CONFERENCE APPLICATIONS AND REPORTS
Applications Previously Approved
December 15-January 14

RSS  Crisis Resource Management Training: Advanced (1.5 Cat. 1/ ea)
RSS  Crisis Resource Management Training: Introduction (3 Cat. 1/ ea)
RSS  Crisis Resource Management Training: Ongoing (1.5 Cat. 1/ ea)
RSS  Orthopedic Trauma Fracture Conference (1 Cat. 1/ ea)
03.05.15  Cardiovascular Conference Series: Advances in Antithrombotic Therapy: Update on NOACs (1 Cat. 1)
03.10.15  Pediatric Conference Series: Delayed Diagnosis in Pediatric Acute Care - Avoid Legal Issues (1.5 Cat. 1)
03.13.15  Ob/Gyn Conference Series: Cosmetics for the Gynecologist (1 Cat. 1)
03.20.15  Conversations in Ethics: Ethical Challenges with Severely Ill Neonates (1 Cat. 1 each)
04.30.15  FOURTH ANNUAL OMAR PASALODOS, M.D., MEMORIAL LECTURE: The State of Ovarian Cancer in the US: Why Aren’t We Making More Progress? (1.5 Cat. 1)
CME ACTIVITY TITLE: Crisis Resource Management Training: Advanced

DATE: January 2015 to January 2016

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: Maria Victoria Lopez-Beecham, M.D.

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

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

EXPECTED NUMBER OF ATTENDEES: 200-250 per year

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
- 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
- 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

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

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

Other: _____________________________
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.

► Medical teams may not be aware of the value of successful team behavior and effective communication techniques and their impact on patient outcomes. High acuity and rare events occur in the inpatient hospital setting. This may present stressful scenarios in which the team may have limited experience.

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

► The inter-professional healthcare team appreciates the importance of successful teamwork and effective communication techniques during a crisis, utilizes effective teamwork, communication skills and CRM principles to improve patient safety and outcomes during a crisis.

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.)

► Practitioners will practice effective teamwork and communicate skills during a crisis situation to enhance team function and collaboration and to improve patient outcomes.

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

► This form of education simulates the stress of a crisis situation allowing the healthcare team to react as they would in a real scenario without risking harm to a real patient. Simulation-based mastery learning in medical education can produce downstream results. Such results derive from integrated education and health services research programs that are thematic, sustained and cumulative. The new discipline of implementation science holds promise to explain why medical education innovations are adopted slowly and how to accelerate innovation dissemination. (A critical review of simulation-based mastery learning with translational outcomes William C McGaghie, Saul B Issenberg, Jeffrey H Barsuk & Diane B Wayne, Med Educ. 2014 Apr;48(4):375-85)

EDUCATIONAL OBJECTIVES

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

▪ Demonstrate basic principles of effective teamwork- leadership, role clarity and closed loop communication.
▪ Explain the advanced principles of team dynamics- situational awareness and shared mental models.
▪ Assess how human factors affect individual and team performance.
▪ Summarize the impact of crisis resource management on patient safety and outcomes.

FORMAT AND SCENARIOS:

A. Introduction & Orientation: 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 information regarding the scenarios presented.

B. Case Scenario: Participants will participate in one simulation scenario that will take about fifteen to twenty minutes to complete.

C. Debriefing: A thirty 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 reinforce SBAR and CUS techniques. These materials have helpful visual reminders regarding these patient safety techniques.

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
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Medical Director, Baptist Health Patient Safety Simulation Lab

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Joseph Nirmal, M.D.
Kenda Plasencia
Linda Johnson
Marrice King
Matt Kaczmarski, M.D.
Norma Bonilla
Paula Barrass
Rachel Mayers
Shamma LeGrand
Susana Flores
Victor Gonzalez, M.D.
Victor Ospina
David Mishkin, M.D.

CONTENT AREAS/SCENARIOS/TARGET AUDIENCE

SPECIALTIES: Emergency Medicine, Obstetrics, Neonatology, Pediatrics, Anesthesia, Critical Care, Internal Medicine, Internal Medicine Subspecialties, Surgery, and Radiology

Scenarios: Septic Shock, Ruptured Ectopic Pregnancy, ED STEMI and Sarin Exposure, Cardiac Tamponade, Malignant hyperthermia, Addisonian Crisis, Myxedema Coma, Thyroid Storm, Shoulder Dystocia, Eclampsia, Hemorrhage, Eclampsia/Aspiration/PEA, High Epidural/Spinal, Magnesium Toxicity, Pulmonary Embolism, Two Triage Patients (Breech/PE), Cardiac Tamponade, Diaphragmatic Hernia, Gastrochisis, UAC dislodged, Hydrops and Pneumothorax, Pediatric Resuscitation, Local Anesthetic Toxicity Scenario, High Spinal/Epidural in an Obstetrical Patient, Anaphylaxis, Unstable SVT, Adrenal Hemorrhage, Mega Code, Maternal Code, Hypertensive Crisis

Target Audience: Physicians, Nurses, Nurse Anesthetists (CRNAs), Respiratory Therapists, Technicians, Clinical Partners, and Pharmacists

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 ☐ Non-clinical content (See below)

☐ CME Dept. Leadership and Staff ☐ CME Committee
☐ Conference Director (see above) ☐ Others (i.e.: Conference Coordinator, Planning Group etc.)

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.  

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<td><strong>BARRIERS TO PHYSICIAN CHANGE:</strong> (C19)</td>
<td>Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners?</td>
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<td><strong>OVERALL PROGRAM CHANGES:</strong></td>
<td>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?</td>
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In support of the CME Program mission, this activity was developed to improve patient care, safety and treatment outcomes by bringing about change in physician behavior during a crisis situation. The impact of this activity will be measured and documented through evaluation data collected immediately after simulation training session.

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<td><strong>NON-EDUCATION STRATEGIES:</strong></td>
<td>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)</td>
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<td><strong>COLLABORATION:</strong></td>
<td>Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) that are related to this CME activity? (C20)</td>
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If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. This course is planned in collaboration with the Baptist Health Patient Safety Simulation Lab as they partner with departments with the BHSF to improve team communication.

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<td><strong>DATE REVIEWED:</strong></td>
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<td><strong>APPROVED:</strong></td>
<td>☑ YES ☐ NO</td>
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<td>Continuing Psychology Education Credits: # 1 ☐ N/A</td>
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<td><strong>APPLICABLE CREDITS:</strong></td>
<td>AMA Category 1 ☑</td>
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DATE: November 2014 to November 2016

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

LOCATION: Patient Safety Simulation Lab, Baptist Hospital

CREDIT HOUR(S) APPLIED FOR: 3 Cat. 1 each

CONFERENCE DIRECTOR: Maria Victoria Lopez-Beecham, M.D.

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

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

EXPECTED NUMBER OF ATTENDEES: 200-250 per year  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: 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.

► Medical teams may not be aware of the value of successful team behavior and effective communication techniques and their impact on patient outcomes. High acuity and rare events occur in the inpatient hospital setting. This may present stressful scenarios in which the team may have limited experience.

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

► The inter-professional healthcare team appreciates the importance of successful teamwork and effective communication techniques during a crisis, utilizes effective teamwork, communication skills and CRM principles to improve patient safety and outcomes during a crisis.

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.)

► Practitioners will practice effective teamwork and communicate skills during a crisis situation to enhance team function and collaboration and to improve patient outcomes.

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

► This form of education simulates the stress of a crisis situation allowing the healthcare team to react as they would in a real scenario without risking harm to a real patient. Simulation-based mastery learning in medical education can produce downstream results. Such results derive from integrated education and health services research programs that are thematic, sustained and cumulative. The new discipline of implementation science holds promise to explain why medical education innovations are adopted slowly and how to accelerate innovation dissemination. (A critical review of simulation-based mastery learning with translational outcomes William C McGaghie, Saul B Issenberg, Jeffrey H Barsuk & Diane B Wayne, Med Educ. 2014 Apr;48(4):375-85)

EDUCATIONAL OBJECTIVES

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

• Explain the basic principles of effective teamwork - leadership, role clarity and closed loop communication.
• Utilize effective communication skills within a multidisciplinary team.
• Recognize the importance of Crisis Resource Management principles in patient safety.
• Apply improved teamwork and communication skills in daily practice.

FORMAT AND SCENARIOS:
A. Introduction & Orientation: 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 two simulation scenarios that will take about fifteen to twenty minutes each to complete.
C. Debriefing: A thirty 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 reinforces SBAR and CUS techniques. These materials have helpful visual reminders regarding these patient safety techniques.

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: ____________________________________________

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CONTENT AREAS/SCENARIOS/TARGET AUDIENCE

SPECIALTIES: Emergency Medicine, Obstetrics, Neonatology, Pediatrics, Anesthesia, Critical Care, Internal Medicine, Internal Medicine Subspecialties, Surgery, and Radiology

Scenarios: Septic Shock, Ruptured Ectopic Pregnancy, ED STEMI and Sarin Exposure, Cardiac Tamponade, Malignant hyperthermia, Addisonian Crisis, Myxedema Coma, Thyroid Storm, Shoulder Dystocia, Eclampsia, Hemorrhage, Eclampsia/Aspiration/PEA, High Epidural/Spinal, Magnesium Toxicity, Pulmonary Embolism, Two Triage Patients (Breech/PE), Cardiac Tamponade, Diaphragmatic Hernia, Gastroscisis, UAC dislodged, Hydros and Pneumothorax, Pediatric Resuscitation, Local Anesthetic Toxicity Scenario, High Spinal/Epidural in an Obstetrical Patient, Anaphylaxis, Unstable SVT, Adrenal Hemorrhage, Mega Code, Maternal Code, Hypertensive Crisis

Target Audience: Physicians, Nurses, Nurse Anesthetists (CRNAs), Respiratory Therapists, Technicians, Clinical Partners, and Pharmacists

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  ☑ Non-clinical content (See below)
☐ CME Dept. Leadership and Staff  ☐ CME Committee
☐ Conference Director (see above)  ☐ Others (i.e.: Conference Coordinator, Planning Group etc.)

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 

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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)

In support of the CME Program mission, this activity was developed to improve patient care, safety and treatment outcomes by bringing about change in physician behavior during a crisis situation. The impact of this activity will be measured and documented through evaluation data collected immediately after simulation training session.

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: Incorporate/reinforce teamwork and communication skills into daily work processes through checklists, “Plus/Delta” debriefing forms, visual aids.

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 course is planned in collaboration with the Baptist Health Patient Safety Simulation Lab as they partner with departments with the BHSF to improve team communication.

DATE REVIEWED: January 12, 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: Crisis Resource Management Training: Ongoing

DATE: January 2015 – January 2016

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: Maria Victoria Lopez-Beecham, M.D.

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- Joint Commission initiatives
- Mortality/morbidity statistics
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- National/regional data
- Other (Explain): _____________________________
- New or updated policy/protocol
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- 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)

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<th>Resources:</th>
<th>State of Science:</th>
<th>Other:</th>
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**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.

► Medical teams may not be aware of the value of successful team behavior and effective communication techniques and their impact on patient outcomes. High acuity and rare events occur in the inpatient hospital setting. This may present stressful scenarios in which the team may have limited experience.

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

► The inter-professional healthcare team appreciates the importance of successful teamwork and effective communication techniques during a crisis, utilizes effective teamwork, communication skills and CRM principles to improve patient safety and outcomes during a crisis.

**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.)*

► Practitioners will practice effective teamwork and communicate skills during a crisis situation to enhance team function and collaboration and to improve patient outcomes.

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

► This form of education simulates the stress of a crisis situation allowing the healthcare team to react as they would in a real scenario without risking harm to a real patient.

Simulation-based mastery learning in medical education can produce downstream results. Such results derive from integrated education and health services research programs that are thematic, sustained and cumulative. The new discipline of implementation science holds promise to explain why medical education innovations are adopted slowly and how to accelerate innovation dissemination. *(A critical review of simulation-based mastery learning with translational outcomes* William C McGaghie, Saul B Issenberg, Jeffrey H Barsuk & Diane B Wayne, Med Educ. 2014 Apr;48(4):375-85)

**EDUCATIONAL OBJECTIVES**

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

- Practice utilizing crisis resource management principles in a medical crisis.
- Demonstrate effective teamwork and communication skills.
- Evaluate individual and team application of crisis management principles utilizing a plus/delta tool.

**FORMAT AND SCENARIOS:**

A. Introduction & Orientation: 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 scenario that will take about fifteen to twenty minutes to complete.

C. Debriefing: A thirty 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 reinforce SBAR andCUS techniques. These materials have helpful visual reminders regarding these patient safety techniques.

**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

Zulma Berrios, M.D.
Faculty, Baptist Health Patient Safety Simulation Lab

Luis A. De La Cruz, M.D.
Faculty, Baptist Health Patient Safety Simulation Lab

Paul Gluck, M.D.
Faculty, Baptist Health Patient Safety Simulation Lab

William Smalling, 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.

Adrienne Baloun
Aireca Daly
Carolina Garcia, M.D.
Ernesto Valdes, M.D.
Gina Vogt
Jessica Silversmith, M.D.
Jo Ann Aberilla
Joseph Nirmal, M.D.
Kenda Plasencia
Linda Johnson

Marrice King
Matt Kaczmarski, M.D.
Norma Bonilla
Paula Barrass
Rachel Mayers
Shamma Legrand
Susana Flores
Victor Gonzalez, M.D.
Victor Ospina
David Mishkin, M.D.

CONTENT AREAS/SCENARIOS/TARGET AUDIENCE

SPECIALTIES: Emergency Medicine, Obstetrics, Neonatology, Pediatrics, Anesthesia, Critical Care, Internal Medicine, Internal Medicine Subspecialties, Surgery, and Radiology

Scenarios: Septic Shock, Ruptured Ectopic Pregnancy, ED STEMI and Sarin Exposure, Cardiac Tamponade, Malignant hyperthermia, Addisonian Crisis, Myxedema Coma, Thyroid Storm, Shoulder Dystocia, Eclampsia, Hemorrhage, Eclampsia/Aspiration/PEA, High Epidural/Spinal, Magnesium Toxicity, Pulmonary Embolism, Two Triage Patients (Breech/PE), Cardiac Tamponade, Diaphragmatic Hernia, Gastrochisis, UAC dislodged, Hydrops and Pneumothorax, Pediatric Resuscitation, Local Anesthetic Toxicity Scenario, High Spinal/Epidural in an Obstetrical Patient, Anaphylaxis, Unstable SVT, Adrenal Hemorrhage, Mega Code, Maternal Code, Hypertensive Crisis

Target Audience: Physicians, Nurses, Nurse Anesthetists (CRNAs), Respiratory Therapists, Technicians, Clinical Partners, and Pharmacists

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 ☐ Non-clinical content (See below)

☐ CME Dept. Leadership and Staff ☐ CME Committee
☐ Conference Director (see above) ☐ Others (i.e.: Conference Coordinator, Planning Group etc.)

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)

In support of the CME Program mission, this activity was developed to improve patient care, safety and treatment outcomes by bringing about change in physician behavior during a crisis situation. The impact of this activity will be measured and documented through evaluation data collected immediately after simulation training session.

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: Incorporate/reinforce teamwork and communication skills into daily work processes through checklists, “Plus/Delta” debriefing forms, visual aids.

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 course is planned in collaboration with the Baptist Health Patient Safety Simulation Lab as they partner with departments with the BHSF to improve team communication.

DATE REVIEWED: January 12, 2015 REVIEWED BY: ☐ Executive Committee ☑ Chairman

APPROVED: ☑ YES ☐ NO ☑ Credits: AMA/PRA Category 1 Credits: # 1.5

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: Advances in Antithrombotic Therapy: Update on NOACs

DATE: Thursday, March 5, 2015  TIME: 12 noon – 1 p.m.  LOCATION: 5MCVI
VC: HH Mango rm, SMH MCVI Conf. Room and WKBH CL 4 and 5 – LIVE WEBCAST

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

AMA/PRA LEARNING FORMAT:
☒ Live activity  ☑ Test-item writing activity  ☐ Internet point-of-care activity
☐ Enduring material  ☐ Manuscript review activity
☐ Journal-based 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  ☑ Question & Answer  ☐ Enduring Material
☒ Didactic Lecture  ☑ Case Studies  ☐ Internet-Home Study
☐ ARS  ☑ Panel  ☐ Other (specify)_________

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check and explain.)
☐ 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 (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 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)

DESIGNED OUTCOMES (GOAL): Will this result in a change in ☐ Competence? -or- ☐ Performance? -or- ☐ Patient Outcomes**? (C3) (Check one or more.) *(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?

Physicians will consider NOACs for the cardiac patient.

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.
The Joint Commission has mandated educational programming to address this safety goal. It is also in support of our Baptist Health Coumadin Clinic.
CME ACTIVITY TITLE: Ob/Gyn Conference Series: Cosmetics for the Gynecologist
DATE: Friday, March 13, 2015  TIME: 8 a.m. - 9 a.m.
LOCATION: Baptist Hospital of Miami, Classroom 5  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTOR: Jason James, M.D.

AMA/PRA LEARNING FORMAT:

- Live activity
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring material
- Test-item writing activity
- Manuscript review activity
- Internet point-of-care activity
- Journal-based CME activity
- PI CME activity

TARGET AUDIENCE: Ob/Gyns and Nurses.

EXPECTED NUMBER OF ATTENDEES: 30-35  CHARGE: 0

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

<table>
<thead>
<tr>
<th>Live</th>
<th>Didactic Lecture</th>
<th>ARS</th>
<th>Question &amp; Answer</th>
<th>Case Studies</th>
<th>Panel</th>
<th>Enduring Material</th>
<th>Internet-Home Study</th>
<th>Other (specify)</th>
</tr>
</thead>
</table>

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): ACOG Practice Guidelines

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)

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Non-compliance</th>
<th>Lifestyle</th>
<th>Resistance-to-change</th>
<th>Financial/Lack of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician:</td>
<td>Non-compliance</td>
<td>Resistance-to-change</td>
<td>Communication Skills</td>
<td>Financial</td>
</tr>
<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>
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<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
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</tr>
</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.

► Ob/Gyns approached by patients asking about available genital cosmetic surgery procedures, may not be aware of available procedures, patient eligibility and potential complications.

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

► Ob/Gyns capably address patient’s body image concerns and advise them on available cosmetic procedures and potential complications.

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 able to advise patients on available cosmetic procedures, patient eligibility, procedure risks and complications.

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

► The scope of obstetric gynecologic practice includes more than reproductive health care. The specialty’s broad focus on women’s health may include cosmetic services and procedures, just as this broad focus includes a wide variety of primary and preventive care. The obstetrician gynecologist may provide services that fill a need not adequately met in commercial sites, provide safer or more efficacious treatments than those available in nonmedical settings, or provide services as a convenience to patients. Special care must be taken when patients are considering procedures in an effort to enhance sexual appearance or function, as female sexual response has been shown to be an intricate process determined predominantly by brain function and psychosocial factors, not by genital appearance. Such procedures are not medically indicated, and their safety and effectiveness have not been documented. 1(ACOG Statement of Policy 2008 and reaffirmed 7/2012)

Medically indicated surgical procedures may include reversal or repair of female genital cutting and treatment for labial hypertrophy or asymmetrical labial growth secondary to congenital conditions, chronic irritation, or excessive androgenic hormones. Other procedures, including vaginal rejuvenation, designer vaginoplasty, revirgination, and G-spot amplification, are not medically indicated, and the safety and effectiveness of these procedures have not been documented. (ACOG Committee Opinion #378, Reaffirmed 2014)

Dr. James, Chief of ObGyn, requested an educational update on female genital cosmetic surgery, because patient interest is growing and physicians need to be prepared to responsibly and competently answer their patients’ questions.

EDUCATIONAL OBJECTIVES

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

• Assess the gynecologist’s role in genital cosmetic surgery.
• Discuss the labiaplasty debate.
• Advise patients on available genital cosmetic procedures, the logistics of the procedures, patient eligibility, post-op follow-up and common complications.

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.)

Teri Benn, M.D.
Obstetrician and Gynecologist
Baptist Hospital of Miami
Miami, FL

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: January 28, 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: Pediatric Emergency Conference Series: Delayed Diagnosis in Pediatric Acute Care – Avoid Legal Issues

DATE: Tuesday, March 10, 2015
TIME: 6:00 – 7:30 p.m.

LOCATION: Baptist Hospital, Auditorium VC to Homestead Hospital Boardroom

CONFERENCE DIRECTOR: Jennifer Cheney, M.D.

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:
Pediatricians, Internists, Neurologists, Neonatologists, Pediatric Emergency Medicine Physicians, Orthopedists, Pediatric Oncologists and Psychologists and related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 40-45 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
- [x] Question & Answer
- [ ] ARS
- [ ] Case Studies
- [ ] Panel
- [x] Internet-Home Study
- [ ] Other (specify)

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

Resources: [ ] Institutional Capabilities [x] Physician Practice Limitations [ ] Community Service Limitations
State of Science: [ ] Limited or No Treatment Modalities [x] Limited or No Diagnostic Modalities
Other: _____________________________
**EDUCATIONAL OBJECTIVES:**
Upon completion of this conference, participants should be better able to:
1. Discuss common diagnoses that lead to malpractice suits in pediatric acute care and emergency medicine.
2. Identify prominent factors contributing to diagnostic errors by examining previous medical legal cases in pediatrics.
3. Implement strategies in emergency and acute pediatric care to reduce most-frequent diagnostic errors and process breakdowns.

<table>
<thead>
<tr>
<th>PROFESSIONAL PRACTICE GAP (C2)</th>
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<tbody>
<tr>
<td>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.</td>
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**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.

► In a 2009 survey, Pediatricians reported making diagnostic errors relatively frequently, and they endorsed inadequate data-gathering, poor care coordination, and patient/caregiver-related delays as prominent contributing factors. Improved follow-up of patients and access to electronic health records were perceived as the most promising potential interventions.

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

► Pediatricians accurately diagnose and treat children. Properly diagnosed and treated children lessen malpractice claims and improve 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.)

**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.)*

► Pediatricians engage in targeted training and interventions to prevent diagnostic errors in the pediatric emergency room.

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

► Errors of Diagnosis in Pediatric Practice: A Multisite Survey, [http://pediatrics.aappublications.org/content/126/1/70.full?sid=7cc8042c-0f5a-492e-9820-b2874bba13cf](http://pediatrics.aappublications.org/content/126/1/70.full?sid=7cc8042c-0f5a-492e-9820-b2874bba13cf)

► In a 2009 survey, pediatricians were asked their perceptions regarding frequency, contributing factors, and potential system- and provider-based solutions to address diagnostic errors. Pediatricians reported that they made diagnostic errors rather frequently; more than one-half (54%) reported that they made a diagnostic error at least once or twice per month. Diagnostic errors that led to harm also were not infrequent; almost one-half (45%) of respondents reported that diagnostic errors that harmed patients occurred at least once or twice per year. The most-frequent diagnostic error was viral illnesses being diagnosed as bacterial illnesses, followed by misdiagnosis of medication side effects, psychiatric disorders, and appendicitis. Failures in data-gathering (history, examination, and chart review) and care delays by patients or caregivers were reported to be the most-frequent process breakdowns. Of various interventions for prevention of diagnostic errors, pediatricians gave highest rankings to close follow-up of patients and access to electronic medical records.

► Errors in **diagnosis** constitute a sizable proportion of medical errors in the United States and are responsible for significant costs and harm. Data regarding diagnostic errors in pediatric practice settings are especially limited. To date, knowledge of these errors is limited mostly to events that result in malpractice claims. Error in diagnosis is the most-commonly identified reason (32%) in closed pediatric malpractice claims, with the highest median indemnity payments and defense expenses. However, diagnostic errors that result in claims may represent only a small proportion of all diagnostic errors; given their low frequency and high level of severity, they may not be representative of all types of diagnostic errors that occur in routine practice. Furthermore, underlying contributory factors for litigated diagnostic errors might differ systematically from those for nonlitigated errors. In short, malpractice claims have provided useful data for understanding diagnostic errors but may not represent the entire spectrum of diagnostic errors.


**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
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:
Steven M. Selbst, M.D.
Pediatric Emergency Medicine
Division of Pediatric Emergency Medicine
Department of Pediatrics
Nemours Children's Health System
Wilmington, Delaware

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 is planned in collaboration with Baptist Children’s Hospital Emergency Department to meet the educational needs they have identified.

DATE REVIEWED: January 22, 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: Conversations in Ethics: Ethical Challenges with Severely Ill Neonates

DATE: Friday, March 20, 2015
TIME: 12:00 Noon – 1:00 p.m.

LOCATION: Homestead Hospital, Auditorium
CREDIT HOUR(S) APPLIED FOR: 1 Cat 1

Videoconferenced to: BHM CL # 5, MH Educ 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

TARGET AUDIENCE:
Physicians, Psychologists, Nurses, Pediatric Dietitians, Social Workers, Respiratory Therapists, Clergy, Pharmacist, Registered Dietitians and other interested healthcare professionals. (C4)

This activity addresses professional practice gaps relevant to physicians who may seek ethics consultations as well as 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). 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): Bioethics Committee Request
- 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*?

► Physicians involved with high-risk infants and their families, do not always use the process of shared decision making. Provision of interventions to support and engage parents in the care of their infant may improve outcomes for both the parents and the infant.

WHAT IS THE OPTIMAL PRACTICE*?

► Physicians involved with high-risk infants and their families consistently use the process of shared decision making leading to improved outcomes for both the parents and the infant.

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

► Physicians involved with high-risk infants and their families will consistently use the process of shared decision making leading to improved outcomes for both the parents and the infant.

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

► The newborn intensive care unit (NICU) is a common setting for difficult ethical challenges, often involving life-and-death decisions. These may include withholding treatment such as resuscitation, mechanical ventilation, or surgery, or withdrawing life-sustaining medical treatment such as mechanical ventilation and artificial nutrition and hydration. Such decisions are frequently faced because of the high morbidity and mortality of some conditions commonly encountered in this setting, such as extreme prematurity, perinatal asphyxia, and major congenital anomalies. Who should decide when a treatment should be withheld or withdrawn? Ideally, decisions are made by the parents, physicians, and nurses working together, but what is to be done when they disagree? On what basis should decisions be made? Ideally, a careful ethical analysis is carried out, based on solid clinical and prognostic data and the values of those involved in making the decision. In reality, data are often very vague and values are often not shared in common, but a decision must nevertheless be reached. https://www2.aap.org/sections/bioethics/PDFs/Curriculum_Session13.pdf

► Shared decision making should be the commonly used process, requiring shared information among relevant care providers and a willingness and capability to communicate effectively with parents. This process also suggests the need for outcome data. Such data should be relevant to the population seeking care at a given institution. Relying on national or other reported regional or institutional data from outside a particular practice setting is not always valid, because data from different practice settings likely are neither constituted nor controlled in the same fashion. The provision of care, which is decided on by local clinical and population data, and the determination of best interests, or what can be viewed as either effective, beneficial, and appropriate care versus ineffective, burdensome or inappropriate care, demand the availability of data from which to make these determinations with parents. Until such data are available, healthcare professionals should be frank in recognizing and communicating some uncertainty in their decisional process with parents. http://emedicine.medscape.com/article/978997-overview#aw2aab6b4

EDUCATIONAL OBJECTIVES

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

• Identify the limits of viability for extremely premature infants.
• Discuss the limitations of parental decision-making authority for premature babies born at more than 24 weeks’ gestation.
• Describe the purpose and intent of the “Baby Joules Policy” for management of babies born with known lethal congenital anomalies.

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.)
SPEAKER:
Andrew Kairalla, M.D.
Medical Director, Neonatology
Baptist Children's 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 ☒ 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: January 16, 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: # _1 N/A

Script:
The care of critically ill infants occasionally presents ethical conflicts for the healthcare team and the families of those babies. These conflicts often deal with the decision-making regarding whether to resuscitate an extremely premature infant or an infant with a known lethal congenital anomaly. Counseling prospective parents in these situations can be challenging. Who gets to decide what medical care the baby will receive? Join us as we explore the legal and ethical options for managing these difficult situations.
CME ACTIVITY TITLE: FOURTH ANNUAL OMAR PASALODOS, M.D., MEMORIAL LECTURE
The State of Ovarian Cancer in the US: Why Aren’t We Making More Progress?
Co-sponsored CME Activity – In collaboration with Florida International University’s Herbert Wertheim College of Medicine and Health Foundation South Florida

DATE: THURSDAY, APRIL 30, 2015 TIME: 6:30 pm – 8:00 pm
LOCATION: BAPTIST HOSPITAL OF MIAMI, AUDITORIUM CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1

CONFERENCE DIRECTORS: J. Arturo Fridman, M.D., Baptist Health South Florida
Sanford M. Markham, M.D., FACOG, FACS, FIU Herbert Wertheim College of Medicine

AMA/PRA LEARNING FORMAT:

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

TARGET AUDIENCE: Obstetricians, Gynecologists, GYN-Oncologists, Urologists, GYN-Surgeons, Primary Care Physicians, Reproductive Endocrinologists/Fertility Specialists, Maternal Fetal Medicine Specialists, Psychologists, Nurses, Nurse Practitioners, Physician Assistants, AHP, Residents, Medical Students, Radiology Technicians, Sonographers and Educated Female Professionals (non-healthcare background) from the community - all with a common interest in women’s healthcare.

EXPECTED NUMBER OF ATTENDEES: 150-170 CHARGE: 0

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

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

Case Studies

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.
► Women typically are not risk assessed for ovarian cancer, nor are they typically made aware of symptomology. There is no evidence supporting the benefits of screening for ovarian cancer. Screening asymptomatic women can result in unnecessary interventions, including surgery. Once diagnosed poor care often results when women are not treated by doctors and hospitals with expertise in the complex surgery and chemotherapy that can prolong life.

Ovarian cancer is the fifth leading cause of cancer death among women in the United States and has the highest mortality rate of all gynecologic cancers. It is estimated that 21,980 new cases of ovarian cancer will be diagnosed in the United States in 2014, and 14,270 women will die of this disease. The median age at diagnosis is 63 years. The prognosis for survival from ovarian cancer largely depends on the extent of disease at diagnosis, which is usually advanced, with only about 15% of women presenting with localized disease at diagnosis. From 2006 to 2010, incidence rates decreased by 0.9% per year, and mortality rates decreased by 2.8% per year in women younger than 65 years and by 1.7% per year in women aged 65 years and older.

REFERENCE(S)
Awareness of the signs and symptoms of the disease is a woman’s first defense against it, but many of the symptoms of ovarian cancer are similar to those of everyday ailments, like bloating, pain in the abdomen or pelvis, and trouble eating or feeling full quickly. Because there are no tests for early detection of ovarian cancer, many women are only diagnosed when the disease has progressed to more advanced stages.

While ovarian cancer has the highest mortality rate of the gynecologic cancers, it has a very low incidence rate. Consequently women typically are not risk assessed for ovarian cancer. If found to be at elevated risk, usually through genetic testing, patients and their physicians can implement risk reduction strategies. Being aware of symptomology may result in earlier diagnosis, making a significant impact on survival.

If the disease is caught early, before it spreads beyond the ovaries, 70 to 90 percent of the patients survive more than five years. But if the cancer has spread widely, Goff said, survival rate drops to between 20 and 30 percent.

Women with ovarian cancer often receive inadequate care and miss out on treatments that could add a year or more to their lives. About 22,000 new cases are diagnosed annually, most of them discovered at an advanced stage and needing aggressive treatment. Worldwide, there are about 200,000 new cases a year. Cancer specialists around the country said the main reason for the poor care was that most women are not treated by doctors and hospitals with expertise in the complex surgery and chemotherapy that can prolong life.

The main gap in our knowledge that is key to making the case for screening remains the uncertain ability to offer effective treatment of cancer at an early stage to improve the ultimate outcome.

There has been no substantial new evidence (2004-2012) on the benefits of screening for ovarian cancer. Some new information on the harms of screening is available, and confirms what was suspected in 2004 about the hazards of screening—that many women could be subjected to unnecessary surgery. Several large screening studies currently under way should be able to provide direct evidence on the benefits of screening ultrasonography or CA-125 testing in terms of mortality caused by ovarian cancer and other clinically relevant health outcomes.

http://www.cancer.gov/cancertopics/pdq/screening/ovarian/HealthProfessional/page2
http://www.cancer.gov/cancertopics/pdq/screening/ovarian/HealthProfessional/page2#_8_toc
http://www.guideline.gov/content.aspx?id=43948

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
► Physicians delicately balance assessment of potential ovarian cancer risk without regular screening. They assess familial history and recommend genetic testing as indicated. When risk is discovered, they refer patients for risk reduction options with a specialist and/or an institution with expertise in gynecologic oncology (GYO). They screen for possible symptomology of ovarian cancer, and they educate women on symptomology.

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 formulate a plan to assess risk for ovarian cancer, without regular screening, though family history and potentially genetic testing. When risk is discovered, physicians will connect patients with a specialist and/or an institution with expertise in gyn oncology. They screen for possible symptomology of ovarian cancer, and they educate women on symptomology.

EDUCATIONAL OBJECTIVES
Upon completion of this conference, participants should be better able to:
■ Discuss the current best practices for management of ovarian cancer.
■ Identify barriers to appropriate care for patients in the United States.
■ Explore possible solutions to overcome barriers to care.

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: ________________________________

Guest Faculty:
Barbara Goff, M.D.
Professor of Obstetrics and Gynecology, Adjunct Professor of Surgery
Division Director of Gynecologic Oncology
University of Washington School of Medicine
Seattle, Washington

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.
► While ovarian cancer has the highest mortality rate of the gynecologic cancers, it has a very low incidence rate. Consequently women typically are not risk assessed for ovarian cancer. There has been no substantial new evidence (2004-2012) on the benefits of screening for ovarian cancer. Some new information on the harms of screening is available, and confirms what was suspected in 2004 about the hazards of screening—that many women could be subjected to unnecessary surgery. The main gap in our knowledge that is key to making the case for screening remains the uncertain ability to offer effective treatment of cancer at an early stage to improve the ultimate outcome.

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) 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 Health South Florida is collaborating with its academic partner, the Herbert Wertheim College of Medicine at Florida International University (FIU), and the Health Foundation of South Florida, to support the Omar Pasalodos, M.D., Memorial Lecture to be held, April 2013, the anniversary of his passing.

An obstetrician-gynecologist and civic leader, Dr. Omar Pasalodos, dedicated his career to improving the health of women in South Florida. Through caring for his patients, through education and advocacy, and through his volunteer leadership, Dr. Pasalodos exemplified the best of medicine. To honor his passion and commitment, this annual lecture will feature a distinguished speaker and educational event focusing on women’s healthcare issues such as preventative medicine, cancer, aging, heart disease, and obesity. In support of community outreach the presentation topic and format will be equally relevant to a medical professional and an educated female non-medical consumer. The planning group will be comprised of representatives from the Herbert Wertheim College of Medicine, Mrs. Lisa Pasalodos, and representatives of Baptist Health South Florida’s executive leadership and Continuing Medical Education leadership.

PLANNING GROUP:

- Wayne Brackin, Chief Operating Officer, Baptist Health South Florida
- Sanford M. Markham, M.D., FACOG, FACS, Chairman, Emeritus Executive Associate Dean for Student Affairs, Professor of Obstetrics & Gynecology, Herbert Wertheim College of Medicine, Florida International University
- J. Arturo Fridman, M.D., Medical Director, Continuing Medical Education, Baptist Health South Florida
- Javier Hernandez-Lichtl, Chief Executive Officer, West Kendall Baptist Hospital
- Susan R. Jay, Ed.D., Assistant Vice President of Development, Assistant Dean for Medical Advancement, Herbert Wertheim College of Medicine, Florida International University
- Steven E. Marcus, Ed.D., President and CEO, Health Foundation of South Florida
- Lisa D. Pasalodos
- John A. Rock, M.D., Founding Dean and Senior Vice President for Medical Affairs, Herbert Wertheim College of Medicine, Florida International University
- Carolyn D. Runowicz, M.D., Executive Associate Dean for Academic Affairs, Herbert Wertheim College of Medicine, Florida International University
- Linda N. Santos, Corporate Director, Continuing Medical Education, Baptist Health South Florida

DATE REVIEWED: 2/2/2015  REVIEWED BY: ☒ Executive Committee  ☐ Accelerated Approval

APPROVED: ☒ YES ☐ NO  ■ Credits: AMA/PRA Category 1 Credits: #1.50

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

SCHEDULE

5:30 p.m.  Reception and Light Dinner Buffet
6:15 p.m.  Welcome Remarks and Recognition
           Wayne Brackin, Lisa D. Pasalodos, John A. Rock, M.D., and Steven Marcus
6:25 p.m.  Introduction
           Carolyn D. Runowicz, M.D.
6:30 p.m.  The State of Ovarian Cancer in the US: Why Aren’t We Making More Progress?
           Barbara Goff, M.D.
7:30 p.m.  Questions and Discussion
8:00 p.m.  Adjourn