50 p.m.</td>
<td>Break</td>
</tr>
<tr>
<td>3:00 p.m.</td>
<td>Post-operative Surgical Complications</td>
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<tr>
<td></td>
<td>Adam Landsman, DPM, Ph.D.</td>
</tr>
<tr>
<td>3:50 p.m.</td>
<td>Imaging: Current Modalities for Effective Diagnosis and Treatment of Osteomyelitis</td>
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<tr>
<td></td>
<td>John S. Steinberg, DPM, FACFAS</td>
</tr>
<tr>
<td>4:40 p.m.</td>
<td>Round Table: Current Controversies in the Surgical Approach to the Foot and Ankle</td>
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<tr>
<td></td>
<td>Adam Landsman, DPM, Ph.D., John S. Steinberg, DPM FACFAS, and</td>
</tr>
<tr>
<td></td>
<td>Jason R. Hanft, DPM, FACFAS</td>
</tr>
<tr>
<td>5:20 p.m.</td>
<td>Adjourn</td>
</tr>
</tbody>
</table>

**TOPICS, LEARNING OBJECTIVES, REFERENCES**

**Charcot Foot: Treatment & Reconstruction**  
John S. Steinberg, DPM, FACFAS

**Learning Objectives:**
- Establish when surgical versus non-surgical interventions are indicated for the treatment of Charcot Foot condition.

**References:** Most patients with CN can be treated with immobilization and protected weightbearing. Utilization of a Total contact casting (TCC) is the preferred method of a non-surgical management. The overall benefit of the antiresorptive therapies on healing remains unclear, and the benefit of anabolic therapy with parathyroid hormone is yet to be established in chronic Charcot foot treatment. Although non-operative treatment with use of a TCC followed by an appropriate bracing and footwear is considered to be the gold standard treatment for CN, surgical treatment is essential when conservative treatment fails. Surgical treatment is reserved for chronic recurrent ulcers, unbraceable deformity, acute fracture, dislocation or infection.  

**Imaging: Current Modalities for Effective Diagnosis and Treatment of Osteomyelitis**  
John S. Steinberg, DPM, FACFAS

**Learning Objectives:**
- Determine when to utilize imaging studies to assess and diagnosis foot infections.
- Develop patient treatment plan based on imaging findings.

**Reference:** Diagnosing the presence of infection in the foot of a patient with diabetes can sometimes be a difficult task. Because open wounds are always colonized with microorganisms, most agree that infection should be diagnosed by the presence of systemic or local signs of inflammation. Determining whether or not infection is present in bone can be especially difficult. Diagnosis begins with a history and physical examination in which both classic and 'secondary' findings suggesting invasion of microorganisms or a host response are sought. Serological tests may be helpful, especially measurement of the erythrocyte sedimentation rate in osteomyelitis, but all (including bone biomarkers and procalcitonin) are relatively non-specific. Cultures of properly obtained soft tissue and bone specimens can diagnose and define the causative pathogens in diabetic foot infections. Newer molecular microbial techniques, which may not only identify more organisms but also virulence factors and antibiotic resistance, look very promising. Imaging tests generally begin with plain X-rays; when these are inconclusive or when more detail of bone or soft tissue abnormalities is required, more advanced studies are needed. Among these, magnetic resonance imaging is generally superior to standard radionuclide studies, but newer hybrid imaging techniques (single-photon emission computed tomography/computed tomography, positron emission tomography/computed tomography and positron emission tomography/magnetic resonance imaging) look to be useful techniques, and new radiopharmaceuticals are on the horizon. In some cases, ultrasonography, photographic and thermographic methods may also be diagnostically useful. Improved methods developed and tested over the past decade have clearly increased our accuracy in diagnosing diabetic foot infections. ([Diabet Med.](http://www.sciencedirect.com/science/article/pii/S0899763414002184) 2015 Mar 15, 32(3):188-93) Challenges in diagnosing infection in the diabetic foot. Glaudemans AW, Uckay I, Lipsky BA.)

**Onychomycosis: Reality vs. Fiction**  
Adam Scott Landsman, Ph.D., D.P.M.

**Learning Objectives:**
- Explain available treatment options that effectively cure onychomycosis, and determine appropriate course of treatment based on patient assessment.

**References:** Onychomycosis is an often overlooked and/or undertreated disease. This may be in part due to an under appreciation among both physicians and patients of its impact on quality of life and the potential for significant complications, from tinea corporis and cruris, to bacterial superinfection. Some health care providers are unaware of the effective low-risk treatments currently available. Changing demographic characteristics such as the relative aging of the population; the increasing prevalence...
of diabetes and peripheral vascular disease, and widespread iatrogenic immunosuppression; and changes in lifestyle practices such as earlier and greater participation in sports, are likely to lead to an increased prevalence of onychomycosis in both adults and children. Two topical onychomycosis treatments, efinaconazole 10% solution, and tavaborole 5% solution were recently approved by the FDA. (J Drugs Dermatol. 2015 Mar 1;14(3):223-8. Onychomycosis: epidemiology, diagnosis, and treatment in a changing landscape. Rosen T, et. al)

**Post-operative Surgical Complications**
Adam Scott Landsman, Ph.D., D.P.M.

- Implement a thorough post-surgery physical examination to identify potential complications and initiate appropriate treatment in a timely manner.
- Delineate state-of-the-art treatment modalities available for post-operative foot and ankle surgical complications.

**Reference:** Surgical site infections are one of the most common post-operative complications encountered by foot and ankle surgeons. The incidence reported in the literature varies between 0.5 and 6.5%. The results of a 12-month Australia-wide clinical audit analyzing the rates of postoperative infections in association with podiatric surgery are presented. A total of 1339 patient admissions and 2387 surgical procedures were reported using the International Classification of Diseases (ICD-10) and Medicare Benefit Schedule (MBS) coding systems. The overall infection rate was 3.1% and the rate of infection resulting in hospital readmission was 0.25%. The benchmark results presented in this paper suggest that infection rates associated with podiatric surgery are well within accepted industry standards as stated in recent literature. (Aust Health Rev. 2010 May;34(2):180-5. Postoperative infection rates in foot and ankle surgery: a clinical audit of Australian podiatric surgeons, January to December 2007. Butterworth P, et. al)

The incidence of postoperative surgical site infection (SSI) reported in the published data for foot and ankle surgery has been 1.0% to 5.3%. A variety of interventions have been used before, during, and after surgery to decrease the patient's risk of acquiring an infection at the surgical site. Foot and ankle surgeons often keep the incision site dry and covered until the sutures and pins have been removed, with the goal of preventing a SSI, despite the lack of available published evidence to support this practice. We undertook a prospective observation of 110 elective surgical patients to determine the rate of SSI when early surgical site exposure and showering were allowed. The risk factors for infection were recorded, and a series of logistic regression analyses was performed to determine the associations between the infection rate and early showering. The patients were evaluated at each postoperative appointment for signs of infection. For the present study, mild infection was defined as the subjective presence of erythema and/or swelling beyond that typically expected in the early postoperative period. These cases of presumed or mild SSI were managed with oral antibiotics until they had resolved. Major infection was defined as any infection altering the course of recovery or requiring admission or additional surgery. The overall infection rate was 4.5%, with all infections considered mild. Logistic regression analysis showed that none of the recorded risk factors significantly predicted infection. The results of the present study suggest that early daily showering of a surgical site after foot and ankle surgery will not be significantly associated with an increased risk of infection. *Incidence of Surgical Site Infection in the Foot and Ankle with Early Exposure and Showering of Surgical Sites: A Prospective Observation, The Journal of Foot and Ankle Surgery, February 2014*