Internet CME – Enduring Materials
Advances in Genomic Medicine Focus on Head and Neck Cancers (0.5 Cat. 1/each)
Can we avoid DVT and PE role in Prophylaxis (0.5 Cat. 1 / each)
Controversies in CVDP (.5 Cat. 1 / each)
Genetics of Women’s Cancers: New Opportunities through Genomic Medicine (1 Cat. 1)
Immunotherapy concepts and potential future applications in head and neck cancer treatment at the Miami Cancer Institute (0.5 Cat. 1)
The Mediterranean Diet (.5 Cat. 1)
The Obesity Epidemic (1 Cat. 1 / each)
Thrombophilia testing are we wasting cash and blood (0.5 Cat. 1)

Live CME
05.31.16 Depression Screening and Management (1.5 Cat. 1)
09.23-9.24 Echocardiography Symposium (11 Cat. 1)
11.13-11.16.16 Emergency Radiology Symposium (18.5 Cat. 1)
CME ACTIVITY TITLE: Advances in Genomic Medicine: Focus on Head and Neck Cancers

DATE/TIME: Recorded at the Fifth Annual Head and Neck Cancer Symposium, April 30, 2016, Baptist Hospital, Auditorium

CREDIT HOUR(S) APPLIED FOR: 0.75 Cat 1

TARGET AUDIENCE: Primary Care Physicians, Dentists, Otolaryngologists, Gastroenterologists, Radiologists, Medical Oncologists, Oral Maxillofacial Surgeons, Surgeons, Pathologists, Pediatricians, Hospitalists.

CONFERENCE DIRECTOR: Joseph P. McCain, DMD

EXPECTED NUMBER OF ATTENDEES: 40-50 Annually

LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.

ARS
Case studies
Didactic lecture
Enduring material (DVD/booklet)
Internet activity enduring material
Internet live course (live webcast)
Internet point-of-care activity
Journal-based CME activity
Learning from teaching
Live activity
Manuscript review activity
Panel
PI CME activity
Question-and-Answer
Regularly scheduled series
Simulation
Test item writing activity
Other (specify)

COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

The implementation of high-throughput molecular profiling and the plummeting costs of genetic sequencing are creating novel opportunities to investigate the inner workings of healthy and diseased cells. While the idea of individualized medicine is not a new concept, the capacity to accurately quantify the defining characteristics of a head and neck patient's tumor lends hope that a targeted approach against its specific biology is possible. This course will explore research-advancing implementation of head and neck cancer genomic medicine.

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

Patient:
- Noncompliance
- Lifestyle
- Resistance to change
- Cost of care/Lack of insurance

Physician:
- Noncompliance
- Resistance to change
- Communication skills
- Reimbursement issues

Resources:
- Institutional capabilities
- Physician practice limitations
- Community service limitations

State of Science:
- Limited or no treatment modalities
- Limited or no diagnostic modalities

Other: Please describe.

BARRIERS TO PHYSICIAN CHANGE: (C19) Briefly explain how this activity addresses the barriers/factors identified.

DESIRABLE PHYSICIAN ATTRIBUTES/COMPETENCIES (C6)

ABMS/ACGME:
- Patient care and procedural skills
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

INSTITUTE OF MEDICINE:
- Provide patient-centered care
- Work in interdisciplinary teams
- Employ evidence-based practice
- Apply quality improvement
- Utilize informatics

INTERPROFESSIONAL EDUCATION COLLABORATIVE:
- Values/ethics for interprofessional practice
- Roles/responsibilities
- Interprofessional communication
- Teams and teamwork
PROFESSIONAL PRACTICE GAP (C2)
The difference between what is (the “actual”) and what should be (the “ideal”).
What is the current professional practice gap? What are physicians doing (or not doing) that needs to change? Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes. (C2)

► 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 that doctors are specifically trained in the appropriate 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 always be possible; early detection and treatment are possible with adequate awareness among clinicians and patients. Screening for oral cancer is useful for detecting 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.

http://www.indianjcancer.com/article.asp?issn=0019-509X;year=2014;volume=51;issue=2;spage=95;epage=97;aulast=Joshi

Indicate if the gap is related to need for change in either/or:
☒ Knowledge and/or (Doctors do not know that they need to be doing something.)
☒ Competence and/or (Doctors do not know how to do it.)
☒ Performance and/or (Doctors know how to do it but are noncompliant – or are not doing it properly.)

DESIRED OUTCOMES (GOAL): Answer one or more of the following questions: What are the desired or expected outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”? (C3)
► Timely interventions by physicians and dentists will improve survival and quality of life for patients with oral cancers and minimize 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 the patients receive care from a coordinated specialized head and neck cancer team.
► Dentists and doctors 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.

Indicate what this activity is designed to change.
☒Designed to change competence
☒Designed to change performance
☐Designed to change patient outcomes

NEEDS ASSESSMENT RESOURCES – HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain below.)
☒ Best-practice parameters
☒ Disease prevention (C12)
☒ Mortality/morbidity statistics
☒ National/regional data
☒ New or updated policy/protocol
☒ Peer review data
☒ Regulatory requirement
☒ Research/literature review
☐ Consensus of experts
☐ Joint Commission initiatives (C12)
☐ National Patient Safety Goals
☐ New diagnostic/therapeutic modality (C12)
☐ Patient care data
☒ Process improvement initiatives (C16 & 21)
☐ Other need identified (Explain): _____________________________

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► The field of cancer has seen a bolus of data emerging from a combination of old and new sources. The digitization of hospitals and the spread of electronic medical records have created large archives of traditional data, making meta-analyses of large patient cohorts almost facile. Furthermore, the adoption of high-throughput molecular profiling and the plummeting costs of genetic sequencing are creating new opportunities to probe the inner workings of healthy and diseased cells. Although the idea of personalized medicine is clearly not new, our ability to accurately quantify the defining characteristics of an individual patient's tumor lends hope that a targeted attack against its specific biology is possible.
► In head and neck squamous cell carcinoma (HNSCC), such molecular biology has proven pivotal to our understanding of the disease. Starting with targeted studies of mRNA, protein expression and analysis of chromosomal gains and losses, the
field slowly pieced together a model in which epidermal growth factor receptor (EGFR) expression is activated and chromosomal abnormalities accumulate, often alongside mutations to the TP53 gene. As cohorts became larger and more high-throughput analysis such as microarrays and sequencing technologies became available, it became clear that the picture was far more complex and that there exist different subtypes of the disease. As genomic profiling in cancer becomes ubiquitous, the promise of the big data paradigm may affect patients with HNSCC by enabling personalized monitoring, diagnosis and treatment of this disease. Although the dystopian vision of machines treating patients is not likely to become a reality anytime soon, the ability to use systematic data to inform better patient treatment is all but inevitable. Gupta N (2015) Cancer Genomic Medicine: Clinical Validation and Utility. J Cancer Prev Curr Res 3(3): 00080. DOI: 10.15406/jcpcr.2015.03.00080

Application of rapidly emerging genomic technologies to identify clinically actionable genetic variants requires more regulated studies and evaluation. Currently no universally accepted standards and references are available for implementation of cancer genome data acquired by various methods. New discoveries suggesting more genetic variations related to different types of cancer are required to be determined as driver or passenger mutations and categorized appropriately if influential on cancer treatment approaches and drug responses. Clinical trials to demonstrate the utility of cancer genome profiles developed by various techniques and to establish the relationship between genomic variations and variable effects on a population should be carefully designed and studied. Additional contributions of various public and private sources would allow the refined representation of clinical significance of cancer genome associated studies. Gupta N (2015) Cancer Genomic Medicine: Clinical Validation and Utility. J Cancer Prev Curr Res 3(3): 00080. DOI: 10.15406/jcpcr.2015.03.00080

EDUCATIONAL OBJECTIVES: Based on the gaps identified above, what are the learning objectives for this activity? Describe the performance (or competence or patient outcome) that should change if participants apply what they learn.

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

- Examine and discuss recent developments in technology and research that are advancing implementation of cancer genomic medicine.
- Recognize advances specific to head and neck cancers that facilitate the practice of precision medicine for this tumor type.

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

☐ Changes in competence. Evaluation method: Baptist Health CME Evaluation Form
☐ Changes in performance. Evaluation method: Follow-up Survey

Provide 3-4 statements based on expected performance outcomes to be evaluated. Example: I have implemented the new Baptist Health policy explained in this CME activity.

☐ Changes in patient outcomes. Evaluation method: Review of hospital, health system, public health data, etc.
☐ Other ______________________

FACULTY: (Name, specialty and/or title(s), institution(s), city, state. For more than two, include list at end of application.)

Jeffrey Boyd, Ph.D.
Geneticist
Director, Translational Research and Genomic Medicine
Miami Cancer Institute, Baptist Health South Florida
Professor and Chair, Department of Human and Molecular Genetics
Herbert Wertheim College of Medicine, Florida International University

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). Note: When using electronic evaluations, disclosure statements for faculty must be included on course landing pages.

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
☐ Others (Conference coordinator, planning group, etc.) __________________________

NON-EDUCATIONAL STRATEGIES: Explain what we are doing (CME or BHSF) – or what we could do – to enhance change as an adjunct to this CME activity. (C17) These would be tactics and tools to facilitate change that go beyond this CME activity. NOTE: Insert this information under course shell>>custom fields>>resources.

☐ 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?
Are we collaborating with internal departments in a purposeful manner to achieve common interests? If yes, describe the collaborative efforts. MSK Cancer Alliance through the Miami Cancer Institute of BHSF and the HWCOM at FIU are collaboratively exploring applications of individualized treatment approaches through genomic medicine.

COMMERICAL SUPPORT: Indicate here if support will come from the Foundation’s General Continuing Medical Education fund.

DATE REVIEWED: May 10, 2016 REVIEWED BY: Accelerated Approval Executive Committee

APPROVED: YES NO  Credits: AMA/PRA Category 1 Credits: # 0.50

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

CME ACTIVITY TITLE: Can we avoid DVT and PE? Role of prophylaxis?

DATE/TIME: Recorded at the Second Annual Venous Thromboembolism Symposium, December 15, 2015, Baptist Hospital, Auditorium

CREDIT HOUR(S) APPLIED FOR: 0.50 Cat 1

COURSE APPROVED: MAY 2016  COURSE EXPIRES: MAY 2018


CONFERENCE DIRECTOR: Ian Del Conde, M.D.  CME MANAGER: Nina Doleyres, MPH

EXPECTED NUMBER OF ATTENDEES: 40-50 Annually  CHARGE: None

LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.

ARS  Case studies  Didactic lecture  Enduring material (DVD/booklet)  Internet activity enduring material  Internet live course (live webcast)  Internet point-of-care activity  Journal-based CME activity  Learning from teaching  Live activity  Manuscript review activity  Panel  PI CME activity  Question-and-Answer  Regularly scheduled series  Simulation  Test item writing activity  Other (specify)

COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

This course provides a comprehensive overview of assessment and prevention approaches to the care of patients who are susceptible to deep-vein thrombosis and pulmonary embolism. Many preventive measures will be discussed along with strategies for patient management.

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

Patient:  Noncompliance  Lifestyle  Resistance to change  Cost of care/Lack of insurance
Physician:  Noncompliance  Resistance to change  Communication skills  Reimbursement issues
Resources:  Institutional capabilities  Physician practice limitations  Community service limitations
State of Science:  Limited or no treatment modalities  Limited or no diagnostic modalities
Other: Please describe.

BARRIERS TO PHYSICIAN CHANGE: (C19) Briefly explain how this activity addresses the barriers/factors identified.

DESERABLE PHYSICIAN ATTRIBUTES/COMPETENCIES (C6)
ABMS/ACGME: ☑Patient care and procedural skills ☑Medical knowledge ☑Practice-based learning and improvement
☐Interpersonal and communication skills ☐Professionalism ☐Systems-based practice

INSTITUTE OF MEDICINE: ☑Provide patient-centered care ☐Work in interdisciplinary teams
☐Employ evidence-based practice ☑Apply quality improvement ☐Utilize informatics

INTERPROFESSIONAL EDUCATION COLLABORATIVE: ☑Values/ethics for interprofessional practice
☐Roles/responsibilities ☑Interprofessional communication ☐Teams and teamwork
PROFESSIONAL PRACTICE GAP (C2)
The difference between what is (the “actual”) and what should be (the “ideal”).

What is the current professional practice gap? What are physicians doing (or not doing) that needs to change? Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes. (C2)

► Physicians do not consistently employ proper workup to assess patients who present with suspected or possible venous thromboembolism (VTE) or pulmonary embolism (PE). Additionally, physicians may not be aware of the various available interventional treatments, their risks and complications and the type of patients who would benefit from them.

Indicate if the gap is related to need for change in either/or:
- Knowledge and/or (Doctors do not know that they need to be doing something.)
- Competence and/or (Doctors do not know how to do it.)
- Performance and/or (Doctors know how to do it but are noncompliant – or are not doing it properly.)

DESIRED OUTCOMES (GOAL): Answer one or more of the following questions: What are the desired or expected outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”? (C3)

► Physicians will provide optimal care and achieve best outcomes when they consistently perform proper workup to assess patients presenting with possible VTE or PE, and they will determine the most appropriate interventional treatments when indicated.

Indicate what this activity is designed to change.
- Designed to change competence
- Designed to change performance
- Designed to change patient outcomes

NEEDS ASSESSMENT RESOURCES – HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain below.)
- Best-practice parameters
- Disease prevention (C12)
- Mortality/morbidity statistics
- National/regional data
- New or updated policy/protocol
- Peer review data
- Regulatory requirement
- Research/literature review
- Consensus of experts
- Joint Commission initiatives (C12)
- National Patient Safety Goals
- New diagnostic/therapeutic modality (C12)
- Patient care data
- Process improvement initiatives (C16 & 21)
- Other need identified (Explain): _____________________________

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

► Surgical patients — Certain high-risk patients undergoing surgery (especially bone or joint surgery and cancer surgery) may be given anticoagulants to decrease the risk of blood clots. Anticoagulants may also be given to women at high risk for venous thrombosis during and after pregnancy. In surgical patients with a moderate to low risk of blood clots, other preventive measures may be used. For all patients, walking as soon as possible after surgery can decrease the risk of a blood clot. Pai,M., Douketis, JD, (2016). Patient information: Deep vein thrombosis (DVT) (Beyond the Basics). Retrieved from: http://www.uptodate.com.


EDUCATIONAL OBJECTIVES: Based on the gaps identified above, what are the learning objectives for this activity? Describe the performance (or competence or patient outcome) that should change if participants apply what they learn.

Upon completion of this conference, participants should be better able to:
- Recognize and avoid the risks of venous thromboembolism in hospitalized medical and surgical patients.
- Explain and implement the most appropriate DVT prophylaxis regimens, including pharmacological and non-pharmacological options.

EVALUATION METHODS: Analyze the overall changes in competence, performance or patient outcomes as a result of this CME activity. (C11)
- Changes in competence. Evaluation method: Baptist Health CME Evaluation Form
- Changes in performance. Evaluation method: Follow-up Survey
Provide 3-4 statements based on expected performance outcomes to be evaluated. Example: I have implemented the new Baptist Health policy explained in this CME activity.

☐ Changes in patient outcomes. Evaluation method: Review of hospital, health system, public health data, etc.
☐ Other ____________________

FACULTY: (Name, specialty and/or title(s), institution(s), city, state. For more than two, include list at end of application.)
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

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). Note: When using electronic evaluations, disclosure statements for faculty must be included on course landing pages.
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
☐ Others (conference coordinator, planning group, etc.) __________________________

NON-EDUCATIONAL STRATEGIES: Explain what we are doing (CME or BHSF) – or what we could do – to enhance change as an adjunct to this CME activity. (C17) These would be tactics and tools to facilitate change that go beyond this CME activity. NOTE: Insert this information under course shell>>custom fields>>resources.
☐ 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, describe the collaborative efforts. This is a collaborative project between the Miami Cardiac & Vascular Institute and the Department of CME to improve patient care via implementation of evidence-based approaches to care for patients with venous thromboembolism or pulmonary embolism.

COMMERCIAL SUPPORT: ☐ Indicate here if support will come from the Foundation’s General Continuing Medical Education fund.

DATE REVIEWED: May 17, 2016 REVIEWED BY: ☑ Accelerated Approval ☑ Executive Committee ☐ Live Committee
APPROVED: ☑ YES ☐ NO Credits: AMA/PRA Category 1 Credits: # 0.50
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: Controversies in Cardiovascular Disease Prevention: Answers to Key Questions Your Patients Are Asking

DATE: Approval: May 15, 2016 Course Expiration: May 15, 2017 CREDIT HOURS APPLIED FOR: .5 Cat. 1

LOCATION: Recorded at the 13th Annual Cardiovascular Disease Prevention International Symposium, February 20, 2015

TARGET AUDIENCE: Cardiologists, family physicians, general internists, endocrinologists, physician assistants

CONFERENCE DIRECTOR: Arturo Fridman, M.D. CME MANAGER: Isabel R. Morgan

EXPECTED NUMBER OF ATTENDEES: 20-50 CHARGE: None

LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.
☐ ARS ☐ Case studies
☐ Didactic lecture ☐ Enduring material (DVD/booklet)
COURSE DESCRIPTION: This short summary will be used on course shell. Please note keyword searches will pull from this description.

► Primary prevention is aimed at preventing the onset of disease. Secondary prevention is aimed at treating a disease after its onset, but before it causes serious complications. This course is designed to assist physicians in controlling risk factors in healthy people that may lead to cardiovascular disease. This course will be of special interest to physicians in the fields of cardiology, family medicine and endocrinology, along with other physicians interested in cardiovascular disease prevention.

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: ☒ Noncompliance ☒ Lifestyle ☐ Resistance to change ☐ Cost of care/Lack of insurance
Physician: ☒ Noncompliance ☒ Resistance to change ☒ Communication skills ☐ Reimbursement issues
Resources: ☐ Institutional capabilities ☐ Physician practice limitations ☐ Community service limitations
State of Science: ☐ Limited or no treatment modalities ☐ Limited or no diagnostic modalities
Other: Please describe.

BARRIERS TO PHYSICIAN CHANGE: (C19) Briefly explain how this activity addresses the barriers/factors identified.

This activity will address ways to support the translation of best practice and provision of treatments with clear evidence of effectiveness into clinical reality for patients at risk of cardiovascular events.

DESIRABLE PHYSICIAN ATTRIBUTES/COMPETENCIES (C6)

ABMS/ACGME: ☒ Patient care and procedural skills ☒ Medical knowledge ☒ Practice-based learning and improvement
                          ☒ Interpersonal and communication skills ☒ Professionalism ☒ Systems-based practice

INSTITUTE OF MEDICINE: ☒ Provide patient-centered care ☐ Work in interdisciplinary teams
                          ☒ Employ evidence-based practice ☒ Apply quality improvement ☐ Utilize informatics

INTERPROFESSIONAL EDUCATION COLLABORATIVE: ☒ Values/ethics for interprofessional practice
                          ☒ Roles/responsibilities ☒ Interprofessional communication ☐ Teams and teamwork
PROFESSIONAL PRACTICE GAP (C2)
The difference between what is (ACTUAL) and what should be (IDEAL).

What is the current professional practice gap? What are physicians doing (or not doing) that needs to change? Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes. (C2)

- Current physician practice does not include appropriate/consistent use of cardiovascular disease prevention strategies that can serve to reduce cardiovascular disease.

Indicate if the gap is related to need for change in either/or:
- Knowledge and/or (Doctors do not know that they need to be doing something.)
- Competence and/or (Doctors do not know how to do it.)
- Performance and/or (Doctors know how to do it but are noncompliant – or are not doing it properly.)

DESIRED OUTCOMES (GOAL): Answer one or more of the following questions: What are the desired or expected outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”? (C3)

- Physicians will provide optimal care and achieve optimal outcomes when they consistently implement evidence-based best-practice strategies to prevent cardiovascular disease morbidity and mortality. Physicians will apply the principles of cardiovascular disease prevention with lifestyle intervention and medical therapy.

Indicate what this activity is designed to change.
- Designed to change competence.
- Designed to change performance.
- Designed to change patient outcomes.

NEEDS ASSESSMENT RESOURCES – HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply.)

- Best-practice parameters
- Disease prevention (C12)
- Mortality/morbidity statistics
- National/regional data
- New or updated policy/protocol
- Peer review data
- Regulatory requirement
- Research/literature review
- Consensus of experts
- Joint Commission initiatives (C12)
- National Patient Safety Goals
- New diagnostic/therapeutic modality (C12)
- Patient care data
- Process improvement initiatives (C16 & 21)
- Other need identified (Explain): _____________________________

REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
References:
- Primary prevention is aimed at preventing the onset of disease. One way of doing this is by controlling risk factors in healthy people that may lead to disease. Secondary prevention is aimed at treating a disease after its onset, but before it causes serious complications. The global epidemic of chronic diseases can be reversed through modest investments in interventions. Some effective approaches are so low in cost that country income levels need not be a major barrier to successful prevention. What is needed are high levels of commitment, good planning, community mobilization and intense focus on a small range of critical actions. With these, quick gains will be achieved in reducing the major behavioral risk factors: tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity, together with key risk factors for cancer, notably some chronic infections. http://www.who.int/nmh/publications/ncd_report_chapter4.pdf

EDUCATIONAL OBJECTIVES: Based on the gaps identified above, what are the learning objectives for this activity? Describe the performance (or competence or patient outcome) that should change if participants apply what they learn.

Upon completion of this lecture, participants should be better able to:
- Communicate with patients regarding effective strategies to identify and reduce heart disease risk.
- Examine reliable sources of information on heart-smart lifestyle choices to share with patients.
- Implement simple evidence-based lifestyle messages to communicate with patients.

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

- Changes in competence. Evaluation method: Baptist Health CME evaluation form
- Changes in performance. Evaluation method: Follow-up survey
- Provide 3-4 statements based on expected performance outcomes to be evaluated. Example: I have implemented the new Baptist Health policy explained in this CME activity.
- Changes in patient outcomes. Evaluation method: Review of hospital, health system, public health data, etc.
- Other _____________________________
FACULTY: (Name, specialty and/or title(s), institution(s), city, state. For more than two, include list at end of application.)

Michael Joseph Blaha, M.D., MPH
Director of Clinical Research, Ciccarone Center for the Prevention of Heart Disease
Assistant Professor of Medicine
Johns Hopkins Hospital
Baltimore, Maryland

Biography: Dr. Blaha’s research interest is in the prevention of heart attacks. His primary work with the Ciccarone Center includes improving cardiovascular risk prediction through novel methods of early detection of atherosclerosis, including the use of cardiac computed tomography. Dr. Blaha has worked for the last seven years on the Multi-Ethnic Study of Atherosclerosis (MESA), an NIH-funded study that seeks to explain the distribution and progression of early atherosclerosis in healthy people. He received a Young Investigator Award from MESA in 2011 for his work that was published in The Lancet.

Disclosures
Michael Blaha, M.D., has indicated that he has no relevant commercial relationships to disclose, and that his presentation will not include discussion of off-label or unapproved usage.

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). Note: When using electronic evaluations, disclosure statements for faculty must be included on course landing pages.

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
☒ Others (i.e., conference coordinator, planning group, etc.) ____________________________

NON-EDUCATIONAL STRATEGIES: Explain what we (CME or BHSF) are doing – or what we could do – to enhance change as an adjunct to this CME activity. (C17) These would be tactics and tools to facilitate change that go beyond this CME activity. NOTE: Insert this information under course shell>>custom fields>>resources.

☐ Process redesign or new protocol ☐ Reminders (posters, mailings, email blasts) ☐ New order sheets
☒ Other tools or tactics Explain: Patient information
➤ http://www.fda.gov/Drugs/ResourcesForYou/Consumers/QuestionsAnswers/ucm071879.htm

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) who 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, describe the collaborative efforts. ____________________________________________________________

COMMERCIAL SUPPORT: ☐ Indicate here if support will come from Baptist Health Foundation’s General Continuing Medical Education Fund.

DATE REVIEWED: April 5, 2016 REVIEWED BY: ☒ Accelerated Approval ☐ Executive Committee
☐ Live Committee

APPROVED: ☒ YES ☐ NO ■ Credits: AMA/PRA Category .5 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: Genetics of Women’s Cancers: New Opportunities through Genomic Medicine

DATE: Recorded at Fifth Annual Omar Pasalodos, M.D., Memorial Lecture, April 28, 2016, South Miami Hospital

CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1
Approved: May 2016 Course Expires: May 2016

TARGET AUDIENCE:
Obstetricians, Gynecologists, Gynecologic Oncologists, Gynecologic Surgeons, Primary Care Physicians, Physician Assistants and Nurse Practitioners.
LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.

ARS
Case Studies
Didactic Lecture
Enduring Material (DVD/Booklet)
Internet Activity Enduring Material
Internet Live Course (Live Webcast)
Internet point-of-care activity
Journal-based CME activity
Learning from Teaching
Live activity
Manuscript review activity
Panel
PI CME activity
Question & Answer
Regularly Scheduled Series
Simulation
Test item writing activity
Other (specify)

COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

The potential benefits of genomic medicine, or the use of an individual patient’s genomic information in clinical decision making, are increasingly being recognized. This course explores the evolution from “genetics to genomics,” providing the history of genetics and the genesis of cancer. Dr. Boyd discusses translational research in the genetics and molecular genetics of gynecologic and breast cancers and the molecular diagnostics of cancer using next-generation sequencing technology to inform the prevention and targeted treatment of cancer. This lecture was recorded at the fifth annual Omar Pasalodos, M.D., Memorial Lecture, which honors Dr. Pasalodos’ dedication to women’s healthcare, community outreach and education.

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

Patient: ☑ Noncompliance ☑ Resistance to change ☑ Cost of care/Lack of insurance
Physician: ☑ Noncompliance ☑ Resistance to change ☑ Communication skills ☑ Reimbursement issues
Resources: ☑ Institutional Capabilities ☑ Physician Practice Limitations ☑ Community Service Limitations
State of Science: ☑ Limited or no treatment modalities ☑ Limited or no diagnostic modalities
Other: Please describe.

BARRIERS TO PHYSICIAN CHANGE: (C19) Briefly explain how this activity addresses the barriers/factors identified.

DESIRABLE PHYSICIAN ATTRIBUTES/COMPETENCIES (C6)

ABMS/ACGME: ☑ Patient care and procedural skills ☑ Medical knowledge ☑ Practice-based learning and improvement ☑ Interpersonal and communication skills ☑ Professionalism ☑ Systems-based practice

INSTITUTE OF MEDICINE: ☑ Provide patient-centered care ☑ Work in interdisciplinary teams ☑ Employ evidence-based practice ☑ Apply quality improvement ☑ Utilize informatics

INTERPROFESSIONAL EDUCATION COLLABORATIVE: ☑ Values/ethics for interprofessional practice ☑ Roles/responsibilities ☑ Interprofessional communication ☑ Teams and teamwork

PROFESSIONAL PRACTICE GAP (C2)

The difference between what is (the “actual”) and what should be (the “ideal”).

What is the current professional practice gap? What are physicians doing (or not doing) that needs to change? Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes. (C2)

► The science of medicine is progressing at a very rapid pace, particularly the role of genomic medicine. Physicians who lack this knowledge will ultimately experience competency issues in the practice of medicine, particularly in the area of cancer diagnosis, assessment and management.

Indicate if the gap is related to need for change in either/or:

Knowledge and/or (Doctors do not know that they need to be doing something.)
Competence and/or (Doctors do not know how to do it)
Performance and/or (Doctors know how to do it but are noncompliant – or are not doing it properly.)

DESIRED OUTCOMES (GOAL): Answer one or more of the following questions: What are the desired or expected
outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”? (C3)

► Physicians will implement genomic medicine in cancer treatment, prognosis, and diagnosis

Indicate what this activity is designed to change.

☑ Designed to change competence
☐ Designed to change performance
☐ Designed to change patient outcomes

NEEDS ASSESSMENT RESOURCES – HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain below.)

☐ Best practice parameters
☐ Disease prevention (C12)
☐ Mortality/morbidity statistics
☑ National/regional data
☐ New or updated policy/protocol
☐ Peer review data
☐ Regulatory requirement
☑ Research/literature review

☒ Consensus of experts
☐ Joint Commission initiatives (C12)
☐ National Patient Safety Goals
☐ New diagnostic/therapeutic modality (C12)
☐ Patient care data
☐ Process improvement initiatives (C16 & 21)
☐ Other need identified (Explain): _____________________________

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

► The potential benefits of genomic medicine, or the use of an individual patient’s genomic information (as reflected by family history, genotyping, sequencing or other DNA-based technology) into clinical decision making, are increasingly being recognized. However, challenges exist to widespread clinical implementation of genomic medicine, a prerequisite for developing evidence of its real-world utility … enable more precise genome-informed medical care …[to the] research and clinical community.

To address these challenges, the National Institutes of Health-funded IGNITE (Implementing Genomics In practice; www.ignite-genomics.org. Network, comprised of six projects and a coordinating center, was established in 2013 to support the development, investigation and dissemination of genomic medicine practice models that seamlessly integrate genomic data into the electronic health record and that deploy tools for point of care decision making.


EDUCATIONAL OBJECTIVES: Based on the gaps identified above, what are the learning objectives for this activity? Describe the performance* that should change if participants apply what they learn. *(or competence or patient outcome)

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

- Recognize the critical role of genetics in cancer pathogenesis.
- Explain the evolution of cancer genomics, and the role of genomic medicine in cancer treatment, prognosis, and diagnosis.
- Evaluate gynecologic and breast cancers based on their genomic architecture rather than site of origin.

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

- Changes in competence. Evaluation method: Baptist Health CME Evaluation Form
- Changes in performance. Evaluation method: Follow-up Survey
  Provide 3-4 statements based on expected performance outcomes to be evaluated. Example: I have implemented the new Baptist Health policy explained in this CME activity.
- Changes in patient outcomes. Evaluation method: Review of hospital, health system, public health data, etc.
- Other______________

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

Jeffrey Boyd, Ph.D.
Professor and Chair, Department of Human and Molecular Genetics
Professor, Department of Obstetrics and Gynecology
Herbert Wertheim College of Medicine, Florida International University
Director, Translational Research and Genomic Medicine
Miami Cancer Institute, Baptist Health South Florida
Miami, Florida

Faculty disclosure statement (as it should appear on course shell):

Dr. Boyd has indicated that he has no relevant financial relationships and that his discussion will not include mention of investigational or off-label usage. All other individuals in a position to control or influence content have no relevant financial relationships with commercial interests.

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). Note: When using electronic evaluations, disclosure statements for faculty must be included on course landing pages.

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
- Others (Conference Coordinator, Planning Group, etc.) ____________________________________________

NON-EDUCATIONAL 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. NOTE: Insert this information under course shell>>custom fields>>resources.

- 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, describe the collaborative efforts. _____________________________________________

- Baptist Health South Florida is collaborating with the Herbert Wertheim College of Medicine at Florida International University (FIU) to advance the role of genomic medicine particularly in the area of cancer diagnosis, assessment and management.
- Additionally both institutions along with the Health Foundation of South Florida, are in their fifth year of collaboration in support of the Omar Pasalodos, M.D., Memorial Lecture.
- An obstetrician-gynecologist and civic leader, Dr. Omar Pasalodos, dedicated his career to improving the health of women in South Florida. Through caring for his patients, through education and advocacy, and through his volunteer leadership, Dr. Pasalodos exemplified the best of medicine. To honor his passion and commitment, this annual lecture will feature a distinguished speaker and educational event focusing on women’s healthcare issues such as preventative medicine, cancer, aging, heart disease, and obesity. In support of community outreach the presentation topic and format will be equally relevant to a medical professional and an educated female non-medical consumer. The planning group will be comprised of representatives from the Herbert Wertheim College of Medicine, Mrs. Lisa Pasalodos, and representatives of Baptist Health South Florida’s executive leadership and Continuing Medical Education leadership.
COMMERCIAL SUPPORT: □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

DATE REVIEWED: ___________ REVIEWED BY: □ Accelerated Approval □ Executive Committee □ Live Committee
APPROVED: □ YES □ NO □ Credits: AMA/PRA Category 1 Credits: #1.0
Continuing Psychology Education Credits: # ___ N/A □ Continuing Dental Education Credits: # ___ N/A

CME ACTIVITY TITLE: Immunotherapy Concepts and Potential Future Applications in Head and Neck Cancer Treatment at the Miami Cancer Institute

DATE/TIME: Recorded at the Fifth Annual Head and Neck Cancer Symposium, April 30, 2016, Baptist Hospital of Miami

CREDIT HOUR(S) APPLIED FOR: 0.50 Cat 1

COURSE APPROVED: MAY 2016 COURSE EXPIRES: MAY 2018

TARGET AUDIENCE: Primary Care Physicians, Dentists, Otolaryngologists, Gastroenterologists, Radiologists, Medical Oncologists, Oral Maxillofacial Surgeons, Surgeons, Pathologists, Pediatricians, Hospitalists and Physician Assistants.

CONFERENCE DIRECTOR: Joseph P. McCain, DMD

CME MANAGER: Nina Doleyres, MPH

EXPECTED NUMBER OF ATTENDEES: 40-50 Annually

LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.

□ ARS □ Case Studies □ Didactic Lecture □ Enduring Material (DVD/Booklet)
□ Internet Activity Enduring Material □ Internet Live Course (Live Webcast) □ Internet point-of-care activity
□ Journal-based CME activity □ Learning from Teaching □ Live activity
□ Manuscript review activity □ Panel □ PI CME activity
□ Question & Answer □ Regularly Scheduled Series □ Simulation
□ Test item writing activity □ Other (specify)

COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

Studies with other solid malignancies have demonstrated the advantages of combining immunotherapeutic strategies with either chemo or radiation therapies, or using combinations of immunotherapeutic approaches. This course provides practitioners with historical perspective in immune vigilance, concepts on immunotherapy and recent results of studies using this approach in head and neck cancer. Plans for patient-centric immunotherapeutic treatment research to be performed at the Miami Cancer Institute will also be reviewed.

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

Patient: □ Noncompliance □ Lifestyle □ Resistance to change □ Cost of care/Lack of insurance
Physician: □ Noncompliance □ Resistance to change □ Communication skills □ Reimbursement issues
Resources: □ Institutional Capabilities □ Physician Practice Limitations □ Community Service Limitations
State of Science: □ Limited or no treatment modalities □ Limited or no diagnostic modalities
Other: Please describe.

BARRIERS TO PHYSICIAN CHANGE: (C19) Briefly explain how this activity addresses the barriers/factors identified.
Lack of research into novel treatment approaches for head and neck squamous cell carcinomas (HNSCC) has meant limited treatment options which have yielded minimal improvement. Exposing physicians and other healthcare providers to emerging treatment options through a review of future research trials will lay the groundwork for application of emerging novel treatment approaches.

**DESIRABLE PHYSICIAN ATTRIBUTES/COMPETENCIES (C6)**

**ABMS/ACGME:**
- Patient care and procedural skills
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

**INSTITUTE OF MEDICINE:**
- Provide patient-centered care
- Work in interdisciplinary teams
- Employ evidence-based practice
- Apply quality improvement
- Utilize informatics

**INTERPROFESSIONAL EDUCATION COLLABORATIVE:**
- Values/ethics for interprofessional practice
- Roles/responsibilities
- Interprofessional communication
- Teams and teamwork

**PROFESSIONAL PRACTICE GAP (C2)**

<table>
<thead>
<tr>
<th>What is the current professional practice gap?</th>
<th>What are physicians doing (or not doing) that needs to change? Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes. (C2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians use conventional treatment methods instead of targeted treatments with head and neck cancer patients.</td>
<td></td>
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<tr>
<td>Lack of time and communication strategies/resources have been blamed for ineffective physician/patient communication and may negatively impact delivery of poor diagnoses.</td>
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<tr>
<td>There is a need to ensure doctors are specifically trained in the appropriate referral and care pathway for oral cancers so that they are equipped to adequately support their patients and not contribute further to any delay. Timely intervention is important in improving survival and quality of life in patients with oral cancers. <a href="http://www.indianjcancer.com/article.asp?issn=0019-509X;year=2014;volume=51;issue=2;spage=95;epage=97;aulast=Joshi">http://www.indianjcancer.com/article.asp?issn=0019-509X;year=2014;volume=51;issue=2;spage=95;epage=97;aulast=Joshi</a></td>
<td></td>
</tr>
</tbody>
</table>

**Indicate if the gap is related to need for change in either/or:**
- Knowledge and/or
- Competence and/or
- Performance and/or

**DESIRABLE OUTCOMES (GOAL):** *Answer one or more of the following questions: What are the desired or expected outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”? (C3)*

- Timely interventions by physicians and dentists will improve survival and quality of life for patients with oral cancers and minimize negative outcomes.
- Dentists and doctors will accurately identify or diagnose patients with head and neck cancers (or suspected cancer) and they will refer to 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.

**Indicate what this activity is designed to change.**
- Designed to change competence
- Designed to change performance
- Designed to change patient outcomes

**NEEDS ASSESSMENT RESOURCES – HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain below.)**
- Best practice parameters
- Disease prevention (C12)
- Mortality/morbidity statistics
- National/regional data
- New or updated policy/protocol
- Peer review data
- Regulatory requirement
- Research/literature review
- Consensus of experts
- Joint Commission initiatives (C12)
- National Patient Safety Goals
- New diagnostic/therapeutic modality (C12)
- Patient care data
- Process improvement initiatives (C16 & 21)
- Other need identified (Explain): _____________________________
Head and neck squamous cell carcinomas (HNSCC) are aggressive malignancies, and treatment options have traditionally involved surgery or, more recently, also radiation plus chemotherapy. There is the realization that novel treatment approaches for HNSCC patients are essential due to the minimal levels of improvement in patient survival over the last few decades. Immunotherapy could be a strong candidate for one such approach. However, clinical studies testing immunotherapeutic approaches for treatment of HNSCC have lagged significantly compared to trials using immunotherapeutic strategies for treatment of other solid cancers such as breast, lung and colorectal cancers. Studies with other malignancies have demonstrated the advantages of combining immunotherapeutic strategies with either chemo or radiation therapies, or using combinations of immunotherapeutic approaches. However, a great deficiency persists in use of these combined therapies for treatment of HNSCC patients.

Approaches to actively stimulate immune reactivity also need to consider incorporating approaches that target the multitude of immune inhibitory mechanisms that are induced by HNSCC. While the testing of these treatment approaches for HNSCC patients is lagging, future studies should take advantage of what has been learned from the results of immunotherapeutic treatment approaches that have been used in patients with other solid malignancies and then to apply this knowledge to optimize the treatment of HNSCC patients.


EDUCATIONAL OBJECTIVES:

Based on the gaps identified above, what are the learning objectives for this activity? Describe the performance* that should change if participants apply what they learn. *(or competence or patient outcome)

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

- Examine the prospects of immunotherapeutic treatment for head and neck squamous cell carcinomas, and review the role of this treatment in emerging patient-centric research at the Miami Cancer Institute.

EVALUATION METHODS:

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

- Changes in competence. Evaluation method: Baptist Health CME Evaluation Form
- Changes in performance. Evaluation method: Follow-up Survey
  
  Provide 3-4 statements based on expected performance outcomes to be evaluated. Example: I have implemented the new Baptist Health policy explained in this CME activity.

- Changes in patient outcomes. Evaluation method: Review of hospital, health system, public health data, etc.
- Other __________________________

FACULTY:

Miguel A. Villalona - Calero, M.D.
Chief Scientific Officer and Deputy Director, Miami Cancer Institute, Miami, Florida
Hematologist/Oncologist
Baptist Health Medical Group - Oncology
Baptist, Doctors and South Miami Hospitals
Professor Dept of Medicine, Family Medicine and Community Health
Florida International University
Miami, Florida

Faculty disclosure statement (as it should appear on course shell):

Miguel A Villalona-Calero, M.D., has indicated that he has no relevant commercial relationships to disclose. Dr. Villalona-Calero has also indicated that his discussions will not include mention of investigational or off-label usage.

RELEVANT FINANCIAL RELATIONSHIPS:

List individuals in control of the content of this CME activity (other than faculty). Note: When using electronic evaluations, disclosure statements for faculty must be included on course landing pages.

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

☐ Others (Conference Coordinator, Planning Group, etc.) __________________________

NON-EDUCATIONAL 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. NOTE: Insert this information under course shell>>custom fields>>resources.

- 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?
CME ACTIVITY TITLE: The Mediterranean Diet: The Optimal Diet for Cardiovascular Health

DATE: May 20, 2016, to May 20, 2017  CREDIT HOURS APPLIED FOR: .5 Cat. 1

LOCATION: Recorded at the 13th Annual Cardiovascular Disease Prevention International Symposium, Thursday, February 19, 2015

TARGET AUDIENCE: Cardiologists, Family Physicians, General Internists, Endocrinologists, Psychologists, Physician Assistants, ARNPs

CONFERENCE DIRECTOR: Arturo Fridman, M.D.  CME MANAGER: Isabel R. Morgan

EXPECTED NUMBER OF ATTENDEES: 20-50  CHARGE: None

LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.

☐ ARS  ☐ Live activity
☐ Case studies  ☐ Manuscript review activity
☐ Didactic lecture  ☐ Panel
☐ Enduring material (DVD/booklet)  ☐ PI CME activity
☐ Internet activity enduring material  ☐ Question-and-answer
☐ Internet live course (live webcast)  ☐ Regularly scheduled series
☐ Internet point-of-care activity  ☐ Simulation
☐ Journal-based CME activity  ☐ Test item writing activity
☐ Learning from teaching  ☐ Other (specify)

COURSE DESCRIPTION: This short summary will be used on course shell. Please note keyword searches will pull from this description.

 ► Dietary guidelines can be derived from dietary patterns known to be healthy such as the traditional Mediterranean diet. This lecture is designed to help physicians assess dietary lifestyle changes that can effectively stimulate patients to address the critical role that diet plays in their cardiovascular health. This course will be of special interest to cardiologists, family medicine physicians, endocrinologists, physician assistants and ARNPs, along with other specialists interested in the benefits of the traditional Mediterranean diet.

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:  ☒ Noncompliance  ☒ Lifestyle  ☒ Resistance to change  ☐ Cost of care/Lack of insurance
Physician:  ☒ Noncompliance  ☐ Resistance to change  ☐ Communication skills  ☐ Reimbursement issues
Resources:  ☐ Institutional capabilities  ☐ Physician practice limitations  ☐ Community service limitations
State of Science:  ☐ Limited or no treatment modalities  ☐ Limited or no diagnostic modalities
Other: Please describe.

BARRIERS TO PHYSICIAN CHANGE: (C19) Briefly explain how this activity addresses the barriers/factors identified.

This activity will address the need for ways to support the translation of best practice and provision of effectiveness of interventions aimed at achieving changes associated with the benefits of the traditional Mediterranean diet.

DESIRABLE PHYSICIAN ATTRIBUTES/COMPETENCIES (C6)
ABMS/ACGME: ☑Patient care and procedural skills ☑Medical knowledge ☑Practice-based learning and improvement ☑Interpersonal and communication skills ☑Professionalism ☑Systems-based practice

INSTITUTE OF MEDICINE: ☑Provide patient-centered care ☑Work in interdisciplinary teams ☑Employ evidence-based practice ☑Apply quality improvement ☑Utilize informatics

INTERPROFESSIONAL EDUCATION COLLABORATIVE: ☑Values/ethics for interprofessional practice ☑Roles/responsibilities ☑Interprofessional communication ☑Teams and teamwork
PROFESSIONAL PRACTICE GAP (C2)

The difference between what is (ACTUAL) and what should be (IDEAL). What is the current professional practice gap? What are physicians doing (or not doing) that needs to change? Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes. (C2)

► Current physician practice does not include appropriate/consistent use of cardiovascular disease prevention strategies that can serve to reduce cardiovascular disease.

Indicate if the gap is related to need for change in either/or:
- Knowledge and/or (Doctors do not know that they need to be doing something.)
- Competence and/or (Doctors do not know how to do it.)
- Performance and/or (Doctors know how to do it but are noncompliant – or are not doing it properly.)

DESIRED OUTCOMES (GOAL): Answer one or more of the following questions: What are the desired or expected outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”? (C3)

► Physicians will provide optimal care and achieve optimal outcomes when they consistently implement evidence-based best-practice strategies to prevent cardiovascular disease morbidity and mortality. Physicians will apply the principles of cardiovascular disease prevention with lifestyle intervention and medical therapy.

Indicate what this activity is designed to change.
- Designed to change competence.
- Designed to change performance.
- Designed to change patient outcomes.

NEEDS ASSESSMENT RESOURCES – HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply.)
- Best-practice parameters
- Disease prevention (C12)
- Mortality/morbidity statistics
- National/regional data
- New or updated policy/protocol
- Peer review data
- Regulatory requirement
- Research/literature review
- Consensus of experts
- Joint Commission initiatives (C12)
- National Patient Safety Goals
- New diagnostic/therapeutic modality (C12)
- Patient care data
- Process improvement initiatives (C16 & 21)
- Other need identified (Explain): ____________________________

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

EDUCATIONAL OBJECTIVES: Based on the gaps identified above, what are the learning objectives for this activity? Describe the performance (or competence or patient outcome) that should change if participants apply what they learn.

Upon completion of this lecture, participants should be better able to:
- Review metabolic, epidemiologic and clinical trial evidence regarding diet and cardiovascular disease
- Implement strategies to effectively stimulate patients to address the critical role that diet plays in their cardiovascular health.

EVALUATION METHODS: Analyze the overall changes in competence, performance or patient outcomes as a result of this CME activity. (C11)
- Changes in competence. Evaluation method: Baptist Health CME evaluation form
- Changes in performance. Evaluation method: Follow-up survey
  Provide 3-4 statements based on expected performance outcomes to be evaluated. Example: I have implemented the new Baptist Health policy explained in this CME activity.
- Changes in patient outcomes. Evaluation method: Review of hospital, health system, public health data, etc.
- Other _______________________

FACULTY: (Name, specialty and/or title(s), institution(s), city, state. For more than two, include list at end of application.)
Biography: Dr. Malik's research focuses on evaluating dietary risk factors for obesity, type 2 diabetes and cardiovascular disease. Much of her work has evaluated the health effects of sugar-sweetened beverages. She has published extensively on this topic, including a number of influential review papers and meta-analyses. More recent research interests of Dr. Malik include studying nutritional drivers of the global obesity and diabetes epidemics in countries undergoing epidemiologic transition. The ultimate goal of her work is to inform future large-scale community-based interventions and policy strategies to reduce the risk of obesity and related chronic diseases nationally and internationally.

Disclosures
Vasanti Malik, Sc.D., has indicated that she has no relevant commercial relationships to disclose, and that her presentation will not include discussion of off-label or unapproved usage.

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). Note: When using electronic evaluations, disclosure statements for faculty must be included on course landing pages.
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
☒ Others (i.e., conference coordinator, planning group, etc.)

NON-EDUCATIONAL STRATEGIES: Explain what we (CME or BHSF) are doing – or what we could do – to enhance change as an adjunct to this CME activity. (C17) These would be tactics and tools to facilitate change that go beyond this CME activity. NOTE: Insert this information under course shell>>custom fields>>resources.
☐ Process redesign or new protocol ☐ Reminders (posters, mailings, email blasts) ☐ New order sheets
☒ Other tools or tactics Explain: Patient information

Direct interested individuals to
► http://patient.info/health/how-to-follow-the-mediterranean-diet

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) who 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, describe the collaborative efforts.

COMMERCIAL SUPPORT: ☐ Indicate here if support will come from Baptist Health Foundation’s General Continuing Medical Education Fund.

DATE REVIEWED: May 20, 2016 REVIEWED BY: ☒ Accelerated Approval ☐ Executive Committee ☐ Live Committee

APPROVED: ☒ YES ☐ NO ■ Credits: AMA/PRA Category 1 Credits: .5
Continuing Psychology Education Credits: # __ N/A ■ Continuing Dental Education Credits: # __ N/A

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

CME ACTIVITY TITLE: The Obesity Epidemic: Medical Intervention

DATE: May 20, 2016, to May 20, 2017 CREDIT HOURS APPLIED FOR: 1.0 Cat. 1

LOCATION: Recorded at the 12th Annual Cardiovascular Disease Prevention International Symposium on February 7, 2014

TARGET AUDIENCE: Cardiologists, Family Physicians, General Internists, Endocrinologists, Psychologists, Physician Assistants, ARNPs

CONFERENCE DIRECTOR: Arturo Fridman, M.D. CME MANAGER: Isabel R. Morgan

EXPECTED NUMBER OF ATTENDEES: 20-50 CHARGE: None
LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.

- ARS
- Case studies
- Didactic lecture
- Enduring material (DVD/booklet)
- Internet activity enduring material
- Internet live course (live webcast)
- Internet point-of-care activity
- Journal-based CME activity
- Learning from teaching
- Live activity
- Manuscript review activity
- Panel
- PI CME activity
- Question-and-answer
- Regularly scheduled series
- Simulation
- Test item writing activity
- Other (specify)

COURSE DESCRIPTION: This short summary will be used on course shell. Please note keyword searches will pull from this description.

► Overweight and obesity are complex health problems that affect more than two-thirds of U.S. adults. There are many health conditions associated with overweight and obesity, including hypertension, coronary heart disease and type 2 diabetes. Therefore, it is likely that healthcare practitioners will be advising overweight and obese individuals who also have additional health conditions. This lecture is designed to help physicians assess therapeutic lifestyle changes that can promote weight management and reduce chronic disease risk. This course will be of special interest to cardiologists, family medicine physicians, endocrinologists, physician assistants and ARNPs, along with other specialists interested in obesity management.

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:  
- Noncompliance  
- Lifestyle  
- Resistance to change  
- Cost of care/Lack of insurance

Physician:  
- Noncompliance  
- Resistance to change  
- Communication skills  
- Reimbursement issues

Resources:  
- Institutional capabilities  
- Physician practice limitations  
- Community service limitations

State of Science:  
- Limited or no treatment modalities  
- Limited or no diagnostic modalities

Other: Please describe.

BARRIERS TO PHYSICIAN CHANGE: (C19) Briefly explain how this activity addresses the barriers/factors identified.

This activity will address the need for ways to support the translation of best practice and provision of effectiveness of interventions aimed at achieving changes associated with overweight or obese individuals who also have additional health conditions.

DESIRABLE PHYSICIAN ATTRIBUTES/COMPETENCIES (C6)

ABMS/ACGME:  
- Patient care and procedural skills  
- Medical knowledge  
- Practice-based learning and improvement  
- Interpersonal and communication skills  
- Professionalism  
- Systems-based practice

INSTITUTE OF MEDICINE:  
- Provide patient-centered care  
- Work in interdisciplinary teams  
- Employ evidence-based practice  
- Apply quality improvement  
- Utilize informatics

INTERPROFESSIONAL EDUCATION COLLABORATIVE:  
- Values/ethics for interprofessional practice  
- Roles/responsibilities  
- Interprofessional communication  
- Teams and teamwork

PROFESSIONAL PRACTICE GAP (C2)
The difference between what is (ACTUAL) and what should be (IDEAL). What is the current professional practice gap? What are physicians doing (or not doing) that needs to change? Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes. (C2)

► Current physician practice does not include appropriate/consistent use of cardiovascular disease prevention strategies that can serve to reduce cardiovascular disease.

Indicate if the gap is related to need for change in either/or:

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

DESIRED OUTCOMES (GOAL): Answer one or more of the following questions: What are the desired or expected outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”? (C3)

► Physicians will provide optimal care and achieve optimal outcomes when they consistently implement evidence-based best-practice strategies to prevent cardiovascular disease morbidity and mortality. Physicians will apply the principles of
EDUCATIONAL OBJECTIVES: Based on the gaps identified above, what are the learning objectives for this activity?

Describe the performance (or competence or patient outcome) that should change if participants apply what they learn.

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

● Define the relationship between overweight or obese and chronic disease.
● Explain how Therapeutic Lifestyle Changes (TLC) components can promote weight management and reduce chronic disease risk.
● Discuss approved pharmacologic options for long-term weight management.

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

☑ Changes in competence. Evaluation method: Baptist Health CME evaluation form
☐ Changes in performance. Evaluation method: Follow-up survey

Provide 3-4 statements based on expected performance outcomes to be evaluated. Example: I have implemented the new Baptist Health policy explained in this CME activity.

☑ Changes in patient outcomes. Evaluation method: Review of hospital, health system, public health data, etc.
☐ Other ______________________

FACULTY: (Name, specialty and/or title(s), institution(s), city, state. For more than two, include list at end of application.)

Theodore Feldman, M.D.
Medical Director, Wellness and Prevention, Baptist Health South Florida
Medical Director, South Miami Heart Center
Clinical Associate Professor of Medicine, Herbert Wertheim College of Medicine
Florida International University
Miami, Florida

Biography Dr. Ted Feldman is extensively involved in clinical research and education in cardiovascular disease prevention. He serves as a symposium director for the International Symposium on Cardiovascular Disease Prevention, one of the largest and most prestigious meetings of its kind in the U.S. He also is symposium director of the Miami Cardiac & Vascular Institute Comprehensive Cardiovascular Symposium. Board-certified in internal medicine with a subspecialty in cardiovascular medicine, Dr. Feldman currently serves as medical director of Miami Cardiac & Vascular Institute at South Miami Hospital and is a medical director for the Center for Prevention and Wellness at Baptist Health South Florida. Dr. Feldman is a clinical associate professor of medicine at the FIU Herbert Wertheim College of Medicine as well as the Cardiology Clerkship director at FIU and an interviewer for the FIU HWCOM Admissions committee. Dr. Feldman is in private practice in South Miami and is a member of the executive committee and board of directors of Heartwell LLP, a large single-specialty cardiovascular practice closely affiliated with Miami Cardiac & Vascular Institute.

Disclosures

Theodore Feldman, M.D., has disclosed that he serves as a consultant to AstraZeneca Pharmaceuticals, Merck and
RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). Note: When using electronic evaluations, disclosure statements for faculty must be included on course landing pages.
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
☒ Others (i.e., conference coordinator, planning group, etc.)

NON-EDUCATIONAL STRATEGIES: Explain what we (CME or BHSF) are doing – or what we could do – to enhance change as an adjunct to this CME activity. (C17) These would be tactics and tools to facilitate change that go beyond this CME activity. NOTE: Insert this information under course shell>>custom fields>>resources.
☐ Process redesign or new protocol ☐ Reminders (posters, mailings, email blasts) ☐ New order sheets
☐ Other tools or tactics ☐ Explain: Patient information

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) who 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, describe the collaborative efforts. ____________________________________________________

COMMERCIAL SUPPORT: ☐ Indicate here if support will come from Baptist Health Foundation’s General Continuing Medical Education Fund.

DATE REVIEWED: May 19, 2016 REVIEWED BY: ☒ Accelerated Approval ☐ Executive Committee ☐ Live Committee

APPROVED: ☒YES ☒NO ☒ Credits: AMA/PRA Category 1 Credits: 1.0
Continuing Psychology Education Credits: N/A ☒ Continuing Dental Education Credits: N/A ☒

CME ACTIVITY TITLE: Thrombophilia Testing: Are we wasting cash and blood?

DATE/TIME: Recorded at Second Annual Venous Thromboembolism Symposium, December 12, 2015, Baptist Hospital, Auditorium

CREDIT HOUR(S) APPLIED FOR: 0.50 Cat 1

COURSE APPROVED: MAY 2016 COURSE EXPIRES: MAY 2018

TARGET AUDIENCE:

CONFERENCE DIRECTOR: Ian Del Conde, M.D. CME MANAGER: Nina Doleyres, MPH

EXPECTED NUMBER OF ATTENDEES: 40-50 Annually CHARGE: None

LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.
☐ ARS ☐ Case studies ☒ Didactic lecture ☐ Enduring material (DVD/booklet)
Internet activity enduring material
Internet live course (live webcast)
Internet point-of-care activity
Journal-based CME activity
Learning from teaching
Live activity
Manuscript review activity

COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.
Management of venous thromboembolism (VTE) includes evaluation for hypercoagulable states, particularly when VTE occurs in younger patients, is persistent or is linked with family history. Laboratory tests are costly and evidence is limited in terms of better patient outcomes. Evidence based on observational prospective studies suggests that optimal duration of anticoagulation should be based on clinical risks resulting in VTE, such as transient, permanent and idiopathic or unprovoked risks, and less on abnormal thrombophilia values. This course will address patient screening and selection as well as factors for determining when testing is indicated to assess thrombophilia.

FACTORS OUTSIDE OUR CONTROL – List factors outside our control and beyond the learner performance that impact patient outcomes and contribute to the healthcare “quality gap” being addressed. (C18)
Patient: ☐ Noncompliance ☒ Lifestyle ☐ Resistance to change ☒ Cost of care/Lack of insurance
Physician: ☒ Noncompliance ☐ Resistance to change ☒ Communication skills ☐ Reimbursement issues
Resources: ☒ Institutional capabilities ☒ Physician practice limitations ☐ Community service limitations
State of Science: ☐ Limited or no treatment modalities ☒ Limited or no diagnostic modalities
Other: Please describe.

BARRIERS TO PHYSICIAN CHANGE: (C19) Briefly explain how this activity addresses the barriers/factors identified.

PROFESSIONAL PRACTICE GAP (C2)
The difference between what is (the “actual”) and what should be (the “ideal”).
What is the current professional practice gap? What are physicians doing (or not doing) that needs to change? Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes. (C2)
► Physicians do not consistently employ proper workup to assess patients who present with suspected or possible venous thromboembolism (VTE) or pulmonary embolism (PE). Additionally, physicians may not be aware of the various available interventional treatments, their risk and complications and the type of patients who would benefit from them.

Indicate if the gap is related to need for change in either/or:
☒ Knowledge and/or (Doctors do not know that they need to be doing something.)
☐ Competence and/or (Doctors do not know how to do it.)
☒ Performance and/or (Doctors know how to do it but are noncompliant – or are not doing it properly.)

DESIRABLE OUTCOMES (GOAL): Answer one or more of the following questions: What are the desired or expected outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”? (C3)
► Physicians will provide optimal care and achieve best outcomes when they consistently perform proper workup to assess patients presenting with possible VTE or PE. They will determine the most appropriate interventional treatments for the patients who would benefit from them.

Indicate what this activity is designed to change.
Management of venous thromboembolism (VTE) includes evaluation for hypercoagulable states, especially if the VTE occurs in young patients, is recurrent or is associated with a positive family history. These laboratory tests are costly, and, surprisingly, there is little evidence showing that testing leads to improved clinical outcomes. Evidence based on observational prospective studies suggests that optimal duration of anticoagulation should be based on clinical risks resulting in VTE, such as transient, permanent and idiopathic or unprovoked risks, and less on abnormal thrombophilia values. Thrombophilia screening is important in a subgroup of clinical scenarios, such as when there is clinical suspicion of antiphospholipid antibody syndrome, heparin resistance or warfarin necrosis; with thrombosis occurring in unusual sites (such as mesenteric or cerebral deep venous thrombosis); and for pregnant women or those seeking pregnancy or considering estrogen-based agents. Thrombophilia screening is not likely to be helpful in most cases of first-time unprovoked VTE in the setting of transient risks, active malignant disease, deep venous thrombosis of upper extremity veins or from central lines, two or more VTEs, or arterial thrombosis with pre-existing atherosclerotic risk factors. The desire by both patient and physician for a scientific explanation of the clotting event may alone lead to testing, and, if so, it should be with the understanding that an abnormal test result will likely not change management, and normal results do not accurately exclude a thrombophilic defect because there are likely factors yet to be discovered. Such false assumptions may lead to shorter durations of treatment than are optimal.

CME Dept. leadership and staff □ CME Committee □ Conference director
□ Others (conference coordinator, planning group, etc.)

NON-EDUCATIONAL STRATEGIES: Explain what we are doing (CME or BHSF) — or what we could do — to enhance change as an adjunct to this CME activity. (C17) These would be tactics and tools to facilitate change that go beyond this CME activity. NOTE: Insert this information under course shell>>custom fields>>resources.
□ 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, describe the collaborative efforts. This is a collaborative project between the Miami Cardiac & Vascular Institute and the Department of CME to improve patient care via implementation of evidence-based approaches to care for patients with venous thromboembolism or pulmonary embolism.

COMMERCIAL SUPPORT: □ Indicate here if support will come from the Foundation’s General Continuing Medical Education fund.

DATE REVIEWED: May 17, 2016 REVIEWED BY: □ Accelerated Approval □ Executive Committee
□ Live Committee

APPROVED: □ YES □ NO Credits: AMA/PRA Category 1 Credits: # 0.50
Continuing Psychology Education Credits: # N/A Continuing Dental Education Credits: # N/A

CME ACTIVITY TITLE: Depression Screening and Management

DATE: Tuesday, May 31, 2016 TIME: 7:30 a.m. - 9 a.m.

CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1

LOCATION: Baptist Hospital, Auditorium

TARGET AUDIENCE: Baptist Health Medical Group

CONFERENCE DIRECTOR: Paul DiCapua, M.D. and Tomas Villanueva, M.D.

CME MANAGER: Marie Vital Acle

EXPECTED NUMBER OF ATTENDEES: 50 CHARGE: 0

LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.

□ ARS □ Case Studies □ Didactic Lecture
□ Enduring Material (DVD/Booklet) □ Internet Activity Enduring Material
□ Internet Live Course (Live Webcast) □ Internet point-of-care activity
□ Journal-based CME activity □ Learning from Teaching
□ Live activity □ Manuscript review activity □ Panel
□ PI CME activity □ Question & Answer
□ Regularly Scheduled Series □ Simulation
□ Test item writing activity □ Other (specify)
□ Small Group Discussions
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description. N/A course will not be published.

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

Patient: ☒ Noncompliance ☒ Lifestyle ☒ Resistance to change ☒ Cost of care/Lack of insurance
Physician: ☒ Noncompliance ☒ Resistance to change ☒ Communication skills ☐ Reimbursement issues
Resources: ☐ Institutional Capabilities ☒ Physician Practice Limitations ☐ Community Service Limitations
State of Science: ☐ Limited or no treatment modalities ☐ Limited or no diagnostic modalities
Other: Patient: Inability to Reconcile, Patient Preference with Guideline Recommendations; Guideline Factors: Guideline Characteristics, Presence of Contradictory Guidelines; Environmental Factors: Lack of Time, Lack of Resources, Organizational Constraints, Lack of Reimbursement, Perceived Increase in Malpractice Liability

BARRIERS TO PHYSICIAN CHANGE: (C19) Briefly explain how this activity addresses the barriers/factors identified.
The three most common factors that influence practitioner’s ability to diagnose and manage depression are patients resistance to change, patient noncompliance, the mental health system is fragmented and it is difficult for patients and practitioners alike to access depression and practitioners lack of time. This course will address these factors and provide primary care physicians with an effective, evidence-based algorithm of care to provide easy access to manageable changes in clinical practice.

DESIRABLE PHYSICIAN ATTRIBUTES/COMPETENCIES (C6)

ABMS/ACGME: ☐ Patient care and procedural skills ☒ Medical knowledge ☒ Practice-based learning and improvement ☒ Interpersonal and communication skills ☐ Professionalism ☒ Systems-based practice

INSTITUTE OF MEDICINE: ☒ Provide patient-centered care ☒ Work in interdisciplinary teams ☒ Employ evidence-based practice ☐ Apply quality improvement ☒ Utilize informatics

INTERPROFESSIONAL EDUCATION COLLABORATIVE: ☐ Values/ethics for interprofessional practice ☐ Roles/responsibilities ☐ Interprofessional communication ☐ Teams and teamwork
**PROFESSIONAL PRACTICE GAP (C2)**

The difference between what is (the "actual") and what should be (the "ideal").

**What is the current professional practice gap?** What are physicians doing (or not doing) that needs to change? *Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes.* (C2)

► BHMG Primary Care physicians are not consistently screening patients for depression and are not appropriately treating depression when it is identified. Baptist Health Primary Care is implementing a program to further integrate behavioral health into primary care practices.

**Indicate if the gap is related to need for change in either/or:**
- Knowledge and/or (Doctors do not know that they need to be doing something.)
- Competence and/or (Doctors do not know how to do it)
- Performance and/or (Doctors know how to do it but are noncompliant – or are not doing it properly.)

**DESIRED OUTCOMES (GOAL):** *Answer one or more of the following questions: What are the desired or expected outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”?* (C3)

► Primary care physician will overcome provider’s barriers to guideline-concordant care, thus improving the chances of implementation. Primary care physicians will screen all patients for depression and implement depression treatment algorithm consistently.

**Indicate what this activity is designed to change.**
- Designed to change competence
- Designed to change performance
- Designed to change patient outcomes

**NEEDS ASSESSMENT RESOURCES – HOW ARE EDUCATIONAL NEEDS IDENTIFIED?** *(Check all that apply and explain below.)*

- Best practice parameters
- Disease prevention *(C12)*
- Mortality/morbidity statistics
- National/regional data
- New or updated policy/protocol
- Peer review data
- Regulatory requirement
- Other need identified (Explain): Algorithm developed to address physician barrier’s to change.
- Research/literature review

**REFERENCES** supporting the current practice and/or the optimal practice and/or practice gap: *Data below extrapolated from internal surveys conducted by Baptist Health Medical Group.*

**PLEASE RATE YOUR CONFORT LEVEL FOR EACH OF THE FOLLOWING:**

<table>
<thead>
<tr>
<th><strong>Barrier Score</strong></th>
<th><strong>Starting a patient on anti-depression medication</strong></th>
<th><strong>Identifying the anti-depression medication with the ‘best’ side-effect profile for each patient</strong></th>
<th><strong>Adjusting anti-depression medication when symptoms poorly controlled</strong></th>
<th><strong>Changing anti-depression medication when one isn’t working</strong></th>
<th><strong>How likely is the “lack of expertise in medical management of depression” to influence your ability to diagnose and manage depression in your primary care practice?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28</td>
<td>39</td>
<td>39</td>
<td>45</td>
<td>29</td>
</tr>
</tbody>
</table>
Rev. Renato Santos, AVP, Pastoral Care, and David Vittoria, AVP, Addiction Treatment Center at South Miami Hospital, discussed the mental health part of medical health with a focus on community and patient care. Some of the statistics mentioned:

- About 20 percent of adults in the United States experience mental illness in a given year.
- 16 million adults in the United States live with depression.
- 42 million adults in the United States live with anxiety.
- 10.2 million adults in the United States have co-occurring mental health and addiction challenges.
- 16.3 percent of Hispanic adults live with a mental health condition.
- 19.3 percent of white adults live with a mental health condition.
- 18.6 percent of African American adults live with a mental health condition.
- 13.9 percent of Asian adults live with a mental health condition.
- In the United States, people with mental health conditions die 25 years earlier than the general population.
- 68 percent of Americans have co-morbid mental health and medical conditions.
- Medical disorders may lead to mental disorders; mental conditions may place a person at risk for certain medical conditions; and mental and medical disorders may share common risk factors.
- Conditions with increased frequency in mental illness are tuberculosis, HIV, hepatitis B and C, cancer, osteoporosis, diabetes, COPD, hypertension, obstetric complications, stroke, cardiovascular disease, obesity.
There is a financial impact on healthcare if mental illness is not addressed. For example, the average total monthly expenditure for a person with a chronic disease and depression is $560 more than for a person without depression.

Best practices—Training, Screening, Diagnosis, Treatment and Referral.

Progress to date—C.O.M.P.A.S.S. pilot program at West Kendall Baptist Hospital, PHQ2/9 administration in PCCs, HR/Employee Health Baptist Health Committee, Baptist Health discussions with finance and MC.

Source: BHSF Diversity Council Meeting Highlights, April 6, 2016

EDUCATIONAL OBJECTIVES: Based on the gaps identified above, what are the learning objectives for this activity? Describe the performance* that should change if participants apply what they learn. *(or competence or patient outcome)

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

- Screen patients for depression and implement strategies to identify atypical presentations of depression.
- Implement guideline-concordant care utilizing the depression treatment algorithm discussed to improve patient outcomes.
- Consider medication side effects when recommending pharmacological interventions for depression.

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

☑ Changes in competence. Evaluation method: Baptist Health CME Evaluation Form
☐ Changes in performance. Evaluation method: Follow-up Survey

Provide 3-4 statements based on expected performance outcomes to be evaluated. Example: I have implemented the new Baptist Health policy explained in this CME activity.

☐ I have a system in place to screen my patients for depression.
☐ I have identified atypical presentations of depression in my practice.
☐ I have implemented guideline-concordant strategies to address depression in my practice.
☐ I have considered behavioral interventions in my patient treatment plans.
☐ I have implemented the depression treatment algorithm discussed in my practice.

☐ Changes in patient outcomes. Evaluation method: Review of hospital, health system, public health data, etc.
☐ Other______________________

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

Paul Di Capua, MD, MBA, MSHPM
Medical Director of Primary Care Development and Evaluation
Center for Healthcare Advancement & Outcomes
Baptist Health Medical Group
Baptist Health South Florida
Assistant Professor of Medicine
Herbert Wertheim College of Medicine
Florida International University

Tatiana Ivan, MD
Baptist Health Medical Group
Baptist Health South Florida
Associate Program Director, WKBH/ FIU Family Medicine Residency
Assistant Professor of Medicine
Department of Family Medicine, Herbert Wertheim College of Medicine Florida International University

Anaisys Ballesteros, D.O.
Baptist Health Medical Group
Baptist Health South Florida

Melissa Franco, D.O.
Baptist Health Medical Group
Baptist Health South Florida

Ximena Cortada, LCSW
Baptist Health Primary Care
Baptist Health South Florida
Faculty disclosure statement (as it should appear on course shell): Course will not be published. Disclosure statements should be included on sign-in sheet.

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). Note: When using electronic evaluations, disclosure statements for faculty must be included on course landing pages. 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
☐ Others (Conference Coordinator, Planning Group, etc.)

NON-EDUCATIONAL 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. NOTE: Insert this information under course shell>>custom fields>>resources.
☐ Process redesign or new protocol ☐ Reminders (posters, mailings, email blasts) ☐ New order sheets
☐ Other tools or tactics Explain: Depression Treatment Algorithm and PHQ-2 and PHQ-9 assessment tools.

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, describe the collaborative efforts. The CME has partnered with the Baptist Health Medical Group to deliver this activity that address barriers to change and knowledge gaps specific to the Baptist Health Primary Care Group.

COMMERCIAL SUPPORT: ❌ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

DATE REVIEWED: May 17, 2016 REVIEWED BY: ☑ Accelerated Approval ☐ Executive Committee
☐ Live Committee

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: Echocardiography Symposium 35th Annual

DATE: Friday and Saturday – September 23-24, 2016 LOCATION: Trump National Doral, Miami, Florida

TIME: Friday, 8:00 a.m. – 5:00 p.m. and Saturday, 8:00 a.m. – 12:30 p.m.

SYMPOSIUM DIRECTOR: Michael D. Ozner, M.D. CREDIT HOUR(S) APPLIED FOR: 11 Cat. 1

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

TARGET AUDIENCE: Cardiologists, Cardiovascular Surgeons, Interventional Cardiologist, Sonographers, Nurses

EXPECTED NUMBER OF ATTENDEES: 350+

REGISTRATION CHARGES:
Physicians: $389*
BHSF Employees $60 ($35 Fri – $25 Sat)
Non BHSF: $199
*Groups of 3 or more physicians who register together are eligible for a 30% discount.
*International physicians are eligible for a 30% discount.

**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

**LEARNING FORMAT:** Must be appropriate to achieve objectives and desired results (C5). Check all that apply.
- ARS
- Case studies
- Didactic lecture
- Enduring material (DVD/booklet)
- Internet activity enduring material
- Internet live course (live webcast)
- Internet point-of-care activity
- Journal-based CME activity
- Learning from teaching
- Live activity
- Panel
- Enduring Material
- Internet Home Study
- Other

*Education requirement for physicians and sonographers affiliated with accreditation echo lab.

**COURSE DESCRIPTION:** This short summary will be used on course shell. Please note keyword searches will pull from this description.

*This symposium provides a comprehensive update on the latest developments, cutting edge technologies, current controversies and future directions in the field of echocardiography. Clinical presentations and echocardiographic studies will cover doppler hemodynamics, valvular heart disease, cardiomyopathy, pericardial disease, native and prosthetic valve endocarditis, 3D echo, contrast echo, 3D cardiac mechanics, ejection fraction and strain measurements, echo in atrial fibrillation, cardiac remodeling in obesity, congenital heart disease and additional state-of-art topics in echocardiography. This course will be of special interest to physicians in the fields of cardiology, along with sonographers and other physicians interested in echocardiography.

**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:**
- Noncompliance
- Lifestyle
- Resistance to change
- Cost of care/Lack of insurance

**Physician:**
- Noncompliance
- Resistance to change
- Communication skills
- Reimbursement issues

**Resources:**
- Institutional capabilities
- Physician practice limitations
- Community service limitations

**State of Science:**
- Limited or no treatment modalities
- Limited or no diagnostic modalities

**Other:** Please describe.

**BARRIERS TO PHYSICIAN CHANGE:** (C19) Briefly explain how this activity addresses the barriers/factors identified.

This activity will address the need for ways to support the translation of best practice and provision of treatments with clear evidence-based interventions to optimize imaging utilization that will ultimately improve patient care.

**DESIRABLE PHYSICIAN ATTRIBUTES/COMPETENCIES (C6)**

**ABMS/ACGME:**
- Patient care and procedural skills
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

**INSTITUTE OF MEDICINE:**
- Provide patient-centered care
- Work in interdisciplinary teams
- Employ evidence-based practice
- Apply quality improvement
- Utilize informatics

**INTERPROFESSIONAL EDUCATION COLLABORATIVE:**
- Values/ethics for interprofessional practice
- Roles/responsibilities
- Interprofessional communication
- Teams and teamwork

► Education requirement for doctors and sonographers affiliated with accredited echo lab.

**PROFESSIONAL PRACTICE GAP (C2)**

The difference between what is (ACTUAL) and what should be (IDEAL).

What is the current professional practice gap? What are physicians doing (or not doing) that needs to change? Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes. (C2)
Echocardiography is rapidly evolving as a diagnostic modality with indications for more complex procedures. Physicians need regular education in order to keep up with this pace and provide optimal patient care.

**Indicate if the gap is related to need for change in either/or:**
- [x] Knowledge and/or (Doctors do not know that they need to be doing something.)
- [ ] Competence and/or (Doctors do not know how to do it.)
- [ ] Performance and/or (Doctors know how to do it but are noncompliant – or are not doing it properly.)

**DESIRED OUTCOMES (GOAL):** *Answer one or more of the following questions: What are the desired or expected outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”? (C3)*

Physicians competently utilize state-of-the-art echocardiography applications to provide high-quality procedures that are safer, faster, improve patient outcomes, and allow physicians to treat an increasing complex group of patients.

**Indicate what this activity is designed to change.**
- [x] Designed to change competence.
- [x] Designed to change performance.
- [x] Designed to change patient outcomes.

**NEEDS ASSESSMENT RESOURCES – HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply.)**
- [x] Best-practice parameters
- [x] Consensus of experts
- [x] Disease prevention (C12)
- [ ] Joint Commission initiatives (C12)
- [x] Mortality/morbidity statistics
- [x] National Patient Safety Goals
- [x] National/regional data
- [x] New diagnostic/therapeutic modality (C12)
- [x] New or updated policy/protocol
- [x] Patient care data
- [x] Peer review data
- [x] Process improvement initiatives (C16 & 21)
- [x] Regulatory requirement
- [x] Research/literature review
- [ ] Other need identified (Explain): _____________________________

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

The increased use of echocardiography is related to a certain extent to the new available modes (tissue Doppler imaging, strain imaging, speckle tracking imaging, three-dimensional mode, etc.), to the emerging indications (study of myocardial viability and resynchronization, etc.), as well as to the advent of new approaches (intracardiac echo, portable echo, etc.). This fact had a dramatic impact on echocardiography use and potential misuse. Echocardiography must be achievable within a consistent existing framework of clinical standards in current cardiological practice, in order to yield a better clinical outcome, to prevent potential misuse and to preserve resources. [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3914997/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3914997/)

The strengths of echocardiography remain the quantification of cardiac structure and function by a noninvasive technique that is free of ionizing radiation, relatively inexpensive, universally available, and mobile enough to be performed in almost any venue. Efforts must be made to demonstrate that echocardiography quantified parameters correlate with or improve care decisions and outcomes. In particular, the echocardiography community should pursue efforts to satisfy regulatory requirements for establishing the value and practicality of a few select, quantitatively important echocardiographic biomarkers (such as LV ejection fraction and LV mass) by enacting education and policy strategies to ensure their consistency and reproducibility regardless of equipment, patient, or time scanned. [http://asecho.org/wordpress/wp-content/uploads/2013/05/roadmap.pdf](http://asecho.org/wordpress/wp-content/uploads/2013/05/roadmap.pdf)


**EDUCATIONAL OBJECTIVES:** Based on the gaps identified above, what are the learning objectives for this activity? *Describe the performance (or competence or patient outcome) that should change if participants apply what they learn.*

Upon completion of this symposium, participants should be better able to

- Implement evidence-based best practice protocols when assessing patients undergoing echocardiographic studies (i.e., Doppler Hemodynamics, valvular heart disease, cardiomyopathy, pericardial disease, native and prosthetic valve endocarditis, 3D echo, contrast echo, 3D cardiac mechanics, ejection fraction and strain measurements, echo in atrial fibrillation, cardiac remodeling in obesity, congenital heart disease).
- Recognize the usefulness and limitations of imaging techniques, and examine the clinical significance of recent emerging advances in echocardiography research.
- Communicate more effectively within a cross-functional team, following the principles of advanced care management (ACM), to make the vision of value-based care a reality.

**EVALUATION METHODS:** Analyze the overall changes in competence, performance or patient outcomes as a result of this CME activity. (C11)
- [x] Changes in competence. **Evaluation method:** Baptist Health CME evaluation form
Changes in performance. **Evaluation method:** Follow-up survey

*Provide 3-4 statements based on expected performance outcomes to be evaluated. Example: I have implemented the new Baptist Health policy explained in this CME activity.*

Changes in patient outcomes. **Evaluation method:** Review of hospital, health system, public health data, etc.

Impact Assessment questions:

- I apply state-of-the-art echocardiography in the modern echo laboratory in order to optimize clinical decision making.
- I implement evidence-based best practice protocols when assessing patients undergoing echocardiographic studies for most all of the following (Doppler Hemodynamics, valvular heart disease, cardiomyopathy, pericardial disease, native and prosthetic valve endocarditis, 3D echo, contrast echo, 3D cardiac mechanics, ejection fraction and strain measurements, echo in atrial fibrillation, cardiac remodeling in obesity, congenital heart disease).
- I recognize the usefulness and limitations of imaging techniques, and examine the clinical significance of recent emerging advances in echocardiography research.
- I communicate more effectively within a cross-functional team, following the principles of advanced care management (ACM), to make the vision of value-based care a reality.

Commitment to Change Test: ☒Yes ☐No

FACULTY: (Name, specialty and/or title(s), institution(s), city, state. For more than two, include list at end of application.)

---See Attached---

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). Note: When using electronic evaluations, disclosure statements for faculty must be included on course landing pages.

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

☒ Others (i.e., conference coordinator, planning group, etc.)

NON-EDUCATION STRATEGIES: Explain what we (CME or BHSF) are doing – or what we could do – to enhance change as an adjunct to this CME activity. (C17) These would be tactics and tools to facilitate change that go beyond this CME activity. NOTE: Insert this information under course shell>>custom fields>>resources.

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

☒ Other tools or tactics ☒ Explain: **Patient information**

▶ A patient information site dedicated to helping patients and the public better understand heart and circulation ultrasound. Heart and Circulation Ultrasound Experts at the American Society of Echocardiography (ASE).

http://www.intersocietal.org/echo/main/patients.htm

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

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

▶ Intersocietal Accreditation Commission (IAC) Education requirement for physicians and sonographers affiliated with accreditation echo lab.

☑ Yes ☐ No Are we collaborating with internal departments in a purposeful manner to achieve common interests? If yes, describe the collaborative efforts. The BHSF CME Dept offers this course in order that our physicians and sonographers affiliated with our echo labs receive the required education.

COMMERCIAL SUPPORT: ☐ Indicate here if support will come from Baptist Health Foundation’s General Continuing Medical Education Fund.

DATE REVIEWED: May 9, 2016 REVIEWED BY: ☒ Accelerated Approval ☐ Executive Committee

☐ Live Committee

APPROVED: ☒YES ☐NO

☒ Credits: AMA/PRA Category 11 Credits: 1

Continuing Psychology Education Credits: # ☐ N/A

☒ Continuing Dental Education Credits: # ☐ N/A

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

Michael Ozner, M.D., FACC, FAHA

**Symposium Director**

Medical Director, Center for Prevention and Wellness, Baptist Health South Florida
Voluntary Associate Clinical Professor of Cardiology, University of Miami Miller School of Medicine
Miami, Florida

**Biography**  Dr. Ozner is one of America’s leading advocates for heart disease prevention. He is a well-known regional and national speaker in the field of preventive cardiology. Dr. Ozner has frequently appeared in the print, radio and television media including The New York Times, NPR radio and CBS News. He was the recipient of the 2008 American Heart Association Humanitarian Award and has been elected to Top Cardiologists in America by the Consumer Council of America. Dr. Ozner is also the author of The Great American Heart Hoax and Heart Attack Proof. His most recent book, The Complete Mediterranean Diet, was released worldwide April 2014.

Gerard P. Aurigemma, M.D., FAHA, FASE, FACC
Professor of Medicine and Radiology, University of Massachusetts Medical School
Director, Non-Invasive Cardiology, UMass Memorial Medical Center
Worcester, Massachusetts

**Biography**  Dr. Aurigemma has a longstanding interest in applying noninvasive imaging, principally echocardiography and cardiac MR to the study of LV systolic and diastolic function in hypertension, valvular heart disease, and diastolic heart failure. Dr. Aurigemma is the author of over 150 peer reviewed original articles and reviews on LV function and other topics in cardiology, has served as an associate editor of the textbook Cardiology and editor of a monograph on stress echocardiography. He has also served on the editorial board of several cardiology journals, and on the board of directors of the American Society of Echocardiography (ASE). He has served as course director for the ASE Board Review Course for the past ten years and has edited a board exam review CD on behalf of the ASE as well.

Allan L. Klein, M.D.
President, Society of Echocardiography
Director, Pericardial Disease Center
Professor of Medicine, Department of Cardiovascular Medicine
Cleveland Clinic
Cleveland, Ohio

**Biography**  Dr. Klein received his medical degree from McGill University in Montreal, Quebec after completing an undergraduate degree in microbiology and immunology, graduating with honors. While in medical school, he received several scholarships and graduated in the top 10 percent of his class. Dr. Klein completed his clinical training at Mount Sinai Hospital in Toronto and the Royal Victoria Hospital in Montreal. He completed a Cardiology Residency from the University of Ottawa Heart Institute and a Research Fellowship from the Mayo Clinic in Rochester, Minn. He was appointed to Cleveland Clinic in 1989. He is also principal or co-principal investigator for multicenter clinical trials in atrial fibrillation (ACUTE I, ACUTE II, and CLOTS); studies in diastolic function (ADEPT); valvular heart disease (Anorexigens and Valve Disease); and catheter ablation and pulmonary vein flow (ROTEA). Dr. Klein was honored to present the first online video summary of the ROTEA study for the Journal of the American Society of Echocardiography. He has published key articles in such prestigious journals such as New England Journal of Medicine, Lancet, European Heart Journal, Circulation, and the Journal of the American College of Cardiology.

Itzhak Kronzon, M.D., FASE, FACC, FACP, FESC, FAHA
Professor of Cardiology
North Shore LIJ/Hofstra University School of Medicine
Chief, Non Invasive Cardiac Imaging
Department of Cardiovascular Medicine
New York, New York

**Biography**  Dr. Kronzon is world-renowned opinion leader in the area of internal medicine and cardiovascular diseases. He has been the recipient of numerous awards and honors from some of the world’s most prestigious institutions including Avraham Ticho Award in Ophthalmology, Honorable Mention by American Medical Association, Alpha Omega Alpha, NYU School of Medicine, Research Award Finalist, American Society of Echocardiography, Annual Scientific Session, and Henry Neufeld Award for work on Hypertrophic Cardiomyopathy. Prof. Kronzon has been on the Editorial Boards of numerous professional journals such as the Journal of the American College of Cardiology and the Journal of Non-Invasive Cardiology. He published more than 270 original publications in Peer Reviewed Journals, wrote more than 70 book chapters, and was the author of numerous professional editorials and medicine-related abstracts.

Roberto M. Lang, M.D.
Professor of Medicine
Director, Cardiac Imaging
Department of Medicine, Cardiology
University of Chicago Medicine
Chicago, Illinois

**Biography**  Dr. Lang is an internationally renowned cardiologist and specialist in echocardiography, and in the study of heart function using sound waves. Dr. Lang uses his vast knowledge of cardiac imaging techniques to evaluate patients
with a wide variety of heart conditions, including heart failure and valve disease. Dr. Lang is a pioneer in the development of three-dimensional echocardiography, a state-of-the-art method to observe heart function. He is a past president of the American Society of Echocardiography.

Leo Lopez, M.D., FACC, FAAP, FASE
Medical Director, Non Invasive Cardiac Imaging
Associate Director, Division of Pediatric Cardiology
Jack Nicklaus Children’s Hospital
Miami, Florida
**Biography** Dr. Lopez completed his university training at the Johns Hopkins University where he received a Bachelor of Arts in Biophysics in 1982. He then received his Medical Degree at the University of Pennsylvania School of Medicine in 1987. He completed his pediatric residency and pediatric cardiology fellowship at Boston Children's Hospital and Harvard Medical School in 1994, having also completed a year as Chief Fellow and a second additional year as a Senior Advanced Imaging Fellow. He is immediate Past Chair of the American Society of Echocardiography (ASE) Council on Pediatric and Congenital Heart Disease and has served as the President of the Society of Pediatric Echocardiography in the past. He has authored or co-authored over thirty peer-reviewed articles and reviews as well as thirteen book chapters. He is currently co-editing a textbook on Neonatal Cardiology.

Humberto Machado Sr., M.D., FACC, FAHA
Director, Echocardiography Department
Mercy Hospital
Voluntary Associate Clinical Professor of Cardiology, University of Miami Miller School of Medicine
Miami, Florida
**Biography** He is co-founder with Michael Ozner, M.D., of the Greater Miami Society of Echocardiography and its annual symposium, now in its 35th year. He is recertified by the National Board of Echocardiography and has been a consultant and abstract grader for ASE scientific sessions. Dr. Machado has authored a number of publications in the areas of clinical and research cardiology. His current activities in advanced echocardiography involve the application of 3-D echo/polyparametric and 4-D speckle imaging in the E&M of heart failure patients, pulmonary arterial hypertension, resynchronization/ICD therapy, atrial fibrillation, predictors of thromboembolism, 4-D TEE and improved mobile digital networks. Dr. Machado is a graduate of the University of Salamanca, Spain.

Partho P. Sengupta, MD, DM, FACC, FASE
Associate Professor of Medicine
Director, Interventional Echocardiography
Director of Cardiac Ultrasound Research and Core Lab,
The Zena and Michael A. Weiner Cardiovascular Institute
Icahn Mount Sinai School of Medicine
New York, New York
**Biography** Dr. Sengupta graduated as a cardiology fellow from All India Institute of Medical Sciences in New Delhi and then completed his clinical residency and cardiology fellowship from Mayo Clinic Rochester and Arizona respectively. He has over 80 peer-reviewed publications that have focused on the analysis of structure, function, and flow patterns in the cardiovascular system. The primary goal of his research is to detect early stages of cardiovascular disease using state-of-the-art cardiac ultrasound technologies. He is an Associate Editor for the Journal of American College of cardiology: Imaging and has been elected to serves as a Board of Director for the American Society of Echocardiography and as the Chair of the 2013 ASE World Summit on Echocardiography. He has won several excellence awards including ASE's Young Investigator Award in 2004, Mayo Clinic Research Award in 2007, Mayo Brother's Distinguished Fellowship Award in 2009 and AACIO Young Investigator Award in 2010.

**SCHEDULE**

**Friday, September 23 (7.0)**

7:30 a.m.  *Registration, Continental Breakfast and Visit Exhibits*

7:55 a.m.  *Welcome and Opening Remarks*
Michael Ozner, M.D, Humberto Machado, M.D.

**Case-based Approach**

**Moderator:** Michael Ozner, M.D.

8:00 a.m.  *Understanding Doppler Hemodynamics*
Itzhak Kronzon, M.D.

8:30 a.m.  *Morpho-Anatomy of the Mitral Valve: Utility of 3D Echocardiography*
Roberto Lang, M.D.

9:00 a.m.  *Echo in Aortic Stenosis and TAVR: Trends and Challenges*
Partho Sengupta, M.D.

9:30 a.m.  Break and Visit Exhibits

10:00 a.m.  Panel Discussion With Audience Participation: Echo-Oncology: New Frontiers, Renewed Hope
Moderator: Humberto Machado, M.D.
Panel: Gerard Aurigemma, M.D., Roberto Lang, M.D., Allan Klein, M.D., Partho Sengupta, M.D.

10:30 a.m.  “Simple” Adult Congenital Heart Disease
Leo Lopez, M.D.

11:00 a.m.  Diastology 2016: What Do the New Guidelines Say?
Allan Klein, M.D.

11:30 a.m.  Lunch
Moderator: Humberto Machado, M.D.

1:00 p.m.  Left Ventricular Dysfunction: Recognition of the Different Causes and Cardiac Remodeling
Gerard Aurigemma, M.D.

1:30 p.m.  Utility of 3D Echo for the Assessment of the Tricuspid Valve
Roberto Lang, M.D.

2:00 p.m.  Atrial Fibrillation: It is all About the Left Atrial Appendage!
Allan Klein, M.D.

2:30 p.m.  Assessment of Cardiac Deformation Beyond the Left Ventricle
Partho Sengupta, M.D.

3:00 p.m.  Break and Visit Exhibits

3:30 p.m.  Evaluation of the Right Ventricle in Congenital Heart Disease
Leo Lopez, M.D.

4:00 p.m.  Cardiac Remodeling in Obesity
Gerard Aurigemma, M.D.

4:30 p.m.  M-Mode Technique in Today’s Echocardiography
Itzhak Kronzon, M.D.

5:00 p.m.  Adjourn

Saturday, September 24 (4.0)
State-of-the-Art Lectures
Moderator: Humberto Machado, M.D.

7:50 a.m.  Registration, Continental Breakfast and Visit Exhibits

8:20 a.m.  Welcome and Introductions
Michael Ozner, M.D, Humberto Machado, M.D.

8:30 a.m.  Pericardial Disease: Imaging Guided Approach
Allan Klein, M.D.

9:00 a.m.  3D Quantitative Assessment of LV Function: Benefits of the Additional Dimension
Allan Klein, M.D.

9:30 a.m.  Differential Diagnosis of Restrictive Cardiomyopathy versus Constrictive Pericarditis
Partho Sengupta, M.D.

10:00 a.m.  Break and Visit Exhibits

10:30 a.m.  Multimodality Imaging of the Adult with Repaired Transposition of the Great Arteries
Leo Lopez, M.D.

11:00 a.m.  Unusual Cases of Endocarditis
Gerard Aurigemma, M.D.

11:30 a.m.  Chamber Quantification Guidelines: What is New?
Roberto Lang, M.D.

12:00 noon  Future of Echocardiography: The Emerging Paradigm
Partho Sengupta, M.D.

12:30 p.m.  Hemodynamics Without Catheterization: How to Extract All the Data You Need From Routine Doppler
Itzhak Kronzon, M.D.

1:00 p.m.  Adjourn

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

CME ACTIVITY TITLE:  16th Annual Emergency Radiology Symposium:
What You Need to Know to Get You Through the Night

DATE:  Sunday-Wednesday, November 13-16, 2016  LOCATION: Fontainebleau Hotel, Miami Beach, Florida

TIME:  Sunday, 4-7:30 p.m.; Monday-Wednesday, 7:30 a.m.-1 p.m.
SYMPOSIUM DIRECTOR: Myer H. Roszler, M.D.  CREDIT HOUR(S) APPLIED FOR:  18.5 Cat.1

AMA/PRA LEARNING FORMAT:

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

TARGET AUDIENCE: Radiologists, emergency radiologists

REGISTRATION CHARGE:

<table>
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<tr>
<th>Per-day rates</th>
<th>Physicians</th>
<th>Other</th>
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*Groups of three or more physicians who register together are eligible for a discount.

EXPECTED NUMBER OF ATTENDEES:  110-150

LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.

- [ ] ARS
- [ ] Case studies
- [ ] Didactic lecture
- [ ] Enduring material (DVD/booklet)
- [ ] Internet activity enduring material
- [ ] Internet live course (live webcast)
- [ ] Internet point-of-care activity
- [ ] Journal-based CME activity
- [ ] Learning from teaching
- [ ] Live activity
- [ ] Manuscript review activity
- [ ] Panel
- [ ] PI CME activity
- [ ] Question-and-answer
- [ ] Regularly scheduled series
- [ ] Simulation
- [ ] Test item writing activity
- [ ] Other (specify)
COURSE DESCRIPTION: This short summary will be used on course shell. Please note keyword searches will pull from this description.

► Acutely ill adults and pediatric patients are arriving at the emergency room in greater numbers than ever before. This symposium is designed to help radiologists and emergency radiologists maintain optimal competence in the utilization of the most reliable imaging modalities and best-practice strategies, even for unusual conditions. One-third of the lectures will be dedicated to plain films and the remainder will stress state-of-the-art emergency imaging of the central nervous system, chest abdomen and coronary and musculoskeletal systems. This course will be of special interest to physicians in the fields of radiology, emergency radiology and emergency medicine.

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:  □ Noncompliance □ Lifestyle □ Resistance to change □ Cost of care/Lack of insurance  
Physician: □ Noncompliance □ Lifestyle □ Resistance to change □ Communication skills □ Reimbursement issues  
Resources: □ Institutional capabilities □ Physician practice limitations □ Community service limitations  
State of Science: □ Limited or no treatment modalities □ Limited or no diagnostic modalities  
Other: Please describe.

BARRIERS TO PHYSICIAN CHANGE: (C19) Briefly explain how this activity addresses the barriers/factors identified.

► This activity will address the need for ways to support the translation of best practice and provision of treatments with clear evidence-based interventions to optimize imaging utilization that will ultimately improve patient care.

DESIRABLE PHYSICIAN ATTRIBUTES/COMPETENCIES (C6)

ABMS/ACGME: □ Patient care and procedural skills □ Medical knowledge □ Practice-based learning and improvement □ Interpersonal and communication skills □ Professionalism □ Systems-based practice

INSTITUTE OF MEDICINE: □ Provide patient-centered care □ Work in interdisciplinary teams □ Employ evidence-based practice □ Apply quality improvement □ Utilize informatics

INTERPROFESSIONAL EDUCATION COLLABORATIVE: □ Values/ethics for interprofessional practice □ Roles/responsibilities □ Interprofessional communication □ Teams and teamwork

PROFESSIONAL PRACTICE GAP (C2)

The difference between what is (ACTUAL) and what should be (IDEAL).

What is the current professional practice gap? What are physicians doing (or not doing) that needs to change? Describe the current state of knowledge, skill, competence, practice and/or clinical/patient outcomes. (C2)

► Radiologists need to optimize imaging utilization by describing which clinical variables are more predictive of acute disease and, conversely, what combination of variables can obviate the need for imaging.

Indicate if the gap is related to need for change in either/or:

□ Knowledge and/or (Doctors do not know that they need to be doing something.)
□ Competence and/or (Doctors do not know how to do it.)
□ Performance and/or (Doctors know how to do it but are noncompliant – or are not doing it properly.)

DESIGNED OUTCOMES (GOAL): Answer one or more of the following questions: What are the desired or expected outcomes of this conference? What is expected to change or improve as a result of this CME activity? In a “perfect world,” what would doctors be doing if this change were already implemented? What does optimal practice “look like”? (C3)

► Radiologists will determine how to maximize the positive effects of evidence-based interventions on decreasing unnecessary ED imaging while delivering safe, high-quality patient care.

Indicate what this activity is designed to change.

□ Designed to change competence.
□ Designed to change performance.
□ Designed to change patient outcomes.

NEEDS ASSESSMENT RESOURCES – HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply.)

□ Best-practice parameters □ Disease prevention (C12) □ Consensus of experts  
□ Mortality/morbidity statistics □ New or updated policy/protocol □ Joint Commission initiatives (C12)  
□ National/regional data □ Peer review data □ National Patient Safety Goals  
□ New or updated policy/protocol □ Regulatory requirement □ New diagnostic/therapeutic modality (C12)  
□ Patient care data □ Other need identified (Explain): _____________________________
□ Process improvement initiatives (C16 & 21) □ Research/literature review
There are currently numerous evidence-based interventions focused on improving resource utilization for emergency department diagnostic imaging, including clinical practice guidelines, clinical decision instruments, and clinical pathways. Multiple clinical decision instruments have been shown to have high sensitivity and sufficient specificity to safely decrease imaging rates without compromising patient outcomes. Various evidence-based clinical practice guidelines have also been developed to aid emergency department clinicians in certain diagnostic situations to improve resource utilization with regard to emergency department imaging.

References:
► Anna K Sfakianaki, MD, Joshua Copel, MD, Section Editors, Charles J Lockwood, MD, MHCM, Deborah Levine, MD, Deputy Editor, Vanessa A Barss, MD, FACOG. All topics are updated as new evidence becomes available and our peer review process is complete. Literature review current through: Apr 2016. | This topic last updated: Oct 30, 2015.
http://www.uptodate.com
► Pelvic trauma: Initial evaluation and management. Author James Fiechtl, MD, Section Editors. Maria E Moreira, MD, Richard G Bachur, MD, Deputy Editor Jonathan Grayzel, MD, FAAEM. All topics are updated as new evidence becomes available and our peer review process is complete. Literature review current through: Apr 2016. | This topic last updated: Mar 31, 2016.
http://www.uptodate.com
► Initial evaluation and management of blunt abdominal trauma in adults. Authors. Deborah B Diercks, MD, MSc, Samuel Clarke, MD, Section Editor. Maria E Moreira, MD, Deputy Editor. Jonathan Grayzel, MD, FAAEM. All topics are updated as new evidence becomes available and our peer review process is complete. Literature review current through: Apr 2016. | This topic last updated: Jun 29, 2015.
http://www.uptodate.com
► Orthopedic aspects of child abuse. Authors. Susan A Scherl, MD, Erin E Endom, MD, Section Editors. William Phillips, MD, Daniel M Lindberg, MD, Deputy Editor. James F Wiley, II, MD, MPH. All topics are updated as new evidence becomes available and our peer review process is complete. Literature review current through: Apr 2016. | This topic last updated: Jul 17, 2014.
http://www.uptodate.com
► Principles of computed tomography of the chest. Author. Paul Stark, MD, Section Editor. Nestor L Muller, MD, PhD, Deputy Editor. Geraldine Finlay, MD. All topics are updated as new evidence becomes available and our peer review process is complete. Literature review current through: Apr 2016. | This topic last updated: Jun 02, 2015.
http://www.uptodate.com

EDUCATIONAL OBJECTIVES: Based on the gaps identified above, what are the learning objectives for this activity? Describe the performance (or competence or patient outcome) that should change if participants apply what they learn.

Upon completion of this symposium, participants should be better able to:
• Implement the most appropriate imaging technologies and techniques such as CT, ultrasound and MRI to allow prompt assessment of the acutely ill or injured patient presenting to the emergency department.
• Detect important cardiac findings and recognize cardiac pathology and anatomy relevant to emergency department imaging.
• Utilize optimal imaging techniques for various examinations when evaluating acute pelvic pain in the non-pregnant patient and pregnant patient.
• Detect subtle bony fractures in children and infants and differentiate these from adult traumatic lesions.
• Apply continuous high-quality care when evaluating acute ischemic stroke and non-traumatic spine emergencies.
• Identify common etiologies of hip pain in the emergency department, such as femoral acetabular impingement and subtle fractures.
• Recognize subtle radiographic signs of stress and insufficiency fractures and normal variants that present often to the emergency department.

EVALUATION METHODS: Analyze the overall changes in competence, performance or patient outcomes as a result of this CME activity. (C11)
☑ Changes in competence. Evaluation method: Baptist Health CME evaluation form
☐ Changes in performance. Evaluation method: Follow-up survey
Provide 3-4 statements based on expected performance outcomes to be evaluated. Example: I have implemented the new Baptist Health policy explained in this CME activity.
☐ Changes in patient outcomes. Evaluation method: Review of hospital, health system, public health data, etc.
☐ Other______________________

Impact Assessment Questions:
• I now implement the most appropriate imaging technologies and techniques such as CT, ultrasound and MRI.
• I now detect important cardiac findings and recognize cardiac pathology and anatomy relevant to emergency department imaging.
• I now utilize optimal imaging techniques for various examinations when evaluating acute pelvic pain in the non-pregnant patient and pregnant patient.
• I now detect subtle bony fractures in children and infants and I am able to differentiate these from adult traumatic lesions.
• I now apply continuous high-quality care when evaluating acute ischemic stroke and non-traumatic spine emergencies.
• I now identify common etiologies of hip pain in the emergency department, such as femoral acetabular impingement and subtle fractures.
• I now recognize subtle radiographic signs of stress and insufficiency fractures and normal variants that present often to the emergency department.

Commitment to Change Test: ☑ Yes ☐ No

FACULTY: (Name, specialty and/or title(s), institution(s), city, state. For more than two, include list at end of application.)
---See Attached---

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).
Note: When using electronic evaluations, disclosure statements for faculty must be included on course landing pages.

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
☒ Others (i.e., conference coordinator, planning group, etc.) ________________________________

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

NOTE: Insert this information under course shell>>custom fields>>resources.
☐ Process redesign or new protocol ☐ Reminders (posters, mailings, email blasts) ☐ New order sheets
☒ Other tools or tactics Explain: Patient information
► http://www.acr.org/Quality-Safety/Radiology-Safety/Patient-Resources

COLLABORATION: Are we engaged in collaborative and cooperative projects with other stakeholders (internal or external) who 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, describe the collaborative efforts. ______________________________________________________

COMMERCIAL SUPPORT: ☐ Indicate here if support will come from Baptist Health Foundation’s General Continuing Medical Education Fund.

DATE REVIEWED: May 6, 2016 REVIEWED BY: ☑ Accelerated Approval ☐ Executive Committee ☐ Live Committee

APPROVED: ☑ YES ☐ NO ■ Credits: AMA/PRA Category 18.5 Credits: 1
Continuing Psychology Education Credits: # ___ ☑ N/A ■ Continuing Dental Education Credits: # ___ ☐ N/A

Faculty

Myer H. Roszler, M.D.
Symposium Director
Director, Emergency Radiology
Baptist, Homestead and South Miami Hospitals and Baptist Outpatient Services
Miami, Florida

Biography  Dr. Roszler serves as director of Emergency Radiology at Baptist Hospital of Miami, which services one of the busiest ED radiology practices in the country. He is a clinical associate volunteer professor at the University of Miami Miller School of Medicine, and serves as symposium director of the annual Emergency Radiology Symposium.

Previously he was a clinical associate professor of radiology/neurosurgery at Wayne State University, Detroit Receiving Hospital, where he wrote many of the definitive articles on radiology for IV drug abuse, cocaine abuse, trauma and resident education. He was also co-author of the American College of Radiology Educational Syllabus on emergency radiology.

Kevin Abrams, M.D.
Medical Director, Neuroradiology and Magnetic Resonance Imaging
Baptist, Homestead and South Miami Hospitals and Baptist Outpatient Services
Medical Director, Imaging Neuroscience Division
Baptist Hospital of Miami
Voluntary Associate Clinical Professor of Radiology, University of Miami Miller School of Medicine
Clinical Associate Professor of Radiology, Florida International University Herbert Wertheim School of Medicine
Miami, Florida
Biography

Dr. Abrams graduated cum laude from the State University of New York at Stony Brook and received his medical degree from the SUNY Health Science Center at Syracuse. He completed an internship in internal medicine at the University of Connecticut and a diagnostic radiology residency at the Hospital of St. Raphael, a Yale affiliate, where he also served as chief resident. He completed a fellowship in neuroradiology at the University of Miami/Jackson Memorial Hospital. Dr. Abrams has been an attending radiologist at Baptist, South Miami, Homestead, Doctors and West Kendall Baptist Hospitals and Baptist Health’s outpatient facilities, and is medical director of neuroradiology and MRI, as well as chief of radiology, at Baptist Hospital. He is one of the founding members of Baptist Neuroscience Center. Dr. Abrams has conducted research on such topics as spinal imaging, stroke and Alzheimer’s disease. He has published in Neuroradiology, International Journal of Neuroradiology, Cancer Research and American Journal of Radiology.

Dr. Batlle graduated summa cum laude from Duke University before earning a master’s degree in bioethics at the University of Pennsylvania School of Medicine. Concurrently, he took part in an MD/MBA degree program at the university’s Wharton School, graduating with honors. He received numerous awards upon graduation, including the Theodore Friedmann Prize, given to the graduating student who has made the most significant advance in biomedical ethics. Dr. Batlle came to his role as a diagnostic radiologist at Radiology Associates of South Florida from Massachusetts General Hospital (MGH), where he served as a resident physician in the radiology department and a clinical fellow at Harvard Medical School. During his time at the hospital, he spent a year focusing on cardiothoracic imaging, including hands-on supervision of cardiac CT and MRI acquisition and post-processing. He also completed a musculoskeletal fellowship at MGH, specializing in sports medicine, soft tissue and bone tumors, and general musculoskeletal radiology, including musculoskeletal interventional procedures. Dr. Batlle has published numerous abstracts and journal articles, covering several fields of interest, including clinical radiology, informatics, bioethics and health services research. He is fluent in English and Spanish.

Dr. Cury received his medical degree from Santos School of Medical Sciences in São Paolo, Brazil, and completed his residency in diagnostic radiology at Medimagem, Beneficencia Portuguesa Hospital, also in São Paolo. He completed a clinical and research fellowship in cardiovascular imaging at Massachusetts General Hospital/Harvard Medical School, where he was on the clinical staff for four years. He is Board-certified in diagnostic radiology by the American Board of Radiology. Prior to joining Baptist Health, Dr. Cury was on the medical staff at Massachusetts General Hospital and Harvard Medical School in Boston, serving as director of teleradiology and education of cardiac CT, director of clinical cardiac MRI and assistant professor at Harvard Medical School. He has interpreted more than 10,000 coronary CT angiograms and more than 5,000 cardiac MR scans. Dr. Cury is a member of several professional organizations, including the American College of Radiology and the American Heart Association. He is a founding member of the Society of Cardiovascular Computed Tomography and serves on its board of directors. Dr. Cury has written numerous journal articles, including more than 100 original scientific papers in major cardiology and radiology journals, and has lectured throughout the world on cardiac CT.

Dr. Katz has co-authored 737 publications and abstracts, as well as two books. He co-authored 68 award-winning exhibits/posters, including seven poster awards at the Radiological Society of North America’s annual meeting in 2013 and five at its 2014 meeting (one a magna cum laude award), and he was first author of the top poster at the American Society of Emergency Radiology’s 2013 annual meeting. His growing reviewing and editing responsibilities for imaging journals include Consultant to the Editor (essentially, the Conflict of Interest Editor) at Radiology since 2008. He has been a distinguished reviewer for the AJR for the past several years, as well as its top reviewer in volume in 2007-2013 (excluding the paid statisticians). Dr. Katz was the section editor for emergency radiology for the American College of Radiology’s Continuous Professional Improvement (CPI) special module in 2013, and will edit the second version in 2016.

Dr. Peña received an undergraduate degree and an M.S. from Stanford University before receiving his medical degree from Yale University School of Medicine. He completed an internship in internal medicine at Yale-New Haven Hospital and a residency in diagnostic radiology at Massachusetts General Hospital. He also completed a fellowship in vascular intervention at
Massachusetts General Hospital. Dr. Peña has held roles as a clinical assistant in radiology at Massachusetts General Hospital, clinical fellow in radiology at Harvard Medical School, clinical staff member in radiology for vascular imaging and intervention at Massachusetts General Hospital and instructor of radiology at Harvard Medical School. Dr. Peña has been published a number of times, including pieces on adrenal masses, post-transplantation lymphoproliferative disorder of the liver, cervical spine osteoblastoma, liver lesion detection, and surgical conversions from endoluminal aortic aneurysm stent graft repair. In addition to his publications in respected journals such as *Journal of Magnetic Imaging*, *American Journal of Radiology*, *Radiology* and *Korean Journal of Radiology*, Dr. Peña has presented before the American Roentgen Ray Society, Radiological Society of North America and Society of Cardiovascular and Interventional Radiology.

Robert M. Quencer, M.D.
Professor and Chairman
The Robert Shapiro, M.D., Professor of Radiology
University of Miami Miller School of Medicine
Miami, Florida

**Biography**
Dr. Quencer completed his undergraduate studies at Cornell University, his medical degree from Upstate Medical Center, Syracuse (AOA membership in 1966) and his residency at Columbia-Presbyterian Medical Center in New York. Following his residency, he completed an NIH-sponsored fellowship in neuroradiology at the Neurological Institute of New York. Dr. Quencer has published over 150 articles and book chapters in many areas of neuroimaging and has authored two books in neuroradiology. His research interests center mainly on spine imaging, intra-operative neuro-sonography, MR studies of CFS flow and spinal cord injury. He is one of the founding members and former president of the Southeastern Neurological Society (1980-1981). Dr. Quencer was president of the American Society of Neuroradiology in 1994-1995 and served as editor-in-chief of the American Journal of Neuroradiology in 1998-2005. He chaired the Scientific Program Committee of the RSNA in 2008-2010. He has been visiting professor and invited lecturer at many institutions both here and abroad. He was elected Fellow of the American College of Radiology in 1994 and was the recipient of the Gold Medal from the Florida Radiology Society in 2008. In 2007 he received the Gold Medal from the American Society of Neuroradiology.

Leslie M. Scoutt, M.D.
Diagnostic Radiology, Internal Medicine
Yale-New Haven Hospital
New Haven, Connecticut

**Biography**

Leonard Swischuk, M.D.
Professor of Radiology and Pediatrics
Department of Radiology
Director, Pediatric Radiology
University of Texas, Medical Branch at Galveston
Galveston, Texas

**Biography**
Dr. Swischuk graduated from medical school at the University of Alberta in 1960 and completed a radiology residency at the University of Oklahoma in 1968. He moved to the University of Texas’ Medical Branch at Galveston in 1970, where he has been ever since. He found UTMB to be an exceptionally fertile field for his pursuit of patient care, teaching and clinical research. Dr. Swischuk has become a world-renowned pediatric radiologist, who has published more than 300 articles and six textbooks, many of which have been translated into other languages. Two things have made him successful: First, he keeps things simple, especially when teaching; and second, he cuts the frontier. In this regard he has a reputation for always being ahead of the game. Because of these two things, he escalated to the top of his field and to this day remains active and continues to produce new material and ideas via patient care, teaching and clinical research.

Joseph S. Yu, M.D.
Professor, Chief, Musculoskeletal Radiology
Director, Musculoskeletal Radiology Fellowship
Ohio State University
Columbus, Ohio

**Biography**
Dr. Yu obtained his undergraduate and medical degrees from the Ohio State University. After completing a residency in diagnostic radiology at his alma mater, he furthered his training under the tutelage of Dr. Donald Resnick at the University of California, San Diego, in osteoradiology. Since then, he has authored 260 papers, chapters and abstracts, and given 134 national and international lectures. He is the author of the popular *Musculoskeletal Imaging: Case Review*, in its second edition, and was co-editor of the 2008 ARRS categorical course syllabus State-of-the-Art Emergency and Trauma Radiology. He serves on numerous national and international committees in several distinguished radiology societies and has been an advocate of radiology education since the beginning of his career. Most recently, Dr. Yu has been concentrating his research on the imaging of exercise-related injuries in the aging population and has been an active participant in research through the Osteoarthritis Initiative Grants.
Schedule

Sunday, November 13 (3.5)

Body Imaging
3:00 p.m.  Registration and Refreshments
3:55 p.m.  Welcome and introductions
           Myer Roszler, M.D.
4:00 p.m.  Cardiac Imaging for the Emergency Department Radiologist
           Juan Carlos Batlle, M.D.
4:45 p.m.  Coronary CTA: Pearls and Pitfalls
           Ricardo C. Cury, M.D.
5:30 p.m.  Ultrasound Evaluation of Acute Abdominal Pain
           Leslie M. Scoutt, M.D.
6:15 p.m.  CT of the Abdominal “Itises”
           Douglas S. Katz, M.D.
7:00 p.m.  Question-and-Answer Session
7:30 p.m.  Adjourn

Monday, November 14 (5.0)

Body Imaging
7:00 a.m.  Welcome and introductions
           Myer Roszler, M.D.
7:30 a.m.  Incidentalomas in Emergency Abdominal and Pelvic CT: What to Do?
           Douglas S. Katz, M.D.
8:15 a.m.  Ultrasound Evaluation of Acute Pelvic Pain in the Non-Pregnant Patient
           Leslie M. Scoutt, M.D.
9:00 a.m.  Imaging of Non-Appendiceal Causes of the Acute Abdomen in Pregnancy
           Douglas S. Katz, M.D.
9:45 a.m.  Break

Body Imaging
10:15 a.m. Ultrasound Evaluation of Pain and Bleeding in the First Trimester
           Leslie M. Scoutt, M.D.
11:00 a.m. Challenging Acute Abdominal and Pelvic CT Cases
           Douglas S. Katz, M.D.
11:45 a.m. Ultrasound Evaluation of Scrotal Emergencies
           Leslie M. Scoutt, M.D.
12:30 p.m. Question-and-Answer Session
1:00 p.m.  Adjourn

Tuesday, November 15 (5.0)

Musculoskeletal
7:00 a.m.  Welcome and introductions
           Myer Roszler, M.D.
7:30 a.m.  Upper-Extremity Trauma in Children and Infants
           Leonard Swischuk, M.D.
8:15 a.m.  Shoulder Trauma and Instability
           Joseph S. Yu, M.D.
9:00 a.m.  Lower-Extremity Trauma in Children and Infants
           Leonard Swischuk, M.D.
9:45 a.m.  Break

Musculoskeletal
10:15 a.m. Stress and Insufficiency Fractures
           Joseph S. Yu, M.D.
11:00 a.m. Imaging of Child Abuse
           Leonard Swischuk, M.D.
11:45 a.m. Skeletal Normal Variants
           Joseph S. Yu, M.D.
12:30 p.m. Question-and-Answer Session
1:00 p.m.  Adjourn

Wednesday, November 16 (5.0)

Neurological Imaging
7:00 a.m.  Welcome and introductions
           Myer Roszler, M.D.
7:30 a.m.  Stroke Imaging and Intervention
8:15 a.m.  **Non-Traumatic Spine Emergencies**  
Kevin Abrams, M.D.

9:00 a.m.  **Subarachnoid Hemorrhage**  
Robert M. Quencer, M.D.

9:45 a.m.  *Break*

**Miscellaneous**

10:15 a.m.  *Imaging of Mesenteric Ischemia*  
Constantino S. Peña, M.D.

11:00 a.m.  **Abdominal Pain in Infants and Children**  
Leonard Swischuk, M.D.

11:45 a.m.  **Hip Trauma and Pain**  
Joseph S. Yu, M.D.

12:30 p.m.  **Question-and-Answer Session**

1:00 p.m.  *Adjourn*