CONFERENCE APPLICATIONS AND REPORTS
Applications Previously Approved
February 15, 2015 to March 14, 2015

03.19.15 Family Medicine Conference Series: Update on HIV (1 Cat. 1)
03.20.15 Cardiovascular Conference Series: Pregnancy and the Heart (1.5 Cat. 1)
03.30.15 Emergency Medicine Conference Series: Central Nervous System Infections (1 Cat. 1)
04.11.15 Fourth Annual Head and Neck Cancer Symposium: Reconstruction and Restoration for Quality of Life (4.75 Cat 1)
04.11.15 Use of Acoustic Radiation Force Impulse Imaging (ARFI) for the Evaluation of Diffuse Liver Disease (1.5 Cat. 1)
04.15.15 Conversations in Ethics: Ethics and Telehealth (Medicine) (1 Cat. 1)
04.16.15 Mariners Hospital Conference Series: Updates on Wound Care (1 Cat. 1)
04.20.15 The Communication Quality Imperative: Improving Safety & Outcomes and Avoiding Readmissions (1 Cat. 1)
05.08.15 Ob/Gyn Conference Series: Sexual Dysfunction in the Gynecology Patient: Special Cases (1 Cat. 1)
05.21.15 WKBH Grand Rounds: Managing Patients with Brain and Spinal Injuries (1 Cat. 1)
05.28.15 Risk Management and Patient Safety: What’s New in Safety in the OR? (1 Cat. 1)
06.06.15 Sixth Annual State of the Science Symposium - Critical Care Best Practices 2015 (6.25 Cat. 1)
06.11.15 The Art of the Spine: Physical Therapy Treatment of Low Back Pain - Optimal Timing for Optimal Outcomes (1 Cat. 1)
07.24.15 Primary Care Focus - 14th Annual Symposium (13 Cat. 1)
CME ACTIVITY TITLE: Conversations in Ethics: Ethics and Telehealth (Medicine)

DATE: Wednesday, April 15, 2015

TIME: 12:00 Noon – 1:00 p.m.

LOCATION: 5 MCVI Conference Room

CREDIT HOUR(S) APPLIED FOR: 1.0

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

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

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

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

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

In addition, describe how the content of the activity is aligned with the target learners’ current or potential scope of practice (C4).

EXPECTED NUMBER OF ATTENDEES: 50-60

CHARGE: 0

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

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

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

Patient: [ ] Non-compliance [ ] Lifestyle [ ] Resistance-to-change [ ] Financial/Lack of Insurance
Physician: [ ] Non-compliance [ ] Resistance-to-change [ ] Communication Skills [ ] Financial
Resources: [x] Institutional Capabilities [x] Physician Practice Limitations [ ] Community Service Limitations
State of Science: [ ] Limited or No Treatment Modalities [ ] Limited or No Diagnostic Modalities
Other: ____________________________________________________________
The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care, and positive health outcomes. The FSMB Model Policy does not directly address compliance with evidence-based practice guidelines. However, it does encourage providers to comply with nationally recognized health online standards to the extent they are available and advocates parity of ethical and professional standards applied to all aspects of a physician’s practice.

For more than 30 years, clinicians, health services researchers, and others have been investigating the use of advanced telecommunications and computer technologies to improve health care. At the intersection of many of these efforts is telemedicine—a combination of mainstream and innovative information technologies. As defined here, telemedicine is the use of electronic information and communications technologies to provide and support health care when distance separates the participants.

On the commonplace side of the spectrum are familiar uses of the telephone for consultations between patients and clinicians and the use of radio to link emergency medical personnel to medical centers. On the other end of the telemedicine spectrum...
are largely experimental innovations such as telesurgery in which a surgeon receives visual and tactile information to guide robotic instruments to perform surgery at a distant site. In between these two ends of the spectrum lie an array of video, audio, and data transmission technologies and applications. Some, such as relatively expensive interactive video conferencing, allow clinicians to see, hear, examine, question, and counsel distant patients for "real-time" diagnostic and therapeutic purposes. Others, based on "store and forward" technologies, permit digital images and other information to be saved and transmitted relatively cheaply to consultants who can receive and interpret them when convenient, thus offering more scheduling flexibility for those on both ends of the communications link. In addition to patient care, these varied technologies have a multiplicity of current and possible uses in professional education, research, public health, and administration. Such multiple uses potentially allow costs for expensive information and communications investments to be spread more broadly.

This report was prompted by the scarcity of careful evaluations of patient care applications of telemedicine. It presents a broad framework for evaluating clinical applications of telemedicine and argues for more systematic and rigorous assessments of their effects on health care quality, accessibility, costs, and acceptability compared to alternative services. For telemedicine, as for any health technology or service, such assessments are essential for several reasons. They can guide policymakers considering whether to encourage telemedicine by stimulating infrastructure development, funding specific telemedicine programs, or reducing policy barriers; provide clinicians and patients appropriate reassurance or caution about telemedicine applications; inform health plan managers pondering whether clinical telemedicine is feasible, cost-effective, and acceptable to patients and clinicians; and help those who have invested in telemedicine find ways to identify problems and improve programs. http://www.ncbi.nlm.nih.gov/books/NBK45440/

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

- Review potential ethical implications when delivering patient care via telemedicine.
- Examine clinical outcomes with the assistance of remote electronic monitoring.
- Explain and employ measures to protect patient confidentiality.
- Discuss how patients and healthcare professionals have adapted to utilization of these new technologies.
- Formulate standards of care and practice guidelines considering updated ethical guidance on telemedicine from national medical specialty societies, state medical associations and the American Medical Association.

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.)
- Louis Gidel M.D., PhD, FCCP
  Medical Director, Department of Lifeguard Operations Center
  Baptist Health South Florida

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).
- Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
  - Yes
  - No
  - 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.
physician change applicable to our learners? ☐ Yes  ☑ No  If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.

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

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

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

☐ Process redesign or new protocol ☐ Reminders (Posters, mailings, email blasts) ☐ New order sheets
☐ Other tools or tactics
Explain: ____________________________________________________________

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

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

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.

DATE REVIEWED: February 5, 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

Script:
Advances in medical technology create new challenges to patients, their families and the healthcare professionals who care for them. Can a physician looking through a camera from miles away adequately evaluate a patient? Is the confidentiality of the patient protected? Can the patient or family refuse this type of care and evaluation? Join us to discuss the ethical implications of this fascinating subject with an expert in the field.

Applicable Credits: AMA Category 1 ☑  ☐ Continuing Psychology Education ☑  ☐ Continuing Dental Education ☐

CME ACTIVITY TITLE: Family Medicine Conference Series: Update on HIV

DATE:  March 19, 2015       TIME: 6-7p.m.

LOCATION:  SMH MCVI 2nd Floor Conf. Room       CREDIT HOUR(S) APPLIED FOR:  1 Cat. 1

CONFERENCE DIRECTOR:  Manuel Gonzalez, M.D.

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

TARGET AUDIENCE: All physicians including, Family Medicine Practitioners, Internists, Hospitalists and all other interested healthcare providers.

EXPECTED NUMBER OF ATTENDEES: 20-25  CHARGE: 0

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

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

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

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<thead>
<tr>
<th>Patient:</th>
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<tbody>
<tr>
<td></td>
<td>Non-compliance</td>
<td>Lifestyle</td>
<td>Resistance-to-change</td>
<td>Financial/Lack of Insurance</td>
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<td></td>
<td>Non-compliance</td>
<td>Resistance-to-change</td>
<td>Communication Skills</td>
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<th>Resources:</th>
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<tbody>
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<td></td>
<td>Institutional Capabilities</td>
<td>Physician Practice Limitations</td>
<td>Community Service Limitations</td>
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<th>State of Science:</th>
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<tr>
<td></td>
<td>Limited or No Treatment Modalities</td>
<td>Limited or No Diagnostic Modalities</td>
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Other: ________________________________________________________________
PROFESSIONAL PRACTICE GAP (C2)

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

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

► Physicians may not be aware of current HIV clinical management.

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

► Physicians implement current HIV clinical management.

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

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

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

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

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

► Physicians adhere to treatment protocols related to HIV/AIDS.

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

► HIV prevalence is increasing worldwide because people on antiretroviral therapy are living longer, although new infections decreased from 3.3 million in 2002, to 2.3 million in 2012. Global AIDS-related deaths peaked at 2.3 million in 2005, and decreased to 1.6 million by 2012. An estimated 9.7 million people in low-income and middle-income countries had started antiretroviral therapy by 2012. New insights into the mechanisms of latent infection and the importance of reservoirs of infection might eventually lead to a cure. Lancet. 384(9939):258-71, 2014 Jul 19.
http://ovidsp.tx.ovid.com/sp-3.14.0b/ovidweb.cgi?&S=CMCFFPAEABDDPCFNCLKMEFBAFLAAA00&Complete+Reference=S.sh.71%7c2%7c1

EDUCATIONAL OBJECTIVES:

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

- Employ appropriate infection control procedures.
- Discuss the recent advancements in the clinical management of HIV/AIDS.
- Explain methods of prevention.

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.)

Jorge Murillo, M.D.
Infectious Disease Specialist
Baptist, South Miami, Homestead and Doctors Hospitals

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

Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
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: 02-18-2015 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

Applicable Credits: AMA Category 1 Continuing Psychology Education Continuing Dental Education
CME ACTIVITY TITLE: Ob/Gyn Conference Series: Sexual Dysfunction in the Gynecology Patient: Special Cases

DATE: Friday, May 8, 2015 TIME: 8 a.m. - 9 a.m.

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

CONFERENCE DIRECTOR: Jason James, M.D.

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

TARGET AUDIENCE: 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.
☒ 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 ☐ 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): ACOG Practice Bulletin

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18)
Patient: ☐ Non-compliance ☒ Lifestyle ☒ Resistance-to-change ☒ Financial/Lack of Insurance
Physician: ☐ Non-compliance ☐ Resistance-to-change ☒ Communication Skills ☐ Financial
Resources: ☐ Institutional Capabilities ☐ Physician Practice Limitations ☐ Community Service Limitations
State of Science: ☐ Limited or No Treatment Modalities ☐ Limited or No Diagnostic Modalities
Other: ______________________________________________________________
PROFESSIONAL PRACTICE GAP (C2)

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

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

► Physicians may not be familiar with most common sexual dysfunctions and how to properly identify them. Physicians may not be familiar with special patient population concerns including those of cancer patients, LGBT patients and male partners of their patients.

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

► Physicians identify sexual dysfunctions in their patients, evaluate patients with sexual complaints and implement appropriate treatments.

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 implement evaluation algorithm of patient with sexual complaints.

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

► Surveys consistently show that women want to talk about their sexual issues with healthcare providers but are reluctant to begin the conversation. For instance, one study of 3,807 healthy participants indicated that women do not seek help because they are embarrassed, worry that the provider will be embarrassed, fear that the problem may be minimized or classified as being “all in their head,” or that there are no treatments for their condition. (Finding Solutions for Female Sexual Dysfunction, ACOG Publication, VOL. 117, NO. 4, APRIL 2011 Practice Bulletin Female Sexual Dysfunction)

EDUCATIONAL OBJECTIVES

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

• Identify the most common sexual dysfunctions.
• Effectively communicate about a wide range of patients’ special concerns, including those particular to the cancer patient or the LBGT patient.
• Appropriately and ethically discuss your patient’s health with her partner.
• Develop an evaluation algorithm of the patient with sexual complaints.
• Discuss treatments available for the sexual health patient.

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.)

Maureen Whelihan M.D., FACOG
Gynecologist and Sexual Medicine Specialist
President, Center for Sexual Health and Education
Member, International Society for the Study of Women’s Sexual Health
West Palm Beach, Florida

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

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

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

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

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

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

DATE REVIEWED: February 20, 2015 REVIEWED BY: ☑ Executive Committee ☐ Chairman
APPROVED: ☐ YES ☑ NO ☐ Credits: AMA/PRA Category 1 Credits: # 1
Continuing Psychology Education Credits: # ☐ N/A ☐ Continuing Dental Education Credits: # ☐ N/A

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

CME ACTIVITY TITLE: Emergency Medicine Conference Series: Central Nervous System Infections
DATE: Monday, March 30, 2015  TIME: 8-9 a.m.

LOCATION: SMH Classroom E  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTOR: John Baldino, M.D.

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

TARGET AUDIENCE: Hospitalists, General Internists, Family Practitioners, Emergency Medicine and Urgent Care Physicians, and other interested healthcare providers, nurses and physical therapists.

EXPECTED NUMBER OF ATTENDEES: 15-20  CHARGE: 0

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

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

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

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


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.

► While acute nervous system (CNS) infections, such as meningitis and encephalitis, are neurological emergencies for which accurate diagnosis and prompt treatment improve the outcome, many patients receive inadequate tests and diagnosis. Emergency Medicine Physicians may not consistently assess for CNS infections and/or may not implement timely and appropriate tests or treatment of patients with an infection of the central nervous system – namely: encephalitis and meningitis.

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

► Emergency Medicine physicians consistently assess diagnose and initiate treatment for patients presenting with infections of the central nervous system in the emergency department.

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

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

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

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

► Emergency Medicine physicians consistently assess, recognize and initiate treatment for patients presenting with infections of the central nervous system in the emergency department.

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

Acute central nervous system (CNS) infections, such as meningitis and encephalitis, are neurological emergencies for which accurate diagnosis and prompt treatment improve the outcome. Analysis of the cerebrospinal fluid (CSF) obtained at lumbar puncture (LP) is pivotal to establishing the diagnosis and guiding management. PCR analysis of the CSF is an important method to identify the pathogen. However, recent studies have demonstrated that many patients have inadequate CSF sample collection and analysis.

http://ovidsp.tx.ovid.com/sp-3.14.0b/ovidweb.cgi?&S=lAFDFPGBKIDDLBIBNCLKNAJCKJBLAA00&Complete+Reference=S.sh.46%7c8%7c1

EDUCATIONAL OBJECTIVES:

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

- Accurately assess and diagnose patients presenting with symptoms of an infection in the central nervous system.
- Describe imaging findings and initiate treatment for patients with a central nervous system infection.
- List common pathogens of meningitis by age group and risk factors.

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.)

Jorge Murillo, M.D.
Infectious Disease Specialist
Baptist, South Miami, Homestead and Doctors Hospitals

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

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

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

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

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

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

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

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

Explain: __________________________________________ _____________________________________

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

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

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

This meeting is planned in collaboration with the South Miami Hospital Emergency Department leadership team to address Standards of care for common infections in the Emergency Department.

DATE REVIEWED 02-21-2015 REVIEWED BY: ☒ Executive Committee ☐ Chairman

APPROVED: ☒ YES ☐ NO Credits: AMA/PRA Category 1 Credits: # __________
Continuing Psychology Education Credits: # __________ N/A
Continuing Dental Education Credits: # __________ N/A
CME ACTIVITY TITLE: Fourth Annual Head and Neck Cancer Symposium: Reconstruction and Restoration for Quality of Life

DATE: Saturday, April 11, 2015

TIME: 7:50 a.m. – 1:30 p.m.

LOCATION: Baptist Hospital Auditorium

CREDIT HOUR(S) APPLIED FOR: 4.75 Cat. 1

AMA/PRA LEARNING FORMAT:

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

TARGET AUDIENCE: Primary Care Physicians, Dentists, Otolaryngologists, Gastroenterologists, Radiologists, Medical Oncologists, Oral Maxillofacial Surgeons, Surgeons, Pathologists, Pediatricians, Hospitalists, Nurses, Radiation Technologists, Nutritionists, Social Workers and Speech Pathologists.

EXPECTED NUMBER OF ATTENDEES: 75 - 100

CHARGE: 0

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

| ☒ | Live |
| ☐ | Didactic Lecture |
| ☐ | ARS |
| ☐ | Question & Answer |
| ☐ | Case Studies |
| ☐ | Panel |
| ☐ | 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): Head and Neck Cancer Data Group Dashboard |
| ☐ | 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: ______________________________________________________________________________________
The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP?? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
► Physicians use conventional treatment methods instead of targeted treatments with head and neck cancer patients.
► Lack of time and communication strategies/resources have been blamed for ineffective physician/patient communication and may negatively impact delivery of poor diagnoses.
► There is a need to ensure doctors are specifically trained in referral and care pathway for oral cancers so that they are equipped to adequately support their patients and not contribute further to any delay.
► Advanced oral cancers are a challenge for treatment, as they require complex procedures for excision and reconstruction. Moreover they affect the quality of life and survival significantly. Prevention of these tumors may not be possible always, early detection and treatment is possible with adequate awareness among clinicians and patients. Screening for oral cancer is useful to detect cancers in their early stage and can decrease mortality in high-risk populations. Timely intervention is therefore equally important in improving survival and quality of life in patients with oral cancers.

WHAT IS THE OPTIMAL PRACTICE?? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
► Timely interventions by physicians and dentists improve survival and quality of life of patients with oral cancers.
► Physicians are comfortable with utilizing evidence-based communication strategies that foster trust-based relationships and improve the patient experience by instilling hope.
► Dentists and medical doctors are specifically trained in referral and care pathway for oral cancers so that they are equipped to adequately support their patients and not contribute further to any delay.

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

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☑ Competence? -or- ☑ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.) *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)
► Timely interventions by physicians and dentists will improve survival and quality of life for patients with oral cancers by promoting better quality of life and minimizing negative outcomes.
► Dentists and doctors will accurately diagnose patients with head and neck cancers (or suspected cancer) and they will provide evidence based referral so patient receives care from a coordinated specialized head and neck cancer team.
► Doctors and dentists will be effectively trained in referral and care pathway for oral cancers so that they are equipped to adequately support their patients and not contribute further to any delay.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Advanced oral cancers are a challenge for treatment, as they require complex procedures for excision and reconstruction. Despite being occurring at a visible site and can be detected easily, many patients present in advanced stages with large tumors. Timely intervention is important in improving survival and quality of life in these patients. http://www.ncbi.nlm.nih.gov/pubmed/25104185
► In daily life, we often do not realize how important simple things like swallowing, speaking, and eating are for us. Only if a severe disease, such as a head and neck neoplasm, deteriorates these functions do we appreciate the importance of oral health and the related quality of life. http://meetinglibrary.asco.org/content/248-132
► Radiation of the head and neck can irreversibly injure oral mucosa, vasculature, muscle, and bone, resulting in xerostomia, rampant dental caries, trismus, soft tissue necrosis, and osteonecrosis. Management of oral complications of cancer therapy includes identification of high-risk populations, patient education, initiation of pretreatment interventions, and timely management of lesions. Assessment of oral status and stabilization of oral disease before cancer therapy are critical to overall patient care. Care should be both preventive and therapeutic to minimize risk for oral and associated systemic complications. http://www.cancer.gov/cancertopics/pdq/supportivecare/oralcomplications/HealthProfessional

http://www.cancer.gov/cancertopics/pdq/supportivecare/oralcomplications/HealthProfessional
http://www.indiancancer.com/article.asp?issn=0019-509X;year=2014;volume=51;issue=2;spage=95;epage=97;aulast=Joshi
http://meetinglibrary.asco.org/content/248-132
http://meetinglibrary.asco.org/content/248-132
EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:

• Discuss the increasing incidence of oropharyngeal cancer.
• Recognize factors that place patients at greater risk for oropharyngeal cancer and related complications.
• Identify and discuss the psychological needs of patients undergoing intensive therapy.
• Adjust intensity-modulated radiation therapy (IMRT) to reduce acute and late effects of minimally invasive surgery.
• Improve the outcomes of oral cavity and dental health following IMRT by integrating early dental evaluation and dental surveillance.
• Identify prognostic factors that predict response to chemotherapy.
• Discuss organ preservation with chemotherapy.
• Appraise the benefits of induction chemotherapy to increase local control and survival in patients with head and neck cancer.
• Explain quality of life impact when maxillofacial prosthodontics are initiated prior to surgery.
• Examine the utility of an obturator to successfully close maxillary defects that cannot be surgically repaired.
• Manipulate obturators to allow patients to return to their usual activities with improved speech, aesthetics, deglutition and comfort.
• Discuss the indications and protocol for hyperbaric oxygen therapy in extraction of mandibular teeth and placement of dental and craniofacial implants in patients whose oral cavity has had radiation therapy.
• Assess the use of dental and craniofacial implants to retain prostheses.
• Examine improved defect restoration through computer-aided implant placement.
• Examine technological advancements that have impacted the predictability and accuracy of reconstruction following treatment of oral head and neck cancer with surgery, radiation and chemotherapy.
• Distinguish methods of reconstruction of ablative defects following treatment for oral head and neck cancer and the functional restoration of occlusion with implant-supported prostheses.
• Utilize computer-aided surgical simulation systems for the transfer of virtual surgical planning to the head and neck cancer patient.
• Examine reconstructive techniques for primary repair of surgical defects caused by extensive ablation for malignant conditions of the head and neck.
• Explain the complications of mid-face reconstruction after cancer surgery.
• Discuss and assess the benefits and challenges of midface free tissue microvascular flaps.
• Assess approaches to skull base reconstruction after endoscopic cranial base resection.
• Examine and address the unique reconstructive challenges of skull base reconstruction after endoscopic cranial base resection.
• Review recent and emerging reconstruction advances including the introduction of new biomaterials.

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

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

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

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

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

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

The barriers include lack of potential benefits and risks of screening for oral squamous cell carcinomas and the lack of evidence to determine if screening alters disease specific mortality in asymptomatic people seeking dental care.

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 – Oral Cancer Pamphlets for patient education from the National Institute of Dental and Cranofacial Research

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?

The CME Department and the Cancer Data Center collaborate to educate healthcare professionals on best-practice approaches and latest advances in care of the head and neck cancer patients.

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

DATE REVIEWED: February 23, 2015 REVIEWED BY: ☒ Executive Committee ☐ Chairman

APPROVED: ☒ YES ☐ NO

Credits: AMA/PRA Category 1 Credits: # 4.75
Continuing Psychology Education Credits: # N/A
Continuing Dental Education Credits: # 4.50 N/A

Fourth Annual Head and Neck Cancer Symposium
Reconstruction and Restoration for Quality of Life

Baptist Hospital of Miami Auditorium, Miami, Florida
Saturday, April 11, 2015
7:15 a.m. – 1:30 p.m.

Schedule
7:15 a.m. Registration and Continental Breakfast
7:45 a.m. Welcome and Introductions
George Weiss, MHA, R.T. (N), and Ana Viamonte Ros, M.D.
8:00 a.m. Miami Cancer Institute
Leonard A. Kalman, M.D.
8:05 a.m. Baptist Head and Neck Cancer Group Concepts
Joseph P. McCain, DMD
8:15 a.m. Improving Quality of Life for Patients with Head and Neck Cancer
Andre Abitbol, M.D.
8:40 a.m. Chemotherapy in the Management of Unresectable Head and Neck Cancer
Michael Troner, M.D.
9:00 a.m. Functional Restoration of Occlusion Following Treatment for Head and Neck Cancer, Part I
Bryan Bell, M.D., DDS, FACS
9:50 a.m. Question-and-Answer Session
10:00 a.m. Break and Visit Exhibits
10:20 a.m.  Functional Restoration of Occlusion Following Treatment for Head and Neck Cancer, Part II  
Bryan Bell, M.D., DDS, FACS

11:10 a.m.  How to Perform Ablative Head and Neck Surgery with Reconstruction in Mind  
Francisco G. Pernas, M.D.

11:30 a.m.  Question-and-Answer Session

11:40 a.m.  Break and Visit Exhibits

12:00 noon  Midface Free Tissue Microvascular Flaps: Benefits and Challenges  
Jaime Flores, M.D.

12:20 p.m.  Complications of Reconstruction  
Shawn McClure, DMD

12:40 p.m.  Restoring Quality of Life with Implants and Maxillofacial Prosthetics After Cancer  
Carol Horkowitz, M.D.

1:00 p.m.  Skull Base Reconstruction after Endoscopic Cranial Base Resection  
Vitaly Siomin, M.D., and Francisco G. Pernas, M.D.

1:20 p.m.  Question-and-Answer Session

1:30 p.m.  Adjourn

Faculty

Guest Faculty  
R. Bryan Bell, M.D., DDS, FACS  
Head and Neck Surgery and Oncology  
Medical Director, Providence Oral Head and Neck Cancer Program and Clinic  
Providence Cancer Center  
Earle A. Chiles Research Institute  
Providence Portland Medical Center  
Attending Surgeon, Trauma Service  
Legacy Emanuel Medical Center  
Affiliate Professor, Oregon Health and Science University  
Portland, Oregon

Baptist Health Faculty  
Joseph P. McCain, DMD  
SYMPOSIUM DIRECTOR  
Oral and Maxillofacial Surgery  
Baptist, South Miami, Doctors and West Kendall Baptist Hospitals  
Subsection Chief, Oral Surgery, Baptist Hospital

Andre A. Abitbol, M.D.  
Radiation Oncology  
Department of Radiation Oncology  
Baptist and South Miami Hospitals

Jaime I. Flores, M.D.  
Plastic Surgery  
Baptist, Doctors, South Miami and West Kendall Baptist Hospitals  
Miami, Florida

Carol A. Horkowitz, DMD  
Oral and Maxillofacial Surgery  
Baptist Hospital of Miami

Shawn A. McClure, M.D., DMD  
Oral Maxillofacial Surgery  
Baptist and South Miami Hospitals  
Miami, Florida
Andre Abitbol, M.D.
Lecture 1: Improving Quality of Life in Patients with Head and Neck Cancer

Educational Objectives
Upon completion of my presentation, participants should be better able to:
• Discuss the increasing incidence of oropharyngeal cancer.
• Recognize factors that place patients at greater risk for oropharyngeal cancer and related complications.
• Identify and discuss the psychological needs of patients undergoing intensive therapy.
• Adjust intensity-modulated radiation therapy (IMRT) to reduce acute and late effects of minimally invasive surgery.
• Improve the outcomes of oral cavity and dental health following IMRT by integrating early dental evaluation and dental surveillance.

References
► Advanced oral cancers are a challenge for treatment, as they require complex procedures for excision and reconstruction. Despite being occurring at a visible site and can be detected easily, many patients present in advanced stages with large tumors. Timely intervention is important in improving survival and quality of life in these patients. http://www.ncbi.nlm.nih.gov/pubmed/25104185

► Radiation therapy can damage salivary glands, causing salivary hypofunction and xerostomia. In addition, selected chemotherapeutic agents (singly or in combination) have been implicated in causing salivary dysfunction and xerostomia. However, it has not been possible to draw consistent conclusions about the effects of cancer chemotherapy on salivary gland function. http://www.cancer.gov/cancertopics/pdq/supportivecare/oralcomplications/HealthProfessional/page17

► Dysphagia and odynophagia are common in cancer patients and can exist before, during, and after treatment. Dysphagia predisposes to aspiration and potentially life-threatening pulmonary complications. Dysphagia is most prominent in patients with head and neck cancers but may also develop in patients with other malignancies as a symptom of oropharyngeal or esophageal mucositis or infection. http://www.cancer.gov/cancertopics/pdq/supportivecare/oralcomplications/HealthProfessional/page17

► Intensified schedules and the use of chemoradiation therapy have been shown to improve locoregional control and survival but come at the cost of more severe acute and chronic side effects. Intensity-modulated radiation therapy (IMRT) has emerged as an effective technique to deliver the full radiation dose to the tumor and regions at risk while reducing exposure of surrounding healthy tissues. However, the preservation of anatomy does not necessarily translate into the preservation of swallowing function. http://www.cancer.gov/cancertopics/pdq/supportivecare/oralcomplications/HealthProfessional/page17

Michael Troner, M.D.
Chemotherapy in the Management of Unresectable Head and Neck Cancer
Educational Objectives
Upon completion of my presentation, participants should be better able to:

• Identify prognostic factors that predict response to chemotherapy.
• Discuss organ preservation with chemotherapy.
• Appraise the benefits of induction chemotherapy to increase local control and survival in patients with head and neck cancer.

Reference
► Despite several decades of intensive investigation, the optimal sequencing of chemotherapy, radiation, and surgery in the management of locoregionally advanced head and neck squamous cell cancer (HNSCC) remains a subject of intense debate. Chemotherapy combinations such as fluorouracil and cisplatin can produce response rates of 60% to 90%, with complete responses in up to 50% of previously untreated patients. Although these responses are temporary, the use of chemotherapy as induction before definitive surgery and/or radiation is an attractive model.  

Carol Horkowitz, M.D.
Restoring Quality of Life with Implants & Maxillofacial Prosthetics after Trauma and Cancer Treatment
Educational Objectives
Upon completion of my presentation, participants should be better able to:

• Explain quality of life impact when maxillofacial prosthodontics are initiated prior to surgery.
• Examine the utility of an obturator to successfully close maxillary defects that cannot be surgically repaired.
• Manipulate obturators to allow patients to return to their usual activities with improved speech, aesthetics, deglutition and comfort.
• Discuss the indications and protocol for hyperbaric oxygen therapy in extraction of mandibular teeth and placement of dental and craniofacial implants in patients whose oral cavity has had radiation therapy.
• Assess the use of dental and craniofacial implants to retain prostheses.
• Examine improved defect restoration through computer-aided implant placement.

References
► Implant retained prostheses provide subjects with improved perceptions of treatment satisfaction, value, and use when compared to adhesive-retained prostheses. In addition, patient perceptions of quality of retention, ease of placement and removal, and compliance to wear a facial prosthesis show significant improvements when the prosthesis is retained by osseointegrated implants. It is important to understand that the criteria to provide a successful facial prosthesis treatment are multifaceted. The provider must not only note the clinical indicators of success from the treatment team point of view, but also be sensitive to the patient’s psychological responses to treatment. Patients’ perceptions of their facial prostheses in terms of esthetics, comfort, ease of placement and removal, fit, and the quality of retention affect their level of compliance to wear the prostheses. The benefits of the facial prosthesis treatment can be validated only if patients wear the prostheses. Craniofacial implants can resolve some of the limitations of adhesive-retained prostheses, such as movable tissue beds and questionable quality of retention, which may result in greater patient acceptance. 

► Acquired midfacial defects may affect patients’ speech, mastication, quality of life, psychology, and social behavior. Midfacial defects are defined as defects in the middle third of the face in horizontal plane that communicate with intraoral maxillary defects. These defects can be classified into two major categories of midline and lateral-midline midfacial defects. Midline midfacial defects include complete or partial involvement of either nose or upper lip that communicate with an intraoral maxillary defect while the lateral midfacial defects include complete or partial involvement of cheek and orbital contents that communicate with an intraoral maxillary defect. Midfacial defect can result from trauma, burns, most tumors of paranasal sinus, palatal epithelium, minor salivary glands, congenital abnormalities like vascular malformations, and some of other lesions like lethal midline granuloma that require partial or radical maxillectomy. One of the other causes of such defects is mucormycosis that is caused by a fungus of the order Mucorales that is one of the most rapid fatal fungal infections known to man. Rhinocerebral mucormycosis is the most common type, and its extension to the orbit and brain is quite usual. The location of mucormycosis on the palate is rare and of late occurrence. Large midfacial defects are rarely rehabilitated by surgical reconstruction alone. They usually require a facial prosthesis to restore function and esthetic. Satisfactory functional and esthetic results are achievable in patients with a large lateral midfacial defect using a hollow acrylic resin framework for silicon facial prosthesis. Retention of facial prosthesis can be satisfactorily achieved with the use of strong magnets provided that the facial prosthesis is light in weight.

Bryan Bell, M.D., DDS, FACS
Functional Restoration of Occlusion Following Treatment for Head and Neck Cancer - Parts I and II
Educational Objectives
Upon completion of my presentation, participants should be better able to:

• Examine technological advancements that have impacted the predictability and accuracy of reconstruction following treatment of oral head and neck cancer with surgery, radiation and chemotherapy.
• Distinguish methods of reconstruction of ablative defects following treatment for oral head and neck cancer and the functional restoration of occlusion with implant-supported prostheses.
• Utilize computer-aided surgical simulation systems for the transfer of virtual surgical planning to the head and neck cancer patient.

References
► Discuss the indications and protocol for hyperbaric oxygen therapy in extraction of mandibular teeth and placement of dental and craniofacial implants in patients whose oral cavity has had radiation therapy.

► Appraise the benefits of induction chemotherapy to increase local control and survival in patients with head and neck cancer.

► Despite several decades of intensive investigation, the optimal sequencing of chemotherapy, radiation, and surgery in the management of locoregionally advanced head and neck squamous cell cancer (HNSCC) remains a subject of intense debate. Chemotherapy combinations such as fluorouracil and cisplatin can produce response rates of 60% to 90%, with complete responses in up to 50% of previously untreated patients. Although these responses are temporary, the use of chemotherapy as induction before definitive surgery and/or radiation is an attractive model. 

► Implant retained prostheses provide subjects with improved perceptions of treatment satisfaction, value, and use when compared to adhesive-retained prostheses. In addition, patient perceptions of quality of retention, ease of placement and removal, and compliance to wear a facial prosthesis show significant improvements when the prosthesis is retained by osseointegrated implants. It is important to understand that the criteria to provide a successful facial prosthesis treatment are multifaceted. The provider must not only note the clinical indicators of success from the treatment team point of view, but also be sensitive to the patient’s psychological responses to treatment. Patients’ perceptions of their facial prostheses in terms of esthetics, comfort, ease of placement and removal, fit, and the quality of retention affect their level of compliance to wear the prostheses. The benefits of the facial prosthesis treatment can be validated only if patients wear the prostheses. Craniofacial implants can resolve some of the limitations of adhesive-retained prostheses, such as movable tissue beds and questionable quality of retention, which may result in greater patient acceptance.

► Acquired midfacial defects may affect patients’ speech, mastication, quality of life, psychology, and social behavior. Midfacial defects are defined as defects in the middle third of the face in horizontal plane that communicate with intraoral maxillary defects. These defects can be classified into two major categories of midline and lateral-midline midfacial defects. Midline midfacial defects include complete or partial involvement of either nose or upper lip that communicate with an intraoral maxillary defect while the lateral midfacial defects include complete or partial involvement of cheek and orbital contents that communicate with an intraoral maxillary defect. Midfacial defect can result from trauma, burns, most tumors of paranasal sinus, palatal epithelium, minor salivary glands, congenital abnormalities like vascular malformations, and some of other lesions like lethal midline granuloma that require partial or radical maxillectomy. One of the other causes of such defects is mucormycosis that is caused by a fungus of the order Mucorales that is one of the most rapid fatal fungal infections known to man. Rhinocerebral mucormycosis is the most common type, and its extension to the orbit and brain is quite usual. The location of mucormycosis on the palate is rare and of late occurrence. Large midfacial defects are rarely rehabilitated by surgical reconstruction alone. They usually require a facial prosthesis to restore function and esthetic. Satisfactory functional and esthetic results are achievable in patients with a large lateral midfacial defect using a hollow acrylic resin framework for silicon facial prosthesis. Retention of facial prosthesis can be satisfactorily achieved with the use of strong magnets provided that the facial prosthesis is light in weight.
Reconstruction of oral cavity defects must maximize residual function of remaining tissue. The reconstructive surgeon should have the ability to tailor the reconstruction according to the size of the defect and general medical status of the patient. The reconstructive ladder is a useful paradigm to conceptualize different types of reconstruction. Free tissue transfer has allowed reconstruction of massive defects. [http://www.jscimedcentral.com/Dentistry/dentistry-2-1033.pdf](http://www.jscimedcentral.com/Dentistry/dentistry-2-1033.pdf)

Reconstruction of oral cavity defects can be challenging due to the need for preservation of function and recreation of the aesthetic appearance of the lower third of the face. Oral cavity defects whether be from oncologic resection or trauma can be characterized by their subsite. The surgeon will then consider the original function, size, location, soft tissue and or bony involvement of the defect and refer to the reconstructive ladder. While the advancement in microvascular free tissue transfer has revolutionized head and neck reconstruction, the surgeon would be wise to implement simpler and more expedient techniques when available and appropriate and conserve more complex procedures as part of a contingency plan. [http://www.jscimedcentral.com/Dentistry/dentistry-2-1033.pdf](http://www.jscimedcentral.com/Dentistry/dentistry-2-1033.pdf)

Francisco G. Pernas, M.D.
How to Perform Ablative Head and Neck Surgery with Reconstruction as the Goal
Educational Objectives
Upon completion of my presentation, participants should be better able to:
• Examine reconstructive techniques for primary repair of surgical defects caused by extensive ablation for malignant conditions of the head and neck.

References
► Prolonged procedure time in head and neck cancer ablation and free flap reconstruction cases has been shown to significantly increase perioperative complications. [http://www.ncbi.nlm.nih.gov/pubmed/22743875](http://www.ncbi.nlm.nih.gov/pubmed/22743875)

Jaime Flores, M.D.
Midface Free Tissue Microvascular Flaps: Benefits and Challenges
Educational Objectives
Upon completion of my presentation, participants should be better able to:
• Discuss and assess the benefits and challenges of midface free tissue microvascular flaps.

References
► The robust circulation and high reliability of free flaps represent an important advantage of this type of reconstruction. Some flaps can be also raised while the resection is still in progress, and the donor sites are generally well tolerated. Selected flaps can incorporate vascularized muscle or bone in good quantities and provide large areas of skin and subcutaneous tissue meeting the demands of the defect. Microvascular techniques in midface reconstruction therefore, free flaps are increasingly used to remedy problems in midface reconstructions, with the free rectus abdominis, fibular, radial forearm and scapula flaps being the most common flaps used. [http://www.medicinaoral.com/medoralfree01/v15i5/medoralv15i5p746.pdf](http://www.medicinaoral.com/medoralfree01/v15i5/medoralv15i5p746.pdf)

Shawn A. McClure, M.D., DMD
Complications of Reconstruction
Educational Objectives
Upon completion of my presentation, participants should be better able to:
• Explain the complications of mid-face reconstruction after cancer surgery.

References
► The reconstruction of midface defects is a challenge for the plastic surgeon because the malignant diseases originating in the midface can extend beyond it to involve soft tissue or bone of contiguous regions. In the last 25 years, there was an evolution away from the constraints of multistaged flaps to free reconstructive flaps of increasing versatility and sophistication, making the microsurgical reconstruction the preferred method for treating post resection midfacial defects. The free microvascular tissue transfer overcomes many of the limitations of previous types of musculocutaneous flaps. [http://www.medicinaoral.com/medoralfree01/v15i5/medoralv15i5p746.pdf](http://www.medicinaoral.com/medoralfree01/v15i5/medoralv15i5p746.pdf)

Vitaly Siomin, M.D. and Francisco G. Pernas, M.D.
Skull Base Reconstruction after Endoscopic Cranial Base Resection
Educational Objectives
Upon completion of my presentation, participants should be better able to:
• Assess approaches to skull base reconstruction after endoscopic cranial base resection.
• Examine and address the unique reconstructive challenges of skull base reconstruction after endoscopic cranial base resection.
• Review recent and emerging reconstruction advances including the introduction of new biomaterials.

References
The expanded endonasal approach provides access to the entire ventral skull base for resection of neoplasms involving the skull base and brain. The creation of large defects of the bone and dura endoscopically presents unique reconstructive challenges. A layered reconstruction of the dura with inlay and onlay fascial grafts covered with fat grafts is an effective technique for repair. An intranasal balloon catheter is used to provide counterpressure in the early phase of healing and a lumbar spinal drain is a useful adjunct in patients at increased risk of a cerebrospinal fluid leak. Vascularized flaps may be necessary in some patients receiving radiation therapy. Continued advances in surgical technology and the introduction of new biomaterials will facilitate the reconstruction of skull base defects following endonasal brain surgery.


Applicable Credits: AMA Category 1 ☒  ■ Continuing Psychology Education ☐  ■ Continuing Dental Education ☐
CONFERENCE DIRECTOR: Thomas Morrison, M.D.

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


EXPECTED NUMBER OF ATTENDEES: 10-15  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): _____________________________
☒ 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: ____________________________________________
The difference between the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

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

- Physicians may not be familiar with latest clinical applications of recent evidence-based data available for the treatment of an abscess, including when to change a dressing or when to prescribe antibiotics.

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

- Physicians implement current practical applications of recent evidence-based research in their diagnosis and treatment of patients needing wound care.

**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 assess current evidence-based wound care research, evaluate its impact on clinical practice and ultimately implement these changes to improve patient outcomes. Physicians will closely monitor wound healing progress and when indicated and in a timely manner, will reassess treatment plans or refer to a specialist.

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

- There are many types of wound care products available for wound care management. The challenge for many clinicians is knowing what type of dressing is appropriate for the various types of wounds. Clinicians provide an important connection in the physician–patient relationship in home care and especially in wound therapy.

**EDUCATIONAL OBJECTIVES:**

Upon completion of this conference, participants should be better able to:
- Distinguish indications for wound dressing selection, and identify the advantages and disadvantages of different dressing categories.
- Determine when to drain and pack an abscess and when a Penrose drain is indicated.
- Recognize when to implement the use of antibiotics for wound care treatment.

**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
- ☒ Professionalism
- ☒ Systems-based Practice
- ☒ Interpersonal and Communications Skills
- ☒ 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.)

- Alan A. Netzman, D.O.
  General Surgeon and Hyperbaric Medicine
  Mariners Hospital
  Tavernier, Florida
RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).

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

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

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

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

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

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

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

☐ Process redesign or new protocol  ☐ Reminders (Posters, mailings, email blasts)  ☐ New order sheets
☐ Other tools or tactics
Explain: _____________________________________________________________

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

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

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

This meeting had been planned in collaboration with Mariners Hospital to meet the educational needs of the medical staff.

DATE REVIEWED:  February 27, 2015  REVIEWED BY:  ☐ CME Committee  ☐ Chairman

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

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

Applicable Credits: AMA Category 1 ☐ ■ Continuing Psychology Education  ☐ ■ Continuing Dental Education  ☐

CME ACTIVITY TITLE:  WKBH Grand Rounds: Managing Patients with Brain and Spinal Injuries
DATE: November 6, 2014  TIME: 12noon – 1p.m.

LOCATION: WKBH Auditorium  WKBH Classroom 4&5  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTOR: Javier Perez Fernandez, M.D.

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


EXPECTED NUMBER OF ATTENDEES: 15-20  CHARGE: 0

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

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

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

Patient:  [ ] Non-compliance  [ ] Lifestyle  [ ] Resistance-to-change  [ ] Financial/Lack of Insurance
Physician: [ ] Non-compliance  [ ] Resistance-to-change  [ ] Communication Skills  [ ] Financial
Resources: [ ] Institutional Capabilities  [ ] Physician Practice Limitations  [ ] Community Service Limitations
State of Science: [ ] Limited or No Treatment Modalities  [ ] Limited or No Diagnostic Modalities
Other: ____________________________________________
PROFESSIONAL PRACTICE GAP (C2)

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP?? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
► Physicians may be unaware of definitions of levels of care as well as consistent standards of service when managing patients with brain and/or spinal disorders.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
► Physicians are familiar with definitions and follow evidence-based guidelines to determine the right levels of care and prevent adverse outcomes when managing patients with brain and/or spinal disorders.

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.)
► Physician will implement evidence-based guidelines to determine the appropriate levels of care and prevent adverse outcomes.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► The appropriate time for surgical stabilization of traumatic spinal column injuries continues to be controversial regarding prevention of complications connected with recumbency or neurologic outcome. Some studies demonstrate an apparent improvement in neurologic outcome following immediate surgical decompression and stabilization and a significant benefit with regard to the overall hospitalization, ICU length of stay, ventilator days, and the incidence of pneumonia.

   Journal of Trauma and Acute Care Surgery Issue: Volume 76(2), February 2014, p 366–373
   http://ovidsp.tx.ovid.com/sp-3.13.0b/ovidweb.cgi?&S=BMIIFPJKHPDDCNOENCLKMDJCEPBGAA00&Link+Set=S.sh.51%7c3%7csl_10

   Appropriate imaging is critical in the initial assessment of patients with severe trauma. Plain radiographs remain integral to the primary survey. Focused ultrasonography is useful for identifying intraperitoneal fluid likely to represent haemorrhage in patients who are shocked and also has a role in identifying intrathoracic pathology. Modern scanners permit a greater role for CT, being more rapid and exposing the patient to less ionising radiation. ‘Whole body’ (head to pelvis) CT scanning has been shown to identify injuries missed by ‘traditional’ focused assessment and may be associated with an improved outcome. CT identifies more spinal injuries than plain radiographs, is the gold standard for diagnosing blunt aortic injury and facilitates non-operative management of solid organ injury and other bleeding. Coagulopathy occurs early in trauma as a direct result of injury and hypoperfusion. Damage control resuscitation with blood components is associated with an improved outcome in patients with trauma with massive haemorrhage.

   http://ovidsp.tx.ovid.com/sp-3.13.0b/ovidweb.cgi?&S=BMIIFPJKHPDDCNOENCLKMDJCEPBGAA00&Complete+Reference=S.sh.57%7c2%7c1

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
- Appropriately assess patients with brain and spinal injuries to determine if the patient would benefit from treatment at a tertiary facility.
- Summarize best practices for emergency surgical treatment of brain and spinal injuries.

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.)

Sergio Gonzalez-Arias, M.D., Ph.D., FAANS, FACS
Medical Director, Baptist Health Neuroscience Center
Chief, Department of Neuroscience and Neurosurgery
Baptist Hospital of Miami
Professor, Chairman Department of Neurosurgery
Florida International University Herbert Wertheim College of Medicine
Miami, Florida

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

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

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

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

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

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

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

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

- [ ] Yes  [ ] No  Are we partnering with other organizations in a purposeful manner to achieve common interests?
- [ ] Yes  [ ] No  Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. __________________________

DATE REVIEWED: 10-02-2014 REVIEWED BY: [ ] Executive Committee  [x] Chairman

APPROVED:  [x] YES  [ ] NO
Credits: AMA/PRA Category 1 Credits: # 1
Continuing Psychology Education Credits: # 1  [ ] N/A
Continuing Dental Education Credits: # 1  [x] N/A
Applicable Credits: AMA Category 1  ■ Continuing Psychology Education  ■ Continuing Dental Education


DATE: Saturday, June 6, 2015     TIME: 7:55 a.m. – 3:15 p.m.

LOCATION: BHM Auditorium     CREDIT HOUR(S) APPLIED FOR: 6.25  Cat. 1

CONFERENCE DIRECTOR: Louis T. Gidel, M.D., Ph.D., FCCP
CONFERENCE COORDINATOR: Donna Lee Armaignac, Ph.D., RN

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

TARGET AUDIENCE: Critical Care Physicians, Cardiologists, Surgeons, Anesthesiologists, Emergency Medicine Physicians, Nephrologists, Pulmonologists, Infectious Disease Physicians, Neurologists, Gastroenterologists, Nurses, Respiratory Therapists, Pharmacists and other interested healthcare providers.

EXPECTED NUMBER OF ATTENDEES: 200-250     CHARGE: 0

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

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

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

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

Patient: ☐ Non-compliance     ☐ Lifestyle     ☐ Resistance-to-change     ☐ Financial/Lack of Insurance
Physician: ☐ Non-compliance     ☐ Resistance-to-change     ☐ Communication Skills
Resources: ☒ Institutional Capabilities     ☐ Physician Practice Limitations
State of Science: ☐ Limited or No Treatment Modalities
Other: Lack of knowledge of emerging evidence-based practice shown to improve patient care outcomes.

___________________________________________________
___________________________________________________
### PROFESSIONAL PRACTICE GAP (C2)

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

**WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**?

What are physicians doing (or not doing) that needs to change? Describe the practice gap.

- Physicians may not include or may not consistently apply evidence-based best practice approach and or methods in the care of the ICU patient.

**WHAT IS THE OPTIMAL PRACTICE**?

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

- Physicians implement emerging evidenced-based strategies that have proven to improve patient care outcomes in the ICU.

**WHAT IS THE REASON FOR THIS GAP?**

Indicate if the gap is related to either/or:

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

**DESIRED OUTCOMES (GOAL):**

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

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

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

- Physicians will implement and monitor impactful, practical and feasible metrics for improving quality outcomes in the ICU.

**REFERENCES**

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

- Optimal care of critically ill patients remains a challenge within modern medical systems. During the past decade, emerging technologies and organizational improvements have greatly advanced the care of these patients. The effective implementation of best practice initiatives has led to measurable improvement in outcomes while also reducing health care costs. Continued advances in the implementation of these initiatives and ICU organization are required.


**EDUCATIONAL OBJECTIVES:**

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

**Jeffrey F. Barletta, Pharm.D., FCCM**

*Lecture: ICU Pharmacotherapy in Special Populations Part 1*

**Educational Objectives:**

- Implement an individualized medication dosing strategy for patients in the ICU.
- Develop medication regimens for morbidly obese patients in the ICU.

Obesity is a world-wide epidemic associated with significant morbidity and mortality which costs billions of dollars per year. The associated related conditions are many and include heart disease, stroke, type II diabetes mellitus, sleep apnea and certain types of cancer. Given that it is a multifactorial problem, the treatments must also address the numerous causes associated with the development of obesity. The neurohormonal regulation of feeding and energy is a complex system often necessitating modification through more than 1 pathway to achieve weight loss. Therefore, in addition to lifestyle changes, attenuation of caloric intake and increase in caloric expenditure, pharmacotherapies, including combination medications, may prove beneficial in its treatment.

*Surgical Clinics of North America. Issue: Volume 345(4), April 2013, p 284–288*

**Lecture: ICU Pharmacotherapy in Special Populations Part 2**

**Educational Objectives:**

- List factors influencing drug dosing in ICU patients undergoing extracorporeal therapies.
- Describe medication implementation plans for patients undergoing continuous renal replacement therapy (CRRT) and molecular absorbent recirculation systems (MARS) for acute liver failure.

Acute kidney injury requiring continuous renal replacement therapy is common, costly, and associated with mortality rates of up to 60%. Accurate pharmacokinetic data are essential to developing rational individualized dosing strategies and providing optimal care to these patients, yet few such data exist, probably due in part to an absence of regulatory guidance on the issue. The Kidney Health Initiative is working with stakeholders to propose strategies to address this in a standardized
Timothy G. Buchman, M.D.

Lecture: Advanced Practice Providers in Critical Care Medicine: Rationale, Planning, Implementation, Evaluation and Sustainability

Educational Objectives:
- List contributions of advanced practice providers, identifying areas of improved patient health, positive healthcare experience and lower healthcare costs.
- Describe five essential steps to the integration of an advanced practice provider’s role in a critical care delivery system.

Acute care trained APPs are being increasingly used in many US ICUs. Our collaborative physician-APP model at MSKCC has allowed us to develop a well-trained, highly functional and semi-autonomous CCM APP team. Along with the program’s successes, we have experienced challenges in role transition, intra- and interdisciplinary relations, and workforce retention. Similar experiences are likely to be encountered by other institutions intent on developing a program of this magnitude. Understanding and overcoming these obstacles will ensure that APPs will not only thrive in the intensive care setting, but more importantly, will be able to deliver timely, safe, and cost-effective care for all critically ill patients.

AMERICAN JOURNAL OF CRITICAL CARE, September 2013, Volume 22, No. 5

Marilyn Hravnak, Ph.D., RN, ACNP-BC, FCCM, FAAN

Lecture: Causes of Failure to Rescue: Implications for Rapid Response Systems

Educational Objectives:
- Summarize the concepts and evidence of rapid patient-level and hospital-level factors that contribute to rapid response system’s abilities to impact failure to rescue.
- Descriptions of common RRT structures and processes in a large metropolitan area may provide benchmark data, best practices, and evaluation criteria for assessing the efficacy of existing or future RRTs. Nursing and medical students must be prepared with basic assessment techniques and communication skills to recognize and report subtle deviations from expected norms. Health care workers must be oriented to policies, procedures, and systems designed to detect physiological decline, mobilize resources, and save patient lives. Periodic reeducation and/or review of assessment skills, high-risk physiological findings, and available resources serve to keep care providers alert, prepared, and supported.

Lecture: Clinical Instability in Monitored Patients: The State and Promise of Forecasting and Now-Casting

Educational Objectives:
- Explain the importance of more sensitive and specific patient instability detection in the short-term (now-casting) and the future (forecasting).
- Predict how real-time data can be leveraged with machine learning algorithms to treat patient instability proactively and preemptively.

Adverse events are an important reason for (re)admission to the ICU and a considerable proportion of these are preventable. It was not possible to estimate an overall incidence and preventability rate of these events as we found considerable heterogeneity. To decrease adverse events that necessitate ICU admission, several systems are recommended such as early detection of patients with clinical instability on general wards and the implementation of rapid response teams. Step-down or intermediate care units could be a useful strategy for patients who require monitoring to avoid ICU readmissions.

http://ovidsp.tx.ovid.com/sp-3.14.0b/ovidweb.cgi?&S=CPAKFPENMADDABGPNCJFIBNJIEAA00&Complete+Reference=S.sh.97%7c8%7c1

Paul Wischmeyer, M.D., EDIC

Lecture: Malnutrition in Your ICU – What Can You Do?

Educational Objectives:
- List risk factors associated with malnutrition in the ICU setting.
- Implement diagnosis methods discussed in literature in nutrition for critical care, including best practice of enteral nutrition, parenteral nutrition, protein delivery and new lipid formulations.

Decreased nutritional intake or preexisting malnutrition is associated with increased morbidity and mortality during hospital stay. However nutritional support in particular for the ICU patient is not trivial. Hyperalimentation in the acute phase of critical illness but also hypoalimentation in the chronic and stable phase of illness has to be avoided. Ideally about 25 kcal/kg/d should be targeted over a few days during metabolic monitoring. Alternatively indirect calorimetry should be applied where available.

http://ovidsp.tx.ovid.com/sp-3.14.0b/ovidweb.cgi?&S=CPAKFPENMADDABGPNCJFIBNJIEAA00&Complete+Reference=S.sh.102%7c6%7c1

Lecture: Winning The War Against Critical Illness – A Pyrrhic Victory? The Role of Post-ICU Quality of Life

Learning Objectives:
- Implement interventions to diagnose and target treatments for ICU related muscle weakness and loss of function.
- Recommend potential therapeutic interventions to prevent and treat ICU related weakness using nutrition, exercise and antitocatabolic/anabolic agents.

An increasing number of ICU patients survive and develop mental, cognitive, or physical impairments. Various interventions support recovery from this postintensive care syndrome. Physicians in charge of post-ICU patients need to know which interventions are effective.

http://ovidsp.tx.ovid.com/sp-3.14.0b/ovidweb.cgi?WebLinkFrameset=1&S=CPAKFPENMADDABGPNCJFIBNJIEAA00&returnUrl=ovidweb.cgi%3f%26Ttles%3dSh.107%257c3%257c257c10%26FORMAT%3dtitles%26FIELDS%3dui%252526cti%252526cso%252526clm%252526can%252526exp%3d%26S%3dCPAKFPENMADDABGPNCJFIBNJIEAA00&directlink=http%3a%2f%2fgraphics.tx.ovid.com%2fovftpdfs%2fFPDDNCIQJGPMQA00%2fs046%2fovft%2five%2fgv023%2f000003246%2f00003246-201405000-000028.pdf&filename=Rehabilitation+Interventions+for+Postintensive+Care+Syndrome%3a+Systematic+Review%2a&navigation_links=NavLinks.S.sh.107.3%PDFIdLinkField=%2fs046%2fovft%2five%2fgv023%2f000003246%2f00003246-201405000-000028&link_from=S.sh.107%7c3&pdf_key=B&pdf_index=S.sh.107&D=medf

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

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

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

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

Please see below.

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

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

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

The mission of the Continuing Medical Education (CME) Program is to provide continuing education to doctors and allied healthcare professionals that will improve competence and/or performance in order to improve patient care, safety and treatment outcomes. In order to accomplish this, in collaboration with Baptist Health South Florida Adult Critical Care Best Practices Committee we developed the State of the Science –Critical Care Best Practices Symposium to define, implement and monitor impactful, practical and feasible metrics for assessing quality outcomes in the ICU.

**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)
The mission of the Baptist Health South Florida Adult Critical Care Best Practices Committee is to provide the best care to our critically ill patients and families by applying “conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients,” relying on sound wisdom and clinical expertise and patients’ and family’s desires. Application of these practices is aimed at achieving improved clinical outcomes, health and well being for our patients and families.

The Committee is working on a system-wide initiative to accomplish overall mortality, length of stay, and cost reduction. This symposium is part of that initiative to help the Committee reach its patient care improvement goals.

Agenda

7:15 a.m.  
_Breakfast and Registration_

7:45 a.m.  
Welcome and Introductions  
_Louis Gidel, M.D. and Donna Lee Armaignac Ph.D., RN-CNS, CCRN_

7:55 a.m.  
Advanced Practice Providers in Critical Care Medicine: Rationale, Planning Implementation, Evaluation and Sustainability  
_Timothy G. Buchman, Ph.D., M.D._

8:40 a.m.  
Malnutrition in Your ICU – What Can You Do?  
_Paul Wischmeyer, M.D., EDIC_

9:25 a.m.  
Writing, Reviewing, Reading and Using Critical Care Medicine in 2015  
_Timothy G. Buchman, Ph.D., M.D._

10:10 a.m.  
_Break and Exhibits_

10:30 a.m.  
Winning The War Against Critical Illness – A Pyrrhic Victory? The Role of Post-ICU Quality of Life  
_Paul Wischmeyer, M.D., EDIC_

11:15 a.m.  
Causes of Failure to Rescue: Implications for Rapid Response Systems  
_Marilyn Hravnak, Ph.D., R.N., ACP-BC, FCCM, FAAN_

12:00 noon  
_Lunch_

12:45 p.m.  
ICU Pharmacotherapy in Special Populations Part 1  
_Jeffrey F. Barletta, Pharm.D., FCCM_

1:30 p.m.  
Clinical Instability in Monitored Patients: The State and Promise of Forecasting and Nowcasting  
_Marilyn Hravnak, Ph.D., R.N., ACP-BC, FCCM, FAAN_
2:15 p.m.  ICU Pharmacotherapy in Special Populations Part 2
Jeffrey F. Barletta, Pharm.D., FCCM

3:00 p.m.  Q&A

3:15 p.m.  Adjourn

Faculty

Jeffrey F. Barletta, Pharm. D., FCCM
Associate Professor and Vice Chair
Department of Pharmacy Practice
Midwestern University
Glendale, Arizona

Timothy G. Buchman, Ph.D., M.D.
Director, Emory Critical Care Center
Chief, Critical Care Service, Emory Healthcare
Emory University School of Medicine
Atlanta, Georgia

Marilyn Hravnak, Ph.D., R.N., ACNP-BC, FCCM, FAAN
Professor, School of Nursing
University of Pittsburgh
Pittsburgh, Pennsylvania

Paul Wischmeyer, M.D., EDIC
Professor of Anesthesiology
Associate-Chairman for Clinical and Translational Research
Director of Nutritional Therapy Services
University of Colorado
Aurora, Colorado
CME ACTIVITY TITLE: Use of Acoustic Radiation Force Impulse Imaging (ARFI) for the Evaluation of Diffuse Liver Disease

DATE: Monday, April 13, 2015
TIME: 6:00 p.m. - 7:30 p.m.
LOCATION: Baptist Hospital of Miami
5 MCVI and WebEx
CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1

CONFERENCE DIRECTOR: Ann Podrasky, 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: Radiologists, Obstetrics and Gynecology physicians, Hepatologists, Oncologists, Family Medicine Physicians, FIU Medical Students, nurses, radiology technologists, ultrasound technologists and all interested allied health professionals.

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

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

FACTORs OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)
Patient:
- Non-compliance
- Lifestyle
- Resistance-to-change
- Financial/Lack of Insurance
Physician:
- Non-compliance
- Resistance-to-change
- Communication Skills
- Financial
Resources:
- Institutional Capabilities
- Physician Practice Limitations
- Community Service Limitations
State of Science:
- Limited or No Treatment Modalities
- Limited or No Diagnostic Modalities
Other: _____________________________
Developed to facilitate a single ultrasound array transducer for both push and detect function, which makes SDUV compatible with current mode and fit with a theoretical dispersion model to inversely solve for tissue elasticity and viscosity. A special pulse sequence has been introduced to measure wave speeds at multiple frequencies (typically hundreds of Hertz) and related to the tissue’s mechanical properties. Shear contrast. SDUV uses an ultrasound “push” beam to stimulate formation of propagating harmonic shear waves in the studied tissue. The liver fibrosis is a diffuse disease where abnormality is not confined to a local region and there is no normal background tissue to provide contrast. Cirrhosis is a condition afflicting hundreds of millions of patients worldwide. Quantitative measurement of liver elasticity is a promising alternative to liver biopsy to stage liver fibrosis, a condition afflicting hundreds of millions of patients worldwide, in large part attributable to chronic alcohol abuse and other diseases of the modern world: obesity, diabetes and hypertriglyceridemia.

What is the optimal practice? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)

Physicians, more specifically radiologists, will consistently consider non-invasive techniques and tests to accurately evaluate patients with chronic liver diseases; this will lead optimal patient outcomes.

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

- Identify available approaches for noninvasive assessment of liver fibrosis including ultrasound based elastographic...
techniques.

- Explain the patient benefits of noninvasive tests for chronic liver disease.
- Examine the role of shear wave quantification for assessment of chronic liver disease and as an alternative to biopsy.

**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:**

Thomas Grant D.O., FACR,
Professor of Radiology
Northwestern University Feinberg School of Medicine
Chicago, Illinois

**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.

Important educational updates identified by Radiology Department leadership

**DATE REVIEWED:** March 4, 2015 REVIEWED BY: □ Executive Committee □ Chairman

**APPROVED:** □ YES □ NO □ Credits: AMA/PRA Category 1 Credits: # _1.5_
**CME ACTIVITY TITLE:** Cardiovascular Conference Series: Pregnancy and the Heart

**DATE:** Friday, March 20, 2015  
**TIME:** 12:00 – 1:30 p.m.

**LOCATION:** SMHC, CI D  
**CREDIT HOUR(S) APPLIED FOR:** 1.5 Cat. 1

**LIVE WEBCAST**  
VC to WKBH, Imaging Conference Room  
Baptist Hospital, 5MCVI side A

**CONFERENCE DIRECTOR:** Harry Aldrich, M.D.

**AMA/PRA LEARNING FORMAT:**  
- [x] Live activity  
- [x] Didactic Lecture  
- [x] Question & Answer  
- [ ] Test-item writing activity  
- [ ] Enduring material  
- [ ] Case Studies  
- [ ] Journal-based CME activity  
- [ ] Manuscript review activity  
- [ ] Panel  
- [x] Enduring Material  
- [ ] Internet-Home Study  
- [ ] PI CME activity  
- [ ] Other (specify)

**TARGET AUDIENCE:** Cardiologists, Obstetricians, Family Medicine Physicians, Internists, Hospitalists, Emergency Medicine Physicians, Nurses, and other interested healthcare professionals.

*In addition, describe how the content of the activity is aligned with the target learners’ current or potential scope of practice (C4).*  
This activity addresses professional practice gaps relevant to physicians in the practice of 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:** 10-20  
**CHARGE:** 0

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

**NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED?** *(Check all that apply and explain in professional practice gap.)*  
- [ ] Best practice parameters  
- [x] 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:**  
- [x] Non-compliance  
- [x] Lifestyle  
- [ ] Resistance-to-change  
- [ ] Financial/Lack of Insurance

**Physician:**  
- [ ] Non-compliance  
- [ ] Resistance-to-change  
- [x] Communication Skills  
- [ ] Financial

**Resources:**  
- [ ] Institutional Capabilities  
- [ ] Physician Practice Limitations  
- [ ] Community Service Limitations

**State of Science:**  
- [ ] Limited or No Treatment Modalities  
- [ ] Limited or No Diagnostic Modalities

**Other:** __________________________________________________________
PROFESSIONAL PRACTICE GAP (C2)

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
► Physicians may not be aware of physiological changes in the pregnant patient that may indicate cardiac risks.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
► Physicians properly evaluation the pregnant patient for cardiocirculatory changes that can impact underlying cardiac disease.

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 conduct thorough cardiac evaluation of the pregnant patient to identify potential cardiocirculatory changes that could impact underlying cardiac disease.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Although cardiac disease complicates a small percentage of all pregnancies in developed countries (eg, only 1 to 4 percent of pregnancies in the United States), maternal cardiac disease is a major cause of non-obstetric maternal morbidity and mortality. Care of the high-risk patients requires a team approach including a maternal-fetal medicine specialist, cardiologist, and obstetrical anesthesiologist. In the past, rheumatic heart disease was the most common form of cardiac disease in pregnant women; it still predominates in developing countries and in immigrant populations in the United States. Congenital heart disease is now the most common form of heart disease complicating pregnancy in the United States, in part because advances in the treatment of congenital heart disease have made it possible for more affected children to reach adulthood and attempt pregnancy.
In addition, many women are postponing childbearing until the fourth and fifth decades of life; with advancing maternal age, underlying medical conditions such as hypertension, diabetes, and hypercholesterolemia become more common and increase the incidence of acquired heart disease complicating pregnancy.

Pregnancy is associated with several cardiocirculatory changes that can significantly impact underlying cardiac disease. These changes begin early in pregnancy (within the first five to eight weeks), reach their peak during the late second trimester, and then remain relatively constant until delivery. Knowledge of these cardiovascular adaptations is required to correctly interpret hemodynamic and cardiovascular tests in the gravida, to predict the effects of pregnancy on the woman with underlying cardiac disease, and to understand how the fetus will be affected by maternal cardiac disorders.
Normal physical findings may include distended neck veins, basilar rales, a prominent left and right ventricular apical impulse, exaggerated heart sounds, and a “new” systolic ejection murmur best heard over the mid or lower left sternal border. Preexisting murmurs will be louder. A physiologic S3 gallop may be appreciated. Peripheral edema will be present in the last trimester. One of the challenges for the clinician is how to distinguish between these normal symptoms and signs of pregnancy and similar symptoms that may indicate underlying heart disease in the mother.

Women with acquired heart disease may have cardiac complications during pregnancy. Their risk can be assessed by evaluating the severity of their valve lesions and the degree of ventricular dysfunction. The history, physical examination, echocardiogram, and electrocardiogram form the foundation of cardiac evaluation in all patients.


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

1. Review the basic cardiac physiology of pregnancy.
2. Identify the appropriate candidates who will benefit from anti-coagulation management during pregnancy.
3. Evaluate cardiac disease findings in accordance with the cardiac risk score in pregnancy calculation.

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.)

Wayne J. Franklin, MD, FACC
Director, Texas Adult Congenital Heart Program
Texas Children's Hospital
Assistant Professor of Medicine and Pediatrics
Baylor College of Medicine
Houston, Texas

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

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

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

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

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

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

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

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

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

Explain: __________________________________________________________

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

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

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. This activity was planned in collaboration with the MCVI.

DATE REVIEWED: March 10, 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
CME ACTIVITY TITLE: Primary Care Focus – 14th Annual Symposium

DATE: Friday-Saturday, July 24-26, 2015

LOCATION: Ritz-Carlton, Naples – Florida

TIME: Friday 1:00 - 6:30 p.m. Saturday, 8:00 a.m.-12:30 p.m., Sunday, 8:00 - 12:00 a.m.

SYMPOSIUM DIRECTOR: A. Ruben Caride, M.D., FACP

CREDIT HOUR(S) APPLIED FOR: 13 Category 1

TARGET AUDIENCE: Family physicians, general internists, psychologists, hospitalists, physician assistants, nurse practitioners, nurses, pharmacists, dietitians and respiratory therapists

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 primary care medicine. Also included in the target audience are related members of the primary and/or hospital care team, i.e.: nurses, pharmacists, dietitians and respiratory therapists

CHARGES: Physicians: $379
All other healthcare professionals: $195
Baptist Health Employees: $95

EXPECTED NUMBER OF ATTENDEES: 160-180

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

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

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

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

☒ New or updated policy/protocol/guidelines
☐ 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 ☒ 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: Primary Care Physician’s limited time and high patient volume
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.

Primary care physicians are uniquely responsible for diagnosing and managing a wide spectrum of medical conditions at varying stages. They are burdened and challenged with maintaining competencies and adopting best practice models across a variety of medical subspecialty areas. Short of being an expert on everything, there are common knowledge gaps of best practices and potential inconsistent applications resulting in some inconsistencies in quality of care.

The rapidly evolving state of medicine including publication of data that frequently is at odds with the current practice norms makes it particularly challenging in primary care medicine because of the broad nature and depth of knowledge required across all medical subspecialties.

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

Primary care physicians have a wide base of evidence-based knowledge of medical conditions commonly seen in their clinical practice and are able to accurately diagnose and provide first line treatment and effectively determine when referral to a specialist is necessary. The physician frequently seeks out updates on diagnostic and treatment approaches for common medical conditions and new practice guidelines to maintain and improve his/her ability to implement appropriate evidence-based strategies that lead to optimal patient care and outcomes.

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

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

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

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

► Physicians will provide optimal care and achieve best outcomes when consistently implementing evidence-based methods of diagnosis and treatment to effectively identify and manage various common and important medical conditions and determine when a referral to a specialist is warranted.

Topic specific Professional Practice GAPS found at the end of this CME application

LEARNING 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? (See attached)

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

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

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

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

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

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

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

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

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

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. ► Primary care physicians – America’s front line healthcare practitioners -- are usually the first to diagnose illness, refer patients to specialists and coordinate care. The Association of American Medical Colleges (AAMC) projects a shortage of 63,000 physicians by 2015, the vast majority of those in primary care. ► Without effective, timely communication between physicians, both the quality of care and the patient experience can suffer. In a recent study of 4,720 physicians, physicians who reported a lack of timely communication regarding referrals had less confidence in their ability to provide high-quality care than colleagues who received timely communication. Co-author of the study, Ann S. O’Malley, MD, MPH, senior researcher at the Center for Studying Health System Change, believes the results confirm that physicians see a connection between communication and quality.

http://annfammed.org/content/10/6/503.full; http://www.sciencedaily.com/releases/2012/09/120921111040.htm

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 symposium was planned in collaboration with the Baptist Health Quality Network (BHQN) and Baptist Health Medical Group (BHMG). The groups identified topics of need that are implemented in this year’s programming.

DATE REVIEWED: March 11, 2015 REVIEWED BY: ☐ COMMITTEE ☒ CHAIRMAN

APPROVED: ☒ YES ☐ NO Category 1 Credits: 13.0 Continuing Psychology Education Credits: 13.0

The Director of Continuing Education for Psychology has determined that this conference addresses aspects of the ICD and DSM-IV which describes mental disorders due to general medical conditions. This conference addresses ICD and DSM-IV diagnostic categories and their impact on behavior.

FACULTY

Danelle Cayea, M.D.
Assistant Professor, Division of Geriatrics, Department of Medicine
Johns Hopkins University
Baltimore, Maryland

Biography Dr. Cayea has extensive experience in multiple aspects of medical education. Her focus has been on the clinical education of medical students, with an emphasis on communication skills and on infusing geriatrics education into existing programs for medical students, residents, and practicing clinicians. She has experience in curriculum development
and educational administration in her roles as director of several medical student courses and as the Associate Vice-chair for Education for the Department of Medicine. Her teaching has been recognized both locally and nationally. She has experience in faculty development through several CME courses as well as through the American Academy on Communication in Healthcare’s training programs. Her current scholarly interests include assessment of communication skills, the intersection of geriatrics and primary care, and high value care curricula.

Tim Church, M.D., MPH, Ph.D.
Professor of Preventive Medicine
Pennington Biomedical Research Center
Louisiana State University
New Orleans, Louisiana

**Biography**

Dr. Church has received numerous awards for his research in preventive health. He was a consultant in the writing of the U.S. Department of Health and Human Services’ 2008 Physical Activity Guidelines Report, and was an invited speaker at the U.S. Congress’ Committee on Government Reform on the topic of diet, physical activity and dietary supplements. He is also a member of the Mayor’s Council for a Healthier Baton Rouge. Dr. Church has authored over 100 research articles, received numerous awards for preventive health research and co-authored, Move Yourself: The Cooper Clinic Medical Director’s Guide to All Healing Benefits of Exercise. Regarded as an expert source for health stories by national media outlets, Dr. Church has been interviewed by NBC, USA Today, Reuters, Wall Street Journal and CNN. He earned his medical degree at Tulane University and is former vice president of medical research at the Cooper Institute.

Steven Fein, M.D.
Hematologist / Oncologist
Baptist, South Miami, Doctors, Homestead, Mariners and West Kendall Baptist Hospitals
Voluntary Assistant Professor of Medicine, University of Miami Miller School of Medicine
Miami, Florida

**Biography**

Dr. Fein attended medical school at Johns Hopkins School of Medicine, completed his internship in internal medicine at Duke University Medical Center and did his fellowship in hematology/oncology at the University of Miami and Jackson Memorial Hospital. One of Dr. Fein’s passions is teaching. His experience as a medical student and a graduate student made him place teaching at the highest priority. He was voted “Fellow of the Year” once for his teaching skills and dedication. Nowadays, he is a voluntary assistant professor at University of Miami Miller School of Medicine, giving hematology lectures and mentoring medical students. “Teaching patients and their families,” according to Dr. Fein, “is the most important thing a doctor can do.”

Jonathan Fialkow, M.D.
Medical Director, Clinical Cardiology, Stress Lab, ECG, Cardiac Rehabilitation
Miami Cardiac & Vascular Institute
Executive Medical Director, Baptist Health Quality Network
Cardiologist, Baptist and West Kendall Baptist Hospitals
Miami, Florida

**Biography**

Dr. Fialkow is a practicing; Board certified clinical cardiologist and Lipidologist certified by the American Board of Clinical Lipidology. He is a founding member of Heartwell, LLP, and a 23-doctor single specialty cardiovascular care group. He is the Medical Director of Clinical Cardiology at Baptist Cardiac and Vascular Institute where he also heads the Stress Lab, ECG department and cardiac rehabilitation program. He has entered the population health arena as the Executive Medical Director of the Baptist Health Quality Network, a clinically integrated network of over 900 physicians.
Michael Hernandez, M.D.
Pulmonary Critical Care Medicine and eICU
Baptist, South Miami, Doctors, Homestead, Mariners and West Kendall Baptist Hospitals
Assistant Clinical Professor of Medicine
Florida International University Herbert Wertheim College of Medicine
Miami, Florida

**Biography**
Dr. Michael J. Hernandez, a Miami original, graduated from the University of Miami. He completed his Internal Medicine, Pulmonary and Critical Care Medicine residencies at the University of Texas Southwestern, Dallas, Texas. Dr. Hernandez joined the group in 2009. He is board certified in Internal Medicine, Pulmonary Medicine and Critical Care Medicine. He has received numerous awards both during his training and also as a member of the community. He is currently developing our academic curriculum, as the liaison with Florida International University where he also carries a position as Assistant Clinical Professor of Medicine.

Brad Herskowitz, M.D.
Neurologist
Baptist, South Miami, Doctors and West Kendall Baptist Hospitals
Miami, Florida

**Biography**
Dr. Herskowitz is a Board-certified general neurologist, with special training in stroke, concussion, sleep and migraine, as well as expertise in Botox injection therapy for both cosmetic and neurological conditions. He has also served as a Florida boxing ringside physician. He has been a principal investigator in numerous clinical research trials. He has both an office-based and hospital practice and is on staff at Baptist Hospital. Dr. Herskowitz received his medical degree from the University of Miami School of Medicine. He completed a two-year internal medicine residency at Jackson Memorial Hospital before completing a three-year neurology residency at Yale-New Haven University, where he was chief resident.

Javier Jimenez, M.D.
Medical Director, Advanced Heart Failure and Pulmonary Hypertension
South Miami Hospital
Cardiologist, Baptist, South Miami and Doctors Hospitals
Voluntary Associate Professor of Medicine
University of Miami Miller School of Medicine
Clinical Associate Professor of Medicine
Florida International University Herbert Wertheim College of Medicine
Miami, Florida

**Biography**
Dr. Jimenez is currently medical director of Advanced Heart Failure and Pulmonary Hypertension at South Miami Hospital. He is a voluntary associate professor of medicine at the University of Miami Miller School of Medicine and a clinical associate professor of medicine at the Herbert Wertheim College of Medicine at Florida International University. Dr. Jimenez received his medical degree and doctorate at the University of Alcala de Henares in Madrid; completed an internal medicine residency and cardiology fellowship at Brown University; and completed additional fellowships in advanced heart failure/cardiac transplantation at the Cleveland Clinic, Ohio, and in interventional cardiology at Brown University. Dr. Jimenez has published extensively and participated in numerous national and international clinical trials. He is Board-certified in internal medicine, cardiology, interventional cardiology, nuclear cardiology, echocardiology and advanced heart failure and cardiac transplantation. He is a Fellow of the American College of Cardiology and American Society of Nuclear Cardiology. He is currently a member of the American Society of Echocardiography and the Heart Failure Society of America.

Jocelyn Lebow, Ph.D.
Assistant Professor, Department of Psychiatry and Behavioral Sciences
University of Miami Miller School of Medicine
Miami, Florida

**Biography**
Jocelyn Lebow is an Assistant Professor of Clinical Psychology at the University of Miami Miller School of
Dr. Lebow's clinical interests center on the outpatient evaluation and psychological treatment of adolescents and young adults with a range of psychological, interpersonal and adjustment issues. Her specialty areas include adolescent eating disorders, conversion disorders, anxiety and depression, chronic pain and parent training. Dr. Lebow also maintains an active program of research, focused on the treatment and prevention of adolescent eating disorders.

Susan Mitchell, Ph.D., RD
Dietitian/Nutritionist
Author
Winter Park, Florida

Biography
Dr. Mitchell writes and produces How Big is Your BUT? No Excuse Boomer Tips to Eat Smart-Live Smart. As a feature contributor for Growing Bolder Media Group, thousands of faithful listeners tune in to her radio segments, watch her videos or TV segments and read her blog. Known for her smart, sassy straight talk about food and fitness, Dr. Mitchell helps you navigate through the hype of conflicting nutrition information. She takes the science of nutrition and turns it into easy-to-follow health messages that people understand and want to live by. An award-winning licensed nutritionist and registered dietitian with a PhD from The University of Tennessee, Susan is the co-author of three books—Fat is Not Your Fate, I'd Kill for a Cookie and Eat to Stay Young.

Eugenio Hernandez, M.D.
Gastroenterologist
Baptist, Doctors and West Kendall Baptist Hospitals
Miami, Florida

Biography

Wayne M. Sotile, Ph.D., FAACVPR
Special Consultant in Behavioral Health, Carolinas Medical Center
Charlotte, North Carolina
Clinical Assistant Professor, Tulane University School of Medicine, Department of Orthopedic Surgery
New Orleans, Louisiana

Biography
Dr. Sotile is recognized as a pioneer in the fields of cardiac and health psychology. He is the author of nine books, including Thriving with Heart Disease. He lectures internationally on the keys to resilience and burnout prevention for busy health professionals and their patients. A former faculty member of the Wake Forest University School of Medicine, Dr. Sotile served as Director of Psychological Services for the Wake Forest University Cardiac Rehabilitation Program for 25 years. He is the Founder of Sotile Psychological Associates and Real Talk, Inc., in Winston-Salem, North Carolina. He serves as a special consultant in behavioral health for the Carolinas Health System Sanger Heart and Vascular Institute’s cardiac rehabilitation program, and as a clinical assistant professor at the Tulane University School of Medicine. A Fellow in the American Association of Cardiovascular and Pulmonary Rehabilitation, Dr. Sotile received lifetime career achievement awards from the North Carolina Cardiopulmonary Association, the American Academy of Medical Administrators, and he was the 2004 recipient of AACVPR’s L. Kent Smith Award for Excellence in Clinical Practice. Dr. Sotile earned a B.S. degree in psychology from Louisiana State University and a Ph.D. in Clinical Psychology from the University of South Carolina. He completed his clinical training in Medical Psychology in the Department of Psychiatry at Duke University Medical Center.

Raul Valor, M.D.
Pulmonary Critical Care Medicine and eICU
Baptist, South Miami, Doctors, Mariners and West Kendall Baptist Hospitals
Clinical Assistant Professor, Herbert Wertheim College of Medicine Florida International University
Miami, Florida

Biography
Dr. Valor is a pulmonologist in solo practice in Miami. He received his medical degree from Universidad Central Del Este in the Dominican Republic. He was a surgical resident at Miami General Hospital; completed an internship and residency in internal medicine at Conemaugh Hospital/Temple University in Pennsylvania; and a pulmonary and critical care fellowship at Yale-New Haven Hospital, Waterbury Hospital and St. Mary’s Hospital in Connecticut. Dr. Valor’s positions in Miami have included director of the Pulmonary Sleep Disorders Lab in Coral Gables; director of the Sleep Disorders Laboratory at Kendall Regional Medical Center; and chief of pulmonary/respiratory care at Cedars Medical Center. Dr. Valor is a member of the American College of Physicians, American College of Chest Physicians and the Florida Thoracic Society. He is certified by the American Board of Internal Medicine, American Board of Pulmonary Disease and Advanced Cardiac Life Support, and has presented at meetings of the American College of Physicians, American College of Chest Physicians and American Thoracic Society.

Tomas Villanueva, DO, MBA, FACPE, SFHM
Assistant Vice-president and Medical Director
Baptist Health Medical Group, part of Baptist Health South Florida
Miami, Florida

Biography
Dr. Villanueva has been in practice since 1995, first in a traditional internal medicine practice for 10 years and then as a full time hospitalist since 2005. He is a member of the inaugural class of Senior Fellows for the Society of Hospital Medicine and serves in many national committees for the Society of Hospital Medicine, including leadership and transitions of care. He is presently the immediate Past President of the South Florida Chapter of the Society of Hospital Medicine and has published in national journals and books. He received his Doctor of Osteopathic Medicine with Honors from Nova Southeastern University, where he presently holds a position as Clinical Assistant Clinical Professor of Medicine in addition to holding the same teaching position at Florida International University, College of Medicine. He completed his residency in Internal Medicine at the University of Miami, Jackson Memorial Hospital where he received the, “Eric Reiss Award for Outstanding Teaching”. He is double boarded in Internal and Palliative Care Medicine. Dr. Villanueva also has a Masters of Business Administration from the University of Miami, School of Business, in Health Administration and Policy. He is a Fellow of the American College of Physician Executive. He has a vast experience in networking among multiple physician specialties and establishing policies and programs.

SCHEDULE

FRIDAY, JULY 24 (5 Cat. 1)
11:30 – 6 p.m.  Registration and Visit Exhibits
12:55 p.m.  Welcome and Introductions
A. Ruben Caride, M.D.
1:00 p.m.  The Medical Handoff: Improving Transitions in Care
Tomas Villanueva, D.O., MBA, FACPE, SFHM
2:00 p.m.  Eating Disorders
Jocelyn Lebow, Ph.D.
3:00 p.m.  The Role of Exercise and Heart Health: Is it Missing in Action?
Tim Church, M.D., MPH, Ph.D.
4:00 p.m.  Break and Visit Exhibits
4:30 p.m.  Busting Nutrition Myths
Susan Mitchell, Ph.D., RD
5:30 p.m.  Smoking Cessation
Michael Hernandez, M.D.
6:30 p.m.  Adjourn
6:45-7:45 p.m.  Welcome Reception (Light Appetizers)

SATURDAY, JULY 25 (4 Cat. 1)
7:15 a.m.  Registration, Continental Breakfast and Visit Exhibits
7:50 a.m.  Welcome and Introductions
A. Ruben Caride, M.D.
8:00 a.m.  Evaluating the Patient with Chest Pain
Jonathan Fialkow, M.D.
9:00 a.m.  Helping Heart Patients Thrive: Brief Interventions that Really Work
Wayne Sotile, Ph.D.
10:00 a.m.  Break and Visit Exhibits
10:30 a.m. Managing the Patient with Congestive Heart Failure
Javier Jimenez, M.D.

11:30 a.m. Medical Evaluation of Concussions
Brad Herskowitz, M.D.

12:30 a.m. Adjourn
12:45-2 p.m. Lunch

SUNDAY, JULY 26 (4.0 Cat.1)
7:15 a.m. Registration, Continental Breakfast and Visit Exhibits
7:50 a.m. Welcome and Introductions
A. Ruben Caride, M.D.
8:00 a.m. Managing the Patient with Anemia
Steven Fein, M.D.
9:00 a.m. Geriatric Care
Danelle Cayea, M.D.
10:00 a.m. COPD
Raul Valor, M.D.
11:00 a.m. GERD: Who and When to Treat
Eugenio Hernandez, M.D.
12 noon Adjourn

Educational Objectives with References by Topics, Speakers

FRIDAY, JUNE 27
1:00 p.m. The Medical Handoff: Improving Transitions of Care
Tomas Villanueva, D.O., MBA, FACPE, SFHM

Objectives
Upon completion of my presentation, participants should be better able to
• Examine the link between improved provider communication throughout patient's transitions of care and reductions in medical errors and preventable adverse events.
• Identify gaps that lead to poor outcomes during the transitions of care.
• Analyze the importance of medication reconciliation at each level of transitions of care.

References
Quality Improvement Organizations facilitated community-wide quality improvement activities to implement evidence-based improvements in care transitions by community organizing, technical assistance, and monitoring of participation, implementation, effectiveness, and adverse effects. Among Medicare beneficiaries in intervention communities, compared with those in uninvolved communities, all-cause 30-day re-hospitalization and all-cause hospitalization declined. However, there was no change in the rate of all-cause 30-day re-hospitalizations as a percentage of hospital discharges.

Implementation of the handoff program was associated with reductions in medical errors and in preventable adverse events and with improvements in communication, without a negative effect on workflow.
http://patient-project.eu/?p=1235


2:00 p.m.
Eating Disorders
Jocelyn Lebow, Ph.D.

Objectives
Upon completion of my presentation, participants should be better able to
• Identify red flags that indicate the potential presence of an eating disorder.
• Implement early interventions for patients with eating disorder symptoms.

References
Weight-related problems, including obesity, eating disorders, and disordered eating, are major public health problems in adolescents. The identification of shared risk and protective factors for these problems can guide the development of relevant interventions to a broad spectrum of weight-related problems.

Weight-specific socio environmental, personal, and behavioral variables are strong and consistent predictors of overweight status binge eating, and extreme weight-control behaviors later in adolescence. These findings support the need
for research to determine if decreasing weight-related social pressures, personal weight concerns, and unhealthy weight-control behaviors can contribute to reductions in obesity in children and adolescents.  


JAMA Psych. 2002; 59: 545-552.  


3:00 p.m.

The Role of Exercise and Heart Health: Is it Missing in Action?  
Tim Church, M.D., MPH, Ph.D.

Objectives

Upon completion of my presentation, participants should be better able to:

• Initiate effective patient education discussions about the minimal level of exercise needed for improved health.
• Examine the associated health benefits of weight lifting.

References

Low levels of cardiorespiratory fitness are associated with high risk of mortality, and improvements in fitness are associated with reduced mortality risk. However, a poor understanding of the physical activity-fitness dose response relation remains.  


The true causes of the obesity epidemic are not well understood and there are few longitudinal population-based data published examining this issue.  


Among patients with type 2 diabetes mellitus, a combination of aerobic and resistance training compared with the nonexercise control group improved HbA1c levels. This was not achieved by aerobic or resistance training alone.  


4:30 p.m.

Smoking Cessation  
Michael Hernandez, M.D.

Objectives

Upon completion of my presentation, participants should be better able to:

• Implement strategies to effectively motivate smoking cessation behaviors in patients.
• Examine pharmacologic options for smoking cessation therapies.

References

Proven treatment methods fall into two major categories: behavioral support (counseling) and pharmacotherapy (Fiore et al. 2008). Each of these treatments is effective by itself, but combining behavioral support and pharmacotherapy enhances successful cessation, because the treatments are complementary. Although brief interventions of only a few minutes are effective, there is a clear dose-response, whereby more intensive treatment (multiple sessions up to approximately 1.5 hours total per quit attempt) results in greater success rates (Fiore et al. 2008). Behavioral support augments motivation and confidence to quit smoking, and builds coping and other practical skills for quitting; while pharmacotherapy alleviates the withdrawal symptoms that result from nicotine dependence. Adding behavioral support to pharmacotherapy enhances the quit rates produced by medication only, with some evidence of higher quit rates with greater intensity of treatment (Stead and Lancaster 2012). Adding medication to behavioral support produces higher quit rates than behavioral support alone; this is the study design of most trials testing the efficacy of pharmacotherapy for smoking cessation. It is essential that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting. • Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective . . . Clinicians should encourage every patient willing to make a quit attempt to use the counseling treatments and medications recommended . . . Clinicians should encourage [medication] use by all patients attempting to quit smoking—except when medically contraindicated and with specific populations for which there is insufficient evidence of effectiveness. . . Both clinicians and health care delivery systems should ensure patient access to quit lines and promote quit line use.


https://www2.aap.org/richmondcenter/pdfs/PACTReimbursementforSmokingCessation.pdf

www.ncbi.nlm.nih.gov/pubmed/23728690

5:30 p.m.

Busting Nutrition Myths  
Susan Mitchell, Ph.D., RD

Objectives

Upon completion of my presentation, participants should be better able to:

• Identify factors contributing to confusion about nutrition including internet, social media, Millennials and manufactured buzz.
• Distinguish fact from fiction or hype surrounding trending nutrition topics.

References
An in-depth look at new Mintel survey findings, covering 12 top product categories, shows that consumers are more concerned about total added sugars than any specific sweetener.

Historically, honey and maple syrup have been used to replace sugar. Pure cornstarch is by far the biggest source of the other carbohydrate sweeteners used by today’s food manufacturers. Cornstarch is split into a variety of smaller fragments (called dextrins) with acid or enzymes. The smaller fragments are then converted into the various cornstarch sweeteners used by today’s food manufacturers. Hydrolysis is the term used to describe the overall process where starch is converted into various sweeteners. Sweetener products made by cornstarch hydrolysis include dextrose, corn syrup, corn syrup solids, maltodextrin, high fructose corn syrup, and crystalline fructose. A juice concentrate is the syrup produced after water, fiber and nutrients are removed from the original fruit juice.

The ERS Food Availability (Per Capita) Data System (FADS) includes three distinct but related data series on food and nutrient availability for consumption. The data serve as popular proxies for actual consumption at the national level. Food availability data are now updated through 2012, the most recent year available; these data are the foundation for the other two series. Loss-adjusted food availability data are also available through 2012 for most products but are preliminary estimates.

SUNDAY, JUNE 29
8:00 a.m.
Evaluating the Patient with Chest Pain
Jonathan Fialkow, M.D.

Objectives
Upon completion of my presentation, participants should be better able to
• Differentiate ischemic vs. non-ischemic sources of chest pain.
• Examine the evidence based work up of the chest pain patient including labs and diagnostics.
• Recognize when to refer a patient to ER or cardiologist for further evaluation.

References
The first question in evaluation of patients with chest pain who are at low risk for myocardial infarction is not “What test should I order?” but rather “Does this patient need any further testing?” Many patients can be safely discharged from the emergency department to outpatient follow-up without any stress test or imaging such as cardiac computed tomography. Certainly, no one wants to miss a myocardial infarction, but we also do not want to keep people for hours and days to perform additional imaging tests that are not associated with better outcomes but may lead to increased radiation exposure. More time spent talking with patients about their symptoms and their functional status, as well as the risks and benefits of immediate vs. deferred testing, is likely to result in shorter emergency department stays and fewer unnecessary tests.

9:00 a.m.
Helping Heart Patients Thrive: Brief Interventions that Really Work
Wayne Sotile, Ph.D.

Objectives
Upon completion of my presentation, participants should be better able to
• List four psychosocial factors that affect morbidity and mortality rates for recovering cardiopulmonary patients.
• List at least three components of a model for promoting resilience in recovering cardiopulmonary patients.
• Discuss new perspectives on stress and heart disease.

References
Although increased sympathetic nervous system (SNS) activity is commonly associated with major depressive disorder (MDD) and cardiovascular disease (CVD), a biomarker linking these two entities remains elusive. We therefore evaluated the relationship between depressive symptoms and cardiovascular modulation by heart rate variability (HRV), brachial blood pressure (BP), ambulatory BP (ABP), and low frequency component of systolic BP variability (LFSBP), a surrogate of sympathetic vasomotor tone. We hypothesized that LFSBP would be the strongest predictor of depressive symptoms compared with HRV and BP measurements.

The benefits of treating depression include improved quality of life, improved adherence to other therapies and, potentially, improved CHD outcomes.

Managing the Patient with Congestive Heart Failure
Javier Jimenez, M.D.

Objectives
Upon completion of my presentation, participants should be better able to
• Appropriately use the current medications available for heart failure.
• Manage the cross referral relationships between hospital/medical office/specialists.

References
Management of heart failure (HF) due to systolic dysfunction includes correction of systemic factors, lifestyle modification, treatment of underlying cardiac disease, device (implantable cardioverter-defibrillator and cardiac resynchronization) therapy as indicated, as well as pharmacologic therapy to relieve symptoms and prolong survival. The goals of heart failure (HF) therapy are clinical improvement of symptoms and ultimately a reduction in the risk of morbidity (including the rate of hospitalization) and mortality.

http://www.uptodate.com/contents/overview-of-the-therapy-of-heart-failure-due-to-systolic-dysfunction?source=machineLearning&search=Managing+the+Patient+with+Congestive+Heart+Failure&selectedTitle=1%7E150&sectionRank=5&anchor=H27823757#H4

JACC 2013; 62(16) e147-239; J.of Cardiac Failure Vol 15 N6 2010; 475-506

11:30 a.m.
Medial Evaluation of Concussions
Brad Herskowitz, M.D.

Objectives
Upon completion of my presentation, participants should be better able to
• Effectively examine patients with suspected mild concussion in order to determine if a neuroimaging evaluation is indicated.
• Recognize the various clinical presentations of concussion, and evaluate their severity and long term prognosis.

References
Patients suspected to have had a concussion or mild traumatic brain injury (TBI) should be medically evaluated by a trained licensed health professional, whether in a doctor’s office, emergency room, or on an athletic field sideline. The acute evaluation of an individual includes a neurologic assessment and mental status testing. Prolonged unconsciousness, persistent mental status alterations, or abnormalities on neurologic examination require urgent neuroimaging and neurosurgical consultation. Mild TBI and concussion may be unrecognized by both the injured and non-medically-trained observers, particularly if there is no loss of consciousness. Simple questions of orientation have inadequate sensitivity to detect mild TBI after head injury. Some surveys have found that more than 80 percent of individuals with a past concussion did not recognize it as such. A number of diagnostic tools have been developed to aid in concussion-recognition; however, none of these substitute for a more thorough medical evaluation, nor are they intended to be able to rule out concussion.


SUNDAY, JUNE 29
8:00 a.m.
Managing the Patient with Anemia
Steven Fein, M.D.

Objectives
Upon completion of my presentation, participants should be better able to
• Recognize the signs and symptoms of the types of anemia commonly seen in clinical practice
• Determine which laboratory and diagnostic tests to order and/or when referral to specialist is indicated.

References
Anemia can be rigorously defined as a reduced absolute number of circulating red blood cells (ie, a reduced red blood cell mass as determined via blood volume studies). However, blood volume studies are not practical for this purpose, cost-effective, or generally available. As a result, anemia has been defined as a reduction in one or more of the major red blood cell (RBC) measurements obtained as a part of the complete blood count: hemoglobin concentration, hematocrit, or RBC count. In practice, however, a low hemoglobin concentration or a low hematocrit is most widely employed for this purpose. The initial approach to the patient with anemia is to perform a complete history and physical examination along with a review of the results of a complete blood count (CBC) with white blood cell (WBC) differential, platelet count, reticulocyte count, and an examination of the peripheral blood smear

http://www.uptodate.com/contents/approach-to-the-adult-patient-with-anemia?source=machineLearning&search=Anemia&selectedTitle=1%7E150&sectionRank=3&anchor=H52#H1
http://www.hematology.org/Patients/Anemia/Iron-Deficiency.aspx
http://www.hematology.org/Patients/Anemia/

9:00 a.m.
Geriatric Care
Danelle Cayea, M.D.

Objectives
Upon completion of my presentation, participants should be better able to
• Examine preventive strategies and lifestyle changes that reduce the burden of disease and functional decline in older adults.

References
Approximately one-half of the ambulatory primary care for adults older than 65 years is provided by family physicians, and approximately 22 percent of visits to family physicians are from older adults. It is estimated that older adults will comprise at least 30 percent of patients in typical family medicine outpatient practices, 60 percent in hospital practices, and 95 percent
in nursing home and home care practices. A complete assessment is usually initiated when the physician detects a potential problem such as confusion, falls, immobility, or incontinence. However, older persons often do not present in a typical manner, and atypical responses to illness are common. A patient presenting with confusion may not have a neurologic problem, but rather an infection. Social and psychological factors may also mask classic disease presentations. For example, although 30 percent of adults older than 85 years have dementia, many physicians miss the diagnosis. Thus, a more structured approach to assessment can be helpful. 


10:00 a.m.

COPD

Raul Valor, M.D.

Objectives

Upon completion of my presentation, participants should be better able to

• Define and recognize the clinical presentation of COPD including risk factors, natural history and pathophysiology of airway inflammation.
• Identify risk factors which influence morbidity and mortality of COPD.
• Explore the current state of pharmacotherapy and prevention of COPD.

References

Chronic obstructive pulmonary disease (COPD) is a major cause of chronic morbidity and mortality throughout the world, and the fourth cause of death worldwide. COPD is characterized by persistent airflow limitation and is usually progressive. The characteristic symptoms of COPD are cough, productive sputum, and dyspnea on exertion, which lead to poor activities of daily life (ADL) and decreased health-related quality of life. Patients with COPD often require emergency hospital admission because of acute exacerbations of COPD, respiratory failure, and deterioration of general conditions, which would threaten their lives.

Moreover, COPD often coexists with other systemic comorbid diseases, such as lung cancer, cardiovascular disease, osteoporosis, and diabetes mellitus. These comorbidities have shared risk factors with COPD, and can be considered to influence one another. The comorbidities in COPD would also become exacerbated, require emergency hospitalization of the patients, and affect their mortality.

Evaluation of mortality after emergency admission of patients with COPD, including acute exacerbations of COPD and their comorbid diseases, is important and could lead to a better prognosis for the patients through the induction of appropriate interventions. However, there are few available data regarding all-cause mortality in these patients, although there are several studies on the mortality of patients with acute exacerbations of COPD.

In this study, we aimed to evaluate the short-term all-cause in-hospital mortality of patients with COPD who required emergency hospital admission not only for exacerbations of COPD, but also for any cause. We tried to verify factors, including patients’ general conditions and comorbidities at admission, that affect the mortality after emergency admission. The obtained results suggest the importance of understanding the patients’ general conditions and comorbidities at admission.


11:00 a.m.

GERD: Who and When to Treat

Eugenio Hernandez, M.D.

Objectives

Upon completion of my presentation, participants should be better able to

• Recognize the various clinical presentations of GERD including Barrett’s esophagus.
• Consider if, when and how often gastroscopy surveillance for Barrett’s should be done.
• Describe the role of radio frequency ablation in the treatment of Barrett’s esophagus.

References

Symptoms of gastroesophageal reflux disease (GERD) are the primary risk factor for Barrett’s esophagus (BE). However, the significance of age at symptom onset is unknown. We examined the effects of multiple dimensions of GERD exposure on BE risk and whether these associations are modified by other risk factors for BE.

GERD symptoms was associated with highest risk of BE and risk increased linearly with earlier age at onset of symptoms. This association was independent of cumulative GERD symptom duration. People with early onset GERD symptoms who reported ever using proton pump inhibitors were at especially high risk of BE. In people with frequent GERD symptoms, BE risk was almost 80% lower among Helicobacter pylori-positive patients. Risk of BE increased linearly with earlier age at onset of frequent GERD symptoms. Age at symptom onset may help practitioners decide which patients with GERD symptoms to refer for endoscopic screening for BE.

Gastroesophageal reflux disease (GERD) has been strongly implicated as the primary causal factor for BE, and is a very common condition among Western populations. Epidemiological studies have reported >10-fold relative risks for BE associated with frequent GERD symptoms. However, presence of GERD is a poor predictor of BE as only 5–13% of people with symptoms of GERD will develop BE over their lifetime. Thus, the various dimensions of GERD exposure such as frequency, duration, severity, and age at onset of symptoms are likely to have an impact on risk.

CME ACTIVITY TITLE: The Communication Quality Imperative: Improving Safety & Outcomes and Avoiding Readmissions

DATE: Monday, April 20, 2015
TIME: 5:30-6 p.m. Dinner and Registration; 6 – 7 p.m. Lecture

LOCATION: MCVI 5th Floor Conference Room videoconference to and Mariners Hospital, Conference Room

RECORD LECTURE THROUGH VIDEO PRODUCTION

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

CONFERENCE DIRECTOR: Arturo Fridman, M.D.

CONFERENCE COORDINATOR: Ricardo Forbes

AMA/PRA LEARNING FORMAT:
- Live activity
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring material
- Internet-Home Study
- Journal-based CME activity
- Manuscript review activity
- PI CME activity

TARGET AUDIENCE: All Medical Staff, Nurses and Allied Health Professionals.

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.
- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring material
- Internet-Home Study
- Journal-based CME activity
- Manuscript review activity
- PI CME activity

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

NEW OR UPDATED POLICY/PROTOCOL
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review

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

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

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

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

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

Other: _____________________________
PROFESSIONAL PRACTICE GAP (C2)

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

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

► With escalating concerns about ethnic disparities in healthcare and the need for healthcare systems to accommodate increasingly diverse patient populations, cultural competence has become a matter of national concern. Cultural Competence is now recognized as an essential element to improve patients’ health status, provide access to appropriate health care services, and eliminate disparities in health care delivery.

Healthcare professionals are increasingly challenged to provide culturally effective and appropriate care, given the significant cultural and linguistic dimensions associated with providing care for patients of diverse backgrounds. Some of the major causes of poor quality healthcare, especially for diverse populations, include: Misunderstandings due to language barriers and poor communication in the clinical encounter, which can lead to mistrust and medical errors; inadequate understanding of patients’ beliefs and concerns - about taking medications for example. This can contribute to non-adherence, poor health outcomes.

The Institute of Medicine report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, found that racial and ethnic minorities often receive lower quality of care than their white counterparts, even after controlling for factors such as insurance, socioeconomic status, co-morbidities, and stage of presentation.

A JAMA editorial suggests that miscommunication due to language barriers with Spanish, the most common non-English language spoken in the US, lead to substandard health care. For many individuals with limited English proficiency, inability to communicate in English is the primary barrier to accessing health information and services.

Despite the best efforts of health professionals, patient advocates and policymakers, the U.S. still struggles to eliminate pervasive health disparities, especially for racial and ethnic minorities. Physicians know better than anyone that these shortcomings can have serious consequences on patient outcomes that literally can become life-or-death matters.

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

► Physicians link disparities to quality of care, delivery system change, and payment policy. Physicians recognize the traditions and beliefs of diverse patient populations at multiple levels. Physicians implement institutional strategies for delivering culturally effective care. Physicians implement effective cross-cultural communication in clinical encounters.

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

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

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

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

► Physicians will recognize and be prepared to overcome cultural and linguistic barriers that can occur during interactions with patients of diverse backgrounds, and they will provide culturally effective and appropriate health care.

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

► The Joint Commission Standards: HR.01.04.01 The hospital provides orientation to staff. The hospital orients staff on the following: EP 5 Sensitivity to cultural diversity based on their job duties and responsibilities. Completion of orientation is documented. R1.01.01.01 The hospital respects protects and promotes patient rights. EP5 The hospital respects the patient’s right to and need for effective communication. R1.01.01.03 The hospital respects the patient’s right to receive information in a manner he or she understands. EP1 The hospital performs a learning needs assessment for each patient which includes the patient’s cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations and barriers to communication. PC.02.02.01 The hospital provides patient education and training based on each patient’s needs and abilities. EP1 When possible, the hospital accommodates the patient’s cultural and religious or ethnic food and nutrition preferences, unless contraindicated. HR.01.02.01 which requires the organization to define staff qualifications for staff who perform translation or interpretation services. Other relevant standards which may be cited if staff, who are not deemed competent to translate or interpret by the organization, are observed communicating with patients in a language other than English include: R1.01.03/ EP 1 and 2: The hospital provides interpreting and translation services as necessary to meet the patient’s language and ability to understand. RC.02.01.01/ EP 1: The medical record indentifies the patient’s language and communication needs. LD 04.01.01/EP 2 The hospital provides care, treatment in accordance with law and regulation, specifically Title VI of the Civil Rights Act of 1964 with respect to patients with LEP.

http://culturalmeded.stanford.edu/pdf%20docs/INFORMED%20NJCC-Final.pdf

Best Practices to Achieve Cultural Competence in Health Care
http://primeinc.org/cme/online/178/Best_Practices_to_Achieve_Cultural_Competence_in_Health_Care
EDUCATIONAL OBJECTIVES

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

- Link disparities to quality of care, delivery system change, and payment policy
- Recognize the traditions and beliefs of diverse patient populations at multiple levels.
- Implement institutional strategies for delivering culturally effective care.
- Apply effective cross-cultural communication in clinical encounters.

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.)

Neal R. Goodman, Ph.D.
President, Global Dynamics Inc.
Aventura, Florida

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

- Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
  - Yes
  - No

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

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

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

- Yes
- No

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

Healthcare professionals are increasingly challenged to provide culturally effective and appropriate care, given the significant cultural and linguistic dimensions associated with providing care for patients of diverse backgrounds.

Some of the entrenched barriers are hard for doctors to overcome. Tens of millions of patients in the U.S. have limited English proficiency and poor health literacy, making it difficult to ensure that they are receiving the care they need at the
doctor’s office and taking the appropriate steps to stay healthy after they go home. Resources are limited throughout the system, and some practices find that despite their best intentions, they simply cannot find the investment needed to provide some patients with enhanced assistance.

Other impediments are less prosaic; physicians still struggle with a level of deep-seated cultural distrust of health professionals among some minorities that persists decades after the deplorable events that prompted those suspicions.

SOURCE: American Medical Association, Measures of cultural competency developed by the AMA and approved by the National Quality Forum can guide key system changes, Posted Sept. 10, 2012.

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

Yes ☒ No ☐ If yes, please describe the related CME program change.
And describe how the impact of the related program improvement will be measured and documented? (C15)

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

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

Explain: __________________________________________

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

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

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

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

This meeting has been planned in collaboration with the Office of Diversity to meet system-wide educational initiatives.

DATE REVIEWED: ______________________ 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: Risk Management and Patient Safety: What’s New in Safety in the OR?
DATE: Thursday, May 28, 2015
TIME: 5:30 Registration and Dinner; 6-7 p.m.

LOCATION: South Miami Hospital, Classroom E videoconference to Mariners Hospital, Main Conference Room; Homestead Hospital, Mango Room; West Kendall Baptist Hospital, Imaging Services Conference Room

LIVE WEBCAST RECORDING LECTURE

CREDIT HOURS APPLIED FOR: 1 Cat. 1

CONFERENCE COORDINATORS: Yvonne Zawodny, R.N. & Geri Schimmel, R.N.

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

TARGET AUDIENCE: Surgeons, Ob/Gyns, Anesthesiologists, Gastroenterologists, Endoscopy Staff, Outpatient Staff, Nurses and Operating Room Staff. BLURB for FLYER: This topic applies to all healthcare providers who treat patients in a procedural area.

EXPECTED NUMBER OF ATTENDEES: 45-50

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): _____________________________
- 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: ___________________________________________
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.

► Current physician and healthcare team implementation of patient safety protocols is inconsistent and a lack of closed-loop communication can lead to an increased risk of medical errors and delays to delivery of care. Because of these inconsistent practices the team may not be anticipating errors.

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

► Physicians and the healthcare team implement check lists and closed loop communication consistently to reduce risk of errors.

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

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

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

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

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

► Physicians and the healthcare team implement patient safety strategies such as check lists and closed loop communication to standardize practice, reduce risk of medical errors and anticipate errors.

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

► Should implementation of surgical safety checklists be required? Probably not — or at least not yet. Regulation works best when a practice of unquestioned value has become the norm. We are not there yet. Implementing the checklist is still a struggle in most hospitals. However, the process of adoption needs to be greatly accelerated. What should be mandated — and nationally funded — are large-scale state and systemwide collaboratives to motivate, train, and support local efforts to implement checklists. (N England Journal of Medicine 370;11 March 13, 2014 The Checklist Conundrum Lucian Leape, M.D.)

While surgical safety checklists have proven very effective at minimizing perioperative complications, their implementation in real-world settings has been challenging. In this study, formalizing the checklist process to mandate involvement of all team members improved adherence to appropriate checklist usage. In this study, preliminary analysis of a surgeon-led pause revealed only 54% completion of all items, which increased to 97% after the intervention. With the new format, operating team members stopped for the pause in 96% of cases, compared with 78% before the change. Operating team members introduced themselves in 94% of cases, compared with 44% before the change. Follow-up analysis showed sustained performance at 18 months after implementation. A pre-procedural checklist format in which each member of the operating team provides a personal attestation can improve pause compliance and may contribute to improvements in the culture of teamwork within an OR. Successful online implementation of a preprocedural pause (PPP), which includes participation by all operating team members, requires little or no additional expense and only minimal formal coaching outside working situations. (Sustainable, effective implementation of a surgical preprocedural checklist: an "attestation" format for all operating team members. J Am Coll Surg 2011;213:212-219, Gawande)


Sentinel Event Alert 2001: December 5:241-3

World Health Organization Surgical Safety Checklist

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.)

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RELATED 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? (C15)

☐ 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?

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

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

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

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

This meeting planned in collaboration with the departments of Risk Management & Patient Safety.

DATE REVIEWED: March 13, 2015 REVIEWED BY: ☒ Executive Committee ☐ Chairman
APPROVED: ☐ YES ☒ NO  ☐ Credits: AMA/PRA Category 1 Credits: # 1
Continuing Psychology Education Credits: # ☐ N/A  ☐ Continuing Dental Education Credits: # ☐ N/A

BLURB for FLYER: This topic applies to all healthcare providers who treat patients in a procedural area.