CONFERENCE APPLICATIONS AND REPORTS
Applications Previously Approved
May 1, 2019 through August 31, 2019

CME ACTIVITY TITLE:  Pediatric Multispecialty Conference: The ENT Overview – Management of the Routine to the Complicated

DATE:  May 14, 2019  TIME:  6 – 7p.m.  CREDIT HOUR(S) APPLIED FOR:  1 Cat. 1

LOCATION:  BHM Auditorium


CONFERENCE DIRECTOR:  Jennifer Cheney, M.D.  CME MANAGER:  Katie Deane

EXPECTED NUMBER OF ATTENDEES:  40-50  CHARGE:  0

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

☐ ARS  ☒ Didactic Lecture  ☐ Live activity  ☐ Manuscript review activity  ☐ Panel
☐ Case Studies  ☐ Enduring Material (DVD/Booklet)  ☐ PI CME activity  ☐ Question & Answer
☐ Internet Activity Enduring Material  ☐ Internet Live Course (Live Webcast)  ☐ Regularly Scheduled Series  ☐ Simulation
☐ Internet point-of-care activity  ☐ Journal-based CME activity  ☐ Test item writing activity  ☐ Other (specify)
☐ Learning from Teaching
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

Pediatric ear, nose and throat (ENT) disorders remain among the primary reasons children visit a physician. Most pediatricians are well prepared to handle common childhood ENT issues, diagnosing, treating and managing a wide range of conditions that impact the airway, voice, hearing, speech and sinuses, but management of the routine can become identification and treatment of the complicated. Pediatricians are called on to offer initial, if not definitive, management of these patients. Join us to hear experts, Dr. Andrew Schell and Dr. Michael Owens present the ENT Overview – Management of the Routine to the Complicated.

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)

► An estimated 1% to 5% of children have sleep-disordered breathing related to obstructive sleep apnea, with a smaller proportion of children having central or mixed sleep apnea. Improved screening for sleep-disordered breathing in the general pediatrics clinic, coupled with effective management strategies, has the potential to have wide-ranging benefits on the patient’s long-term health and development.

Although we now have strong evidence that chronic, unchecked obstructive sleep apnea (OSA) can lead to hypertension, cardiovascular disease, metabolic disorders, obesity, and neuropsychiatric and developmental issues, the full scope of the effect of sleep-disordered breathing (SDB) on health remains underappreciated by many clinicians. (https://pedsinreview.aappublications.org/content/40/1/3?download=true&sso=1&sso_redirect_count=1&nfstatus=401&ntoken=00000000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token)

► Otitis media, a range of inflammatory conditions of the middle ear, is the second most common illness diagnosed in children. However, the diagnosis can be challenging, particularly in pediatric patients. Otitis media is commonly over-diagnosed and over-treated. (https://www.spiedigitallibrary.org/conference-proceedings-of-spie/9689/96892F/A-short-wave-infrared-otoscope-for-middle-ear-disease-diagnostics/10.1117/12.2209719.short?SSO=1)

► As in other disciplines, the burgeoning knowledge in ENT medicine long ago surpassed our ability to adequately absorb it and maintain a proper overview. This can give rise to actual or assumed evidence gaps that can impede the progress of the discipline and evidence-based treatment of patients. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5169083/)

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)

► Physician utilize the clinical practice guidelines for the diagnosis and treatment of common pediatric ENT issues and mitigate the number of complications and comorbidities associated with these issues.

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.)

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<tr>
<th>Resource Type</th>
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<tr>
<td>Best practice parameters</td>
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<td>Disease prevention (C12)</td>
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<td>New diagnostic/therapeutic modality (C12)</td>
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<td>Patient care data</td>
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<td>Process improvement initiatives (C16 &amp; 21)</td>
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<td>Other need identified (Explain): _____________________________</td>
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### References

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

► See below.

### Educational Objectives:

**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:

- See below.

### Evaluation Methods:

**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:

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

Michael Owens, M.D., FACS  
Otolaryngologist  
South Florida ENT Associates  
Baptist Health South Florida
Andrew Schell, M.D.
Otolaryngologist
South Florida ENT Associates
Baptist Health South Florida

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

Michael Owens, M.D. and Andrew Schell, M.D., indicated that neither they nor their spouses/partners has relevant financial relationships with commercial interest companies, and they will not include off-label or unapproved product usage in their presentations or discussions.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.
Sleep Disordered Breathing and the Pediatric Airway

Michael Owens, M.D., FACS

EDUCATIONAL OBJECTIVES:

- Utilize the clinical practice guidelines for the diagnosis of obstructive sleep disorder breathing in children.
- Evaluate treatment options, including risks and benefits, to minimize serious complications from obstructive sleep disorder breathing.

REFERENCES:

► https://pediatrics.aappublications.org/content/pediatrics/130/3/576.full.pdf


► Sleep is central to a healthy childhood, and sleep-disordered breathing (SDB)—the disruption of normal respiratory patterns and ventilation during sleep—is implicated in several behavioral and physical health issues. Although we now have strong evidence that chronic, unchecked obstructive sleep apnea (OSA) can lead to hypertension, cardiovascular disease, metabolic disorders, obesity, and neuropsychiatric and developmental issues, the full scope of the effect of SDB on health remains underappreciated by many clinicians.


Pediatric Sinus and Middle Ear Disease: From Routine Management to Complications

Andrew Schell, M.D.

EDUCATIONAL OBJECTIVES:

- Utilize clinical criteria in the diagnosis, and recognition of potential complications, of pediatric sinusitis and acute bacterial sinusitis.
- Describe the etiology of recurrent middle ear infections and complications of acute otitis media.

REFERENCES:

Otitis media, a range of inflammatory conditions of the middle ear, is the second most common illness diagnosed in children. However, the diagnosis can be challenging, particularly in pediatric patients. Otitis media is commonly over-diagnosed and over-treated and has been identified as one of the primary factors in increased antibiotic resistance. (https://www.spiedigitallibrary.org/conference-proceedings-of-spie/9689/96892F/A-short-wave-infrared-otoscope-for-middle-ear-disease-diagnostics/10.1117/12.2209719.short?SSO=1)


Diagnostic criteria for acute otitis media include rapid onset of symptoms, middle ear effusion, and signs and symptoms of middle ear inflammation. Streptococcus pneumoniae, Haemophilus influenzae, and Moraxella catarrhalis are the most common bacterial isolates from the middle ear fluid of children with acute otitis media. Fever, otalgia, headache, irritability, cough, rhinitis, listlessness, anorexia, vomiting, diarrhea, and pulling at the ears are common, but nonspecific symptoms. Detection of middle ear effusion by pneumatic otoscopy is key in establishing the diagnosis. Observation is an acceptable option in healthy children with mild symptoms. Antibiotics are recommended in all children younger than six months, in those between six months and two years if the diagnosis is certain, and in children with severe infection. (https://pdfs.semanticscholar.org/561e/f4ac5d524650013ee36268e0ca6d01498d87.pdf)

MCI Radiation Oncology Grand Rounds – Every Single Gray Count

DATE: May 10, 2019  TIME: 12 – 1 p.m.  CREDIT HOUR(S) APPLIED FOR: 1 cat. 1

LOCATION: Miami Cancer Institute – Radiation Oncology Conference Room – 1 N 612

TARGET AUDIENCE: Radiation Oncologists, Medical Oncologists, Oncology surgeons and Radiologists

NOTE: Due to limited space, this conference is open to Baptist Health affiliated Medical Staff and Clinical Employees.

CONFERENCE DIRECTOR: Michael D. Chuong, M.D.  CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 0  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 (DVD/Booklet)
- 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.

Gray zone lymphoma is a rare type of lymphoma, cancer of a part of the immune system called the lymph system. It is called "gray zone" lymphoma because it has features intermediate between classical Hodgkin lymphoma and diffuse large B-cell lymphoma. During this conference Dr. Dabaja will update participants on the current techniques used to treat lymphoma. She will also review new indicators in diagnosing lymphoma.
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
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 quite often shy from using radiation and if they do they use large fields and large doses while now we have enough evidence to change both.

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.)

DESIRE 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 implement the use of radiation with high technology which reduces side effects.

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:
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:

- List new entities and indicators for lymphoma.
- Describe new technology and techniques in the treatment of lymphoma.
- Implement best treatment practices to avoid critical organs.

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.)

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

Bouthaina S. Dabaja, M.D.
Professor, Department of Radiation Oncology, Division of Radiation Oncology
The University of Texas MD Anderson Cancer Center
Houston, TX

Clinical Section Chief of Hematology, Department of Radiation Oncology, Division of Radiation Oncology,
The University of Texas MD Anderson Cancer Center
Houston, TX

Bouthaina S. Dabaja, M.D. indicated that neither she nor her spouse/partner have relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).
Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ______________________________________________________________

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: ___________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee
☐ Live Committee

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

Continuing Psychology Education Credits: # ___ ☒ N/A    Continuing Dental Education Credits: # ___ ☒ N/A
CME ACTIVITY TITLE: Diagnosis and Treatment of Vascular Disease in Women

COURSE APPROVAL: June 2019  COURSE EXPIRATION: June 2022

CREDIT HOUR(S) APPLIED FOR: TBD

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

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

Planning Committee Members

- James Benenati, M.D.
- Mrs. Cristina Alvarez
- Ignacio Rua, M.D.

CME MANAGER: Gaby Fernandez (Live)/Marie Vital Acle (Online)

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.
Women with peripheral arterial disease (PAD) are more likely to present without symptoms. As a consequence, their vascular disease has been underdiagnosed and undertreated. As the population ages, the prevalence of PAD will increase significantly. There has been an increased effort to delineate the effects of sex on the clinical burden and risks presented by PAD. Better knowledge of these effects will hopefully result in the development of strategies to achieve sex-specific cardiovascular risk reduction and improvement in overall quality of life for women. Dr. Julie A. Freischlag discusses how to formulate a preventive clinical plan in the management of vascular disease in women.

**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 may be unaware of consider current research that may influence recommendations in the prevention and management of vascular disease in women.

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

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

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

Atherosclerotic cardiovascular disease (ASCVD) is one of the leading causes of morbidity and mortality, accounting for at least one third of deaths in women worldwide. In the United States, almost 48 million women are affected by ASCVD. The
excess mortality from ASCVD in women compared with men has generated much interest in women's cardiovascular health in recent decades. Research studies have demonstrated an increased risk of hospitalization and higher healthcare expenditure among women compared with men with ASCVD. Some studies have also shown that compared with men, women with ASCVD were more likely to experience delays in undergoing lifesaving revascularization procedures, and less likely to undergo cardiac rehabilitation, or receive recommended preventive pharmacotherapies. Major cardiovascular risk factors such as smoking, obesity, and diabetes mellitus also appear to be more deleterious in women than in men. These overwhelming results have led to the intensification of research, focusing on the influence of sex and gender in cardiovascular disease. These efforts have improved the understanding of gender-specific differences in cardiovascular disease and have resulted in an ≈30% reduction in female mortality from ASCVD.

https://www.ahajournals.org/doi/full/10.1161/JAHA.118.010498


Lower extremity peripheral artery disease (PAD) is a growing epidemic, affecting approximately 8 to 12 million individuals in the United States and more than 200 million people worldwide. The prevalence of PAD in women has traditionally been considered to be less than or equal to that of men. However, recent studies demonstrate an expected rise in the total population burden of PAD in women. Yet, PAD remains underdiagnosed in women, and women have been underrepresented in several PAD revascularization trials. The traditional risk factors for development of PAD include diabetes mellitus, cigarette smoking, advanced age, dyslipidemia, and hypertension. Although these conventional risk factors result in PAD development in women similarly as they do in men, a growing body of evidence has demonstrated additional comorbidities that are prevalent in women with PAD, such as depression and inflammation. Such risk factors are not routinely evaluated in PAD studies, and future trials are necessary to determine whether an association exists between these “novel” risk factors and the development of PAD in women. Intermittent claudication is considered the hallmark symptom of PAD, but women may often be asymptomatic or present with atypical symptoms (eg, leg muscle symptoms at rest and with exercise). Also, women with PAD are more likely to be older at presentation compared to their male counterparts, present with critical limb ischemia (CLI), are less likely to undergo surgery, and are more likely to undergo amputations.


(from PPT) -


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:

- Discuss the risk factors, incidence and prevalence of vascular disease in women.
- Recognize the differences in outcomes in women who undergo medical and/or surgical intervention for their vascular disease.
- Formulate a preventive clinical plan to avert vascular disease in women.

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.)

JULIE A. FREISCHLAG, M.D., FACS, FRCSEd, DFSVS
Chief Executive Officer, Wake Forest Baptist Medical Center
Dean, Wake Forest School of Medicine
Winston-Salem, North Carolina

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

Julie A. Freischlag, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Conference Directors and Planning Committee Members

Cristina Alvarez indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies.

James Benenati, M.D., indicated that he is a consultant for Bard and Penumbra. He also owns stock in Penumbra and Scientia.
Barry T. Katzen, M.D., indicated that he is a consultant for Boston Scientific, Philips Medical, W.L. Gore and Bard Medical.

Howard Katzman, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies.

Ignacio Rua, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies.

Others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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. MCVI

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.
DATE REVIEWED: __________ 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

CME ACTIVITY TITLE: Evidence-based Clinical Care: Pulmonary Embolism Clinical Pathway

COURSE APPROVED: September 2018 COURSE REVIEWED: May 2019

COURSE EXPIRES: September 2020

CREDIT HOUR(S) APPLIED FOR: 1 Cat 1
If pursuing nursing credit we will need 10 total MC questions.

CONFERENCE DIRECTOR:  James F. Benenati, M.D. and Ian del Conde Pozzi, M.D.

CME MANAGER: Marie Vital Acle

ADMINISTRATIVE CHAIR: Andrea Marr-Peralto

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.

This course provides practitioners with the standard treatment, diagnostic process and management of pulmonary embolism, as well as the role of a Pulmonary Embolism Response Team (PERT) program.

Andrea wrote the following:

This course provides practitioners with evidence-based practices related to the risk stratification of pulmonary embolism. This includes practices that promote early suspicion, appropriate diagnostic work-up and consensus treatment algorithms specific to the levels of risk, as well as the recognition of the added value of implementing a Pulmonary Embolism (PERT) Team in the process.

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
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)

► Practitioners may not be aware of classification system and treatment of pulmonary embolism (PE) and the role of a Pulmonary Embolism Response Team (PERT) program.

The role of PERT is similar to that of other rapid response teams, such as trauma teams or sepsis teams, bringing a multidisciplinary approach to the complex patient situation to facilitate prompt development of individualized and standard treatment plan.

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)

► Emergency department physicians, Hospitalists, and all Patient Care Providers quickly identify patients at risk for Pulmonary embolism, risk stratify, diagnose and implement a timely and appropriate collaborative treatment strategy, based on the most current, evidenced based guidelines

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
☐ Other need identified (Explain): Evidence-based Clinical Care Roll-Out

☒ Consensus of experts
☐ Joint Commission initiatives (C12)
☐ National Patient Safety Goals
☐ New diagnostic/therapeutic modality (C12)
☐ Patient care data
☒ Process improvement initiatives (C16 & 21)
Pulmonary Embolism (PE) are common, with over half a million cases annually in the United States, causing over 100,000 deaths. PE exists in a spectrum of disease that ranges from small, asymptomatic PE, to massive PE that causes cardiovascular collapse and is associated with mortality rates in excess of 50%-60%. Most clinicians do not have significant expertise in the assessment and rapid risk-stratification of patients with PE. Patients with acute PE who are identified as having increased risk of death and adverse outcomes may be considered for advanced therapies, including catheter-directed therapies, inferior vena cava filters, systemic thrombolyis, or surgical embolectomy.

Bibliography and Additional Resources:

Stavros V. Konstantinides, MD, Stefano Barco, MD, Mareike Lankeit, MD, Guy Meyer, MD (2016) Management of Pulmonary Embolism. JACC, Vol. 67, No. 8, March 1, 2016: 976-990


Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine, Single Volume 10th Edition

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:

- Explain the necessity of system standardization of treatment options for the pulmonary embolism (PE) patient based on current evidence-based practices.
- Distinguish severity levels of PE, including massive, sub-massive and low-risk PE, the corresponding clinical pathways and associated power plans, based on evidence-based practices in the acute care setting.
- Stratify PE patients based on pulmonary thromboembolism (PTE) risk assessment.
- Identify a PE utilizing standardized echocardiogram and imaging criteria and implement appropriate treatment.
- Monitor quality measures associated with the treatment of PE patients.
- Recognize the role of the Pulmonary Embolism Response Team (PERT) and Rapid Response Team (RRT) in the diagnosis and treatment of PE.

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.)

Javier Perez-Fernandez, M.D.
Javier Perez-Fernandez, M.D., has indicated that he has a speaker role with Boehringer Ingelheim, Sunovion and AstraZeneca. Dr. Perez-Fernandez will not include off-label or unapproved product usage in his presentation or discussion.

James Benenati, M.D., has indicated that he is a stockholder with Penumbra and a consultant with Bard Medical and Penumbra.

Ripal Gandhi, M.D., has indicated that he is a consultant with Bard, BTG, Sirtex, Medtronic and Boston SCI.

Adam Geronemus, M.D., has indicated that he is on the speakers bureau with Gore, Bard and Merit.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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.) ☒ MCVI EBCC Pulmonary Embolism Clinical Pathway

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. ☒ MCVI EBCC Educational Roll-out _________________________________
COMMERCIAL SUPPORT: □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External: 676600
Provider: 2018IEM76

Course video: https://cdn.baptisthealth.net/cme/vol01/olp/Pulmonary_Embolism_Javier_9_20_18.mp4

Course handout:

Quiz Questions (proofed by Dorothy and okay by Laura)

1. You are at risk of developing a pulmonary embolism (PE) if you:
   a. Suffer from obesity.
   b. Have had recent surgery.
   c. Smoke.
   d. All of the above.
2. Which of the following statements is not consistent with PE:
   a. PE exists in a spectrum of disease that ranges from small, asymptomatic PE to massive PE that causes cardiovascular collapse and is associated with mortality rates in excess of 50%-60%.
   b. PE usually occurs in conjunction with deep vein thrombosis (DVT).
   c. Most clinicians have expertise in the assessment and rapid risk stratification of patients with PE.
   d. None of the above.
3. Who is at greater risk for PE?
   a. Men.
   b. Women.
   c. Young women.
   d. The risk is the same for men and women.
4. Signs and symptoms of pulmonary embolism can include:
   a. Redness, warmth, tenderness and swelling.
   b. Shortness of breath, chest pain, coughing blood.
   c. Muscle spasms, vertigo, ringing ears.
   d. All of the above.
5. Having a pulmonary embolism includes the risk of:
   a. Sudden death.
   b. Diabetes.
   c. High blood pressure.
   d. Amputation of limbs.
6. What percentage of people who have suffered from a PE are at risk for another PE?
   a. 25%.
   b. 50%.
   c. 75%.
7. Intervention by the PERT team may include:
   a. Catheter-directed lysis.
   b. Surgical or mechanical embolectomy.
   c. Systemic lysis or anticoagulation.
   d. All of the above.

8. What history and physical exam findings are captured in the Wells Criteria for PTE?
   a. Heart rate.
   b. Hemoptysis.
   c. Immobilization.
   d. All of the above.

2 more questions:

1. According to the Diagnostic Algorithm, a D-Dimer blood test is always indicated for the diagnosis of a Pulmonary Embolism?
   True/False (Correct)

2. Which RV/LV ratio on diagnostics would alert a Provider of potential cardiac compromise related to a possible pulmonary embolism?
   a. RV/LV ratio less than 0.9
   b. RV/LV ratio of 0.001
   c. RV/LV ratio greater than 0.9 → Correct
   d. RV/LV ratio of less than 0.8

DATE REVIEWED: ___________ 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
CREDIT HOUR(S) APPLIED FOR: TBD

TARGET AUDIENCE: Urgent Care Physicians

CONFERENCE DIRECTOR: Philip Weimer, M.D.

CONFERENCE COORDINATORS: Yenny Ceballos, APRN, and Bettina Laier, B.A., MSN, R.N., CEN

EXPECTED NUMBER OF ATTENDEES: 0

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)

COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description. Through a case-based approach learners will review transportation available from urgent care centers and determine which method can appropriately handle patients’ emergent needs. This course will also provide a review of changes to transfer forms and documentation requirements to meet EMTALA requirements.

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)

- Urgent Care Physicians may not be aware of EMTALA compliant transfer process to free-standing emergency departments vs. hospital-based emergency departments.

**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)

- Urgent Care physicians utilize transfer forms successfully to ensure patients are appropriately transferred to the correct facility using the appropriate level of transportation.

**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:
CMS is expanding the definition of “emergency department” under EMTALA
Hospital-based urgent care clinics may have EMTALA duty even though those clinics are not equipped to stabilize true emergency medical conditions. If an urgent care clinic cannot provide diagnostic testing and treatment similar to that provided in an emergency department, there may be a duty to transfer patients with potential emergency medical conditions to a formal emergency department. Determinations of potential EMTALA violations are made retrospectively. As with this case—where the patient's pain did not seem to be cardiac-related—retrospective bias will likely affect the determination if a patient suffers a bad outcome (i.e. “Since the patient died from cardiac disease, the atypical chest pain must have represented an emergency medical condition that wasn't stabilized.”). So far, this decision only applies to Rhode Island, but the court’s reasoning may be used by other courts in the future.

Bibliography and Additional Resources: 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:

• Explain how EMTALA applies to Urgent Cares, what the penalties for EMTALA violations entail, and analyze situations to determine if they were in compliance.
• Differentiate between transportation available to the Urgent Care Centers (911, ALS, or BLS) and determine which transportation method is capable of handling patients’ emergent needs.
• Differentiate between transportation available to the Urgent Care Centers (911, ALS or BLS) and determine which transportation method is capable of handling patients’ emergent needs.
• Quickly assess patients presenting with common indicators of transfer and select adequate transfer method in adherence with criteria.
  Identify – based on patient status – when to transfer to a Free-standing Emergency Department versus a hospital emergency department.
• Recognize the most current transfer form and accurately complete each section as required.

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.)
CONTENT CONTRIBUTORS

Bettina Laier, B.A., MSN, R.N., CEN
BOS Clinical Learning Educator

Yenny Ceballos, APRN
Urgent Care
Family Medicine
Baptist Outpatient Services

Philip Weimer, M.D.
Urgent Care Physician
Baptist Outpatient Services

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

Due to the non-clinical nature of the content discussed, the speakers have no relevant financial relationships to disclose.
This CME activity will not cover content that would involve products or services of commercial interests. Therefore, no opportunity exists for a conflict of interest based on the financial relationships of faculty and those persons in control of content. Since these relationships are not relevant, no disclosure information was collected.

Marie Vital Acle, MPH, MCHES
Narrator
Manager, CME Programs and Online Learning

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. BOS – Urgent Care Centers

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:

Provider: 2019IEM155

Course video:

Course handout:

Quiz Questions

Please answer the following questions. You must score 100% to pass the test.

1. When do you need to complete a transfer form? Choose all that apply:
   a. When a patient is sent to a freestanding emergency department (FSED) for further care.
   b. When a patient is sent to the hospital by ambulance for further care.
   c. When a patient is sent to the hospital by 911 rescue.
   d. All of the above.

2. What revision date is on the newest transfer form?
   a. Rev. 8/24/18
   b. Rev. 9/16/18
   c. Rev. 12/11/18
   d. Rev. 1/31/19

3. Which box is checked by the urgent care center physician in Section 3 – “Reason for Transfer”?
   a. Box 1 – Equipment, services and/or capability not available at this facility.
   b. Box 2 – On-call physician at transferring hospital is unavailable.
   c. Box 3 – Patient request. Services available here and offered to the patient.
   d. Boxes 2 and 3.
4. What must you provide to the clinical staff to begin the transfer process?
   a. Clinical notes printed out.
   b. A medical provider order in Cerner.
   c. A prescription.
   d. EKG.

5. For Section 2 on the transfer form, which elements need to be completed and visible on all copies to be considered correctly filled out?
   a. Provider name printed, signature, date and time.
   b. Provider signature and date.
   c. Date, time and provider signature.
   d. Provider printed name, date and time.

6. When a patient enters the facility and requests a medical screening exam:
   a. Triage by the RN is a screening and could suffice for simple things like a wound check.
   b. The medical provider must offer every patient entering an urgent care center a medical screening exam, regardless of the chief complaint.
   c. In a 911 emergency, if the patient remains in the lobby, the medical screening does not need to be documented in the medical record.
   d. The clinical staff can tell the patient that the services he or she wants are not available that day.

7. What information goes with a patient being transferred to another facility?
   a. Transfer form.
   b. Chart (including intake/triage notes, labs, EKGs).
   c. Face sheet.
   d. All of the above.

8. A patient being transferred via ALS unit has a cardiac arrest on the way to the hospital. The ALS staff:
   a. Can perform ACLS procedures without having to pull over to a safe spot.
   b. Has to stop the ambulance to code the patient, since there are only two individuals on the team.
   c. Should keep driving with the lights and sirens on to get to the hospital more quickly.
   d. Should go back to the urgent care center.

9. Some differences between ALS and 911 ambulance units include:
   a. ALS units cannot give patients any medications other than oxygen and IV fluids.
   b. ALS units are staffed by three people and can proceed in a Code Blue without pulling over.
   c. 911 units will provide transport for the same types of illnesses as ALS units.
   d. 911 criteria for transport include STEMI, stroke, trauma and unstable vital signs.

10. If you decide a patient is a candidate for the FSED, what is the next step?
    a. Call the transfer center.
    b. Call the FSED nurse supervisor to discuss the case.
    c. Tell the nurse to get the patient ready for transport.
    d. Send the patient with the FSED transport team.
CME ACTIVITY TITLE: Detecting and Responding to Human Trafficking

COURSE APPROVED: October 2017    COURSE REVIEWED: October 2019

COURSE EXPIRES: October 2022

CREDIT HOUR(S) APPLIED FOR: 2 Cat. 1

TARGET AUDIENCE: Emergency Medicine Physicians, Obstetricians, Gynecologists, Pediatricians, Internists, Family Medicine Physicians, Hospitalists, Psychologists, Nurses, Respiratory Therapists, Social Workers, Clinical Chaplains, Registered Dietitians, Laboratory Personnel and all other interested healthcare providers including front desk personnel.

NOTE: Per Regina Russell this course meets required learning requirements for Nurse Practitioners on Human Trafficking. Please route for Florida Board of Nursing relicensure approval.

CONFERENCE DIRECTOR: Ana M. Viamonte-Ros, M.D., Medical Director, Bioethics & Palliative Care

CME MANAGER: Katie Deane (live)/Marie Vital Acle (Online)

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. Human trafficking is a major public health problem, both domestically and internationally. Health care providers are often the only professionals to interact with trafficking victims who are still in captivity. Recent studies have
demonstrated that up to 50% of trafficking victims in the United States were seen by healthcare professionals while in captivity and were not identified. This course will help guide health care professionals to identify human trafficking victims when they present in the clinical setting. Attendees will learn how to appropriately assess victims and clearly know when and how to report cases to the National Human Trafficking Hotline.

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)*

► Human trafficking is a global and domestic public health crisis. In the United States there are hundreds of thousands of victims of sex and labor trafficking, and Miami is in the top three cities for human trafficking every year. Up to 50% of trafficking victims in the United States were seen by healthcare professionals while in captivity and were not identified. One study revealed that only 13% of emergency medicine physicians felt confident they could recognize a victim of human trafficking, and less than 3% had received training on doing so. Previous research has supported that providing a short, single-session training to clinicians statistically significantly increased knowledge about human trafficking and what to do about a potential victim. These victims are often mistaken for those of domestic violence, intimate partner violence, sexual assault, or human smuggling, and thus go undetected and unreported. Based on the high incidence of human trafficking cases, particularly in the southeast, and the current lack of training, we feel it is crucial for physicians to receive training on recognizing and responding to human trafficking.

**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)*

► Healthcare providers and all others engaged in patient care are aware of the red flags and indicators for victims of human trafficking. Healthcare providers will recognize victims, understand and empathize with them, build rapport, and empower them to self-report trafficking or allow the healthcare provider to do so on their behalf. Optimal practice would involve these steps as well as thorough knowledge on how to report trafficking, the appropriate hotline, and local resources and appropriate referrals to protect and rehabilitate the victim.

**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
- Consensus of experts
- Joint Commission initiatives *(C12)*
- National Patient Safety Goals
- New diagnostic/therapeutic modality *(C12)*
- Patient care data
Peer review data  □ Process improvement initiatives (C16 & 21)

☐ Regulatory requirement  □ Other need identified (Explain): _____________________________

☐ Research/literature review

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


► The US Department of State estimates that there are between 4 and 27 million individuals worldwide in some form of modern slavery. Recent studies have demonstrated that 28% to 50% of trafficking victims in the United States encountered health care professionals while in captivity, but were not identified and recognized.

Human trafficking has long been recognized as an important issue in the legal, law enforcement, and social service disciplines. However, HT is also an important health care issue12–15 as health care professionals are important for recognizing, caring for, and referring trafficking victims.3,6,12,16–20 Trafficking victims experience a range of physical and psychological health problems resulting from the risks to health involved with trafficking,3,4,12–23 including dangerous workplace conditions, physical and emotional abuse, inhumane living conditions, poor sanitation, inadequate nutrition, and delay in seeking medical care.


► Although most medical trainees and physicians place importance on knowing about human trafficking, they lack knowledge about the scope of the problem, and most would not know where to turn if they encountered a trafficking victim. There exists a need for standardized trafficking education for physicians, residents, and medical students.


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:

- Identify victims of human trafficking who present in the clinical setting
- Differentiate victims of human trafficking from other crimes such as domestic abuse, intimate partner violence and sexual assault.
- Conduct an appropriate medical assessment of trafficking victims.
- Identify when to report cases of human trafficking, and appropriately report to the National Human Trafficking Hotline.

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.)

Amara Fazal, Chika Nwosu, Valerie Polcz, M.S.
Medical Students, Florida International University Herbert Wertheim College of Medicine
Miami, Florida

Ana M. Viamonte-Ros, M.D.
Medical Director, Bioethics & Palliative Care
Baptist Health South Florida
Associate Dean for Women in Medicine and Science
Florida International University Herbert Wertheim College of Medicine
Miami, Florida

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

Ana M. Viamonte-Ros, M.D., Amara Fazal, Chika Nwosu and Valerie Polcz, M.S., have all indicated that neither they nor their spouses/partners have relevant financial relationships with commercial interest companies, and they will not include off-label or unapproved product usage in their presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

**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
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 course has been planned collaboration with Florida International University Herbert Wertheim College of Medicine ________

Commercial Support: ☐ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

Date Reviewed: October 20, 2017 REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee ☐ Live Committee

Approved: ☐ Yes ☐ No Credits: AMA/PRA Category 1 Credits: # 1.5

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

CME Activity Title: MCI Oncology Academic Educational Series: Pharmacology of Early Stage Breast Cancer

Date: Tuesday, May 28, 2019 Time: 12noon – 1p.m. Credit Hour(s) Applied For: 1 Cat. 1

Location: MCI – 3N110

Target Audience: Oncology Nurses, Oncologists, Radiation Oncologists, Hematology Oncologists, Radiation Therapists, Social Workers, Patient Navigators and other interested healthcare providers.

Conference Director: Minesh Mehta, M.D. CME Manager: Eleanor Abreu

Expected Number of Attendees: 0 Charge: 0
LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.

- [ ] ARS
- [ ] Case Studies
- [x] 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.

A treatment plan is a summary of your cancer and the planned cancer treatment. It is meant to give basic information about your medical history to any doctors who will care for you during your lifetime. During this conference, Irene Arias, Pharm.D., will review the literature supporting therapeutic treatment options. Ms. Arias will also help participants understand adverse events associated with therapy and their 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:  
- [x] Noncompliance  
- [x] Lifestyle  
- [ ] Resistance to change  
- [x] Cost of care/Lack of insurance

Physician: 
- [x] Noncompliance  
- [x] Resistance to change  
- [ ] Communication skills  
- [x] Reimbursement issues

Resources:  
- [x] Institutional Capabilities  
- [x] Physician Practice Limitations  
- [x] 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:  
- [x] Patient care and procedural skills  
- [x] Medical knowledge  
- [x] Practice-based learning and improvement  
- [ ] Interpersonal and communication skills  
- [ ] Professionalism  
- [ ] Systems-based practice

INSTITUTE OF MEDICINE:  
- [x] Provide patient-centered care  
- [x] 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 need to have a working knowledge about pharmacology in early-stage breast cancer to minimize the impact of the impairments on function and quality of life in persons with cancer and cancer survivors.

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 appropriate pharmacology treatment options for early stage breast cancer.

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

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

Breast cancer (BC) is the most common cancer in women, and the second most frequent cause of cancer-related deaths in women worldwide. It is a heterogeneous disease composed of multiple subtypes with distinct morphologies and clinical implications. Quantitative systems pharmacology (QSP) is an emerging discipline bridging systems biology with
pharmacokinetics (PK) and pharmacodynamics (PD) leveraging the systematic understanding of drugs’ efficacy and toxicity. Despite numerous challenges in applying computational methodologies for QSP and mechanism-based PK/PD models to biological, physiological, and pharmacological data, bridging these disciplines has the potential to enhance our understanding of complex disease systems such as BC. In QSP/PK/PD models, various sources of data are combined including large, multi-scale experimental data such as -omics (i.e. genomics, transcriptomics, proteomics, and metabolomics), biomarkers (circulating and bound), PK, and PD endpoints. This offers a means for a translational application from pre-clinical mathematical models to patients, bridging the bench to bedside paradigm. Not only can these models be applied to inform and advance BC drug development, but they also could aid in optimizing combination therapies and rational dosing regimens for BC patients. Here, we review the current literature pertaining to the application of QSP and pharmacometrics-based pharmacotherapy in BC including bottom-up and top-down modeling approaches. Bottom-up modeling approaches employ mechanistic signal transduction pathways to predict the behavior of a biological system. The ones that are addressed in this review include signal transduction and homeostatic feedback modeling approaches. Alternatively, top-down modeling techniques are bioinformatics reconstruction techniques that infer static connections between molecules that make up a biological network and include (1) Bayesian networks, (2) co-expression networks, and (3) module-based approaches. This review also addresses novel techniques which utilize the principles of systems biology, synthetic lethality and tumor priming, both of which are discussed in relationship to novel drug targets and existing BC therapies. By utilizing QSP approaches, clinicians may develop a platform for improved dose individualization for subpopulation of BC patients, strengthen rationale in treatment designs, and explore mechanism elucidation for improving future treatments in BC medicine.

http://ovidsp.dcm1.ovid.com/sp-3.33.0b/ovidweb.cgi?&S=MEIDFPFNCCACLCKHPDKIGKIPNJAA00&Complete+Reference=S.sh.67%7c1%7c1&Counter5=SS_view_found_complete%7c28735000%7cmedf%7cmedline%7cmed13&Counter5Data=28735000%7cmedf%7cmedline%7cmed13

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:

- Describe treatment options in early-stage breast cancer based on molecular biomarkers.
- Explain the literature supporting therapeutic treatment options.
- Summarize common adverse events associated with therapy and their 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 2, include list at end of application.)
Faculty disclosure statement (as it should appear on course shell):

Irene Arias, Pharm.D., BCOP
Miami Cancer Institute

Irene Arias, Pharm.D., BCOP indicated that he receives book royalties from Demos Medical Publishers and Elsevier Medical Publishers, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ____________________________________________________________

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: _______________ REVIEWED BY: ☐Accelerated Approval  ☐ Executive Committee
CME ACTIVITY TITLE: Conversations in Ethics - Caring for the Mentally ILL Patient in an Acute Care Setting

DATE: Friday, June 21, 2019  TIME: 12 noon – 1pm  CREDIT HOUR(S) APPLIED FOR: 1.0 Cat. 1

LOCATION: BHM Auditorium

VIDEO CONFERENCED: HH Mango & Pineapple RM; MH- Exec. Conf. Rm; DH Valencia Side A & B;

LIVE WEBCAST

TARGET AUDIENCE: Physicians, Psychologists, Physician Assistants, Nurse Practitioners, Nurses, Social Workers, Respiratory Therapists, Clinical Chaplains, Pharmacists, Medical Students, Registered Dietitians and other interest healthcare professionals.

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH

CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN, Director, Bioethics Program

CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 50-60  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
- [x] Internet Live Course (Live Webcast)
- [ ] Internet point-of-care activity
- [ ] Journal-based CME activity
- [ ] Learning from Teaching
- [ ] Live activity
- [ ] Manuscript review activity
- [ ] Panel
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

The identification and treatment of the mentally ill in an acute care setting frequently presents significant challenges for the provider. Whether the question is to assess the risk to self or to others in an emergency department presentation or the capacity of a patient to make end of life decisions in a critical care unit, the provider is called to make decisions that involve not only clinical issues but also legal and ethical considerations. Unfortunately, our state ranks quite high in the prevalence of mental illness. This makes the presentation of a mentally ill patient to our care a frequent occurrence. Please join us as Dr. Ana Rivas-Vazquez discusses different complex patient care situations and treatments for the psychologically compromised patient.

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)

► Most of the problems that have bedeviled psychiatric epidemiology since its inception remain unresolved. In particular, until epidemiologists develop adequate methods to measure mental illnesses in community populations, the policy contributions of this field will not be fully realized. (https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1468-0009.2011.00645.x)

► Risky behaviors are a leading cause of preventable morbidity and mortality, yet behavioral counseling interventions to address them are underutilized in healthcare settings. Research on such interventions has grown steadily, but the systematic review of this research is complicated by wide variations in the organization, content, and delivery of behavioral interventions and the lack of a consistent language and framework to describe these differences.

Few studies directly address this question, so evidence addressing whether changing individual behavior improves health outcomes and whether behavioral counseling interventions in clinical settings help people change those behaviors must be linked.

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)

► Healthcare professionals utilize behavioral interventions that facilitate the medical treatment of their psychologically compromised patients.

► Health care systems are natural settings for interventions to improve health behaviors for many individuals because repeated contacts typically occur over a number of years. Interventions to help patients change unhealthy behaviors, like treatments for patients with chronic disease, often require repetition for modest effects over time. Continuity of care offers opportunities to sustain individual motivation, assess progress, provide feedback, and adjust behavior change plans. (https://www.sciencedirect.com/science/article/pii/S0749379702004154)

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?

(Choice 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): _Bioethics Committee Requested_

### REFERENCES

Supporting the current practice and/or the optimal practice and/or practice gap:


- ► Nguyen et al (2017) The State of Mental Health in America 2018
  [https://www.mentalhealthamerica.net/sites/default/files/2018%20The%20State%20of%20MH%20in%20America%20-%20FINAL.pdf](https://www.mentalhealthamerica.net/sites/default/files/2018%20The%20State%20of%20MH%20in%20America%20-%20FINAL.pdf)

### 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:

- Differentiate an emotional condition induced by a medical condition or substance use from one indicative of underlying psychopathology.
- Assess patients’ competence to make medical decisions as well as the need to invoke the Baker Act or the Marchman Act.
- Utilize behavioral interventions that would facilitate the medical treatment of their psychologically compromised 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 2, include list at end of application.)

Ana A. Rivas-Vazquez, Ph.D., FAClinP
Diplomate in Clinical Psychology
American Board of Professional Psychology
Baptist and South Miami Hospitals

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

Pending Disclosure Statement

**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. *The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.*
COMMERCIAL SUPPORT: □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

<table>
<thead>
<tr>
<th>DATE REVIEWED:</th>
<th>REVIEWED BY:</th>
<th>□ Accelerated Approval</th>
<th>□ Executive Committee</th>
<th>□ Live Committee</th>
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APPROVED: □ YES □ NO □ Credits: AMA/PRA Category 1 Credits: # 1
Continuing Psychology Education Credits: # 1 □ N/A □ Continuing Dental Education Credits: # □ N/A

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

CME ACTIVITY TITLE: Hyperglycemic Crisis: What’s New, What’s Not and What’s Next?

COURSE APPROVED: November 2017 COURSE RENEWED: May 2019

COURSE EXPIRES: November 2021

CREDIT HOUR(S) APPLIED FOR: 1.0 Cat. 1

TARGET AUDIENCE: Hospitalists, Internists, Family Practitioners, Emergency Medicine Physicians, Surgeons, Cardiologists, Endocrinologists, Podiatrists, Nurses, Pharmacist, Dietitians and other interested healthcare practitioners.

CONFERENCE DIRECTOR: J. Arturo Fridman, M.D. CME MANAGER: Eleanor Abreu (Live)/Marie Vital Acle (Online)

LEARNING FORMAT: Must be appropriate to achieve objectives and desired results (C5). Check all that apply.
□ ARS □ Enduring Material (DVD/Booklet)
□ Case Studies □ Internet Activity Enduring Material
□ Didactic Lecture □ Internet Live Course (Live Webcast)
COURSE DESCRIPTION: This course provides a review of diabetic ketoacidosis and hyperglycemic hyperosmolar syndrome emphasizing that severity of the hyperglycemic crisis should guide choice of therapy.

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)

► Providers may not be aware of the newer hyperglycemic crisis - diabetic ketoacidosis (DKA) and hyperosmolar hyperglycemic state (HHS) guidelines in their care of patients with these conditions in acute care settings. These including changes in dosing recommendations, use of subcutaneous insulin therapy for select patients, and criteria for resolution of DKA. In addition, the challenge of transitioning from intravenous insulin to subcutaneous insulin still exists and new studies support novel approaches to improve this critical period during the care of a patient with insulin deficient diabetes following resolution of ketoacidosis.

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 diagnosis and triage based on severity; proper dosing and titration of insulin infusion therapy; administration of potassium-containing fluids proactively and considering the onset of action and duration of a subcutaneous insulin when transitioning from insulin infusion therapy. Also, it is important to recognize risk factors for recurrent DKA and address them.

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): _____________________________
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:

- Apply updated guidelines in the management of patients in a hyperglycemic crisis.
- Utilize a triage system to determine best location of care and therapeutic approach for patients during a hyperglycemic crisis.
- Discuss method to address risk factors for recurrent diabetic ketoacidosis (DKA) prior to discharge.

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.)

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

Marie E. McDonnell, M.D.
Chief, Diabetes Section, Division of Endocrinology, Diabetes and Hypertension
Harvard Medical School
Director, Diabetes Program
Brigham and Women’s Hospital
Boston, Massachusetts

Marie E. McDonnell, M.D., indicated that neither she nor her spouse/partner have relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).
Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ________________________________________________

Hospital administration, PI Departments, Hospitalist leadership and BHSF community health education centers continue to wage the battle to control blood sugar in both the inpatient and community settings. This CME Symposium addresses concerns, challenges and goals of these internal stakeholders.

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

DATE REVIEWED: May 15, 2019 REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee
☐ Live Committee

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

Continuing Psychology Education Credits: # ___ ☑ N/A ☐ Continuing Dental Education Credits: # ___ ☐ N/A
CME ACTIVITY TITLE: Review of Rapid Diagnostic Tests for Infectious Diseases

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

COURSE APPROVED: October 2017       COURSE REVIEWED: May 2019
COURSE EXPIRES: October 2021


CONFERENCE DIRECTOR: Jennifer Cheney, M.D.       CME MANAGER: Katie Deane (Live)/Marie Vital Acle (Online)

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 & 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 that keyword searches will pull from this description. Bacterial, viral and fungal infections are often clinically indistinguishable and cannot be managed appropriately without the aid of diagnostic tests. Molecular diagnostics are increasingly being used for the rapid and accurate establishment of a microbial cause of infections. Dr. Pablo Marcelo Laufer will discuss the importance of promptly diagnosing the infection, identifying the pathogen utilizing appropriate diagnostic tools available, and administering effective treatments in a timely fashion.

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)

► Whether caring for an individual patient with an infectious disease or responding to a worldwide pandemic, the rapid and accurate establishment of a microbial cause is fundamental to quality care. Despite dramatic advances in diagnostic technologies, many patients with suspected infections receive empiric antimicrobial therapy rather than appropriate therapy dictated by the rapid identification of the infectious agent.

In this IDSA policy paper, we review the current diagnostic landscape, including unmet needs and emerging technologies, and assess the challenges to the development and clinical integration of improved tests.


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 provide timely and accurate diagnosis of infectious diseases to their pediatric patients by utilizing appropriate diagnostic technology.

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

☑ Consensus of experts

☐ Disease prevention (C12)

☐ Joint Commission initiatives (C12)

☐ Mortality/morbidity statistics

☐ National Patient Safety Goals

☐ National/regional data

☐ New diagnostic/therapeutic modality (C12)

☐ New or updated policy/protocol

☐ Patient care data

☐ Peer review data

☐ Process improvement initiatives (C16 & 21)

☐ Regulatory requirement

☐ Other need identified (Explain): _____________________________
Research/literature review

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

► Molecular diagnostics are increasingly used in the blood bank industry. A device that can combine simultaneous detection of multiple targets with the flexibility of inclusion of emerging pathogens is desirable for testing blood products. Results from coded samples demonstrated no false positives among the plasma or whole blood specimens. Ninety-five percent of virus-positive samples were correctly identified. These results show that a high-throughput OpenArray PCR platform can be expanded and adapted for higher discrimination and newly emerging agents, enabling consideration for development as a next-generation device for testing blood products.


► The survival rate of septic patients mainly depends on a rapid and reliable diagnosis. A rapid, broad range, specific and sensitive quantitative diagnostic test is the urgent need.


► The tests available to detect invasive candidiasis have important limitations; accurate diagnosis may require multiple tests. We obtain blood cultures of adequate volume from all patients with suspected invasive candidiasis, and other specimens for culture or biopsy as indicated (eg, scrapings from the base of pustules for Gram stain and culture, biopsy of skin or other focal lesions for culture, fungal stains, and histopathologic examination).

A blood culture positive for Candida is the reference standard for the diagnosis of candidemia. Historically, the sensitivity of blood cultures in detecting invasive candidiasis was relatively low (approximately 50 percent). With newer automated blood culture systems and weight-based recommendations for obtaining appropriate volumes of blood for culture, the rate of detection likely is improved. Candida in a blood culture should prompt immediate treatment and a search for the source (eg, central venous catheter, gastrointestinal tract, deep-seated infection). (https://www.uptodate.com/contents/candidemia-and-invasive-candidiasis-in-children-clinical-manifestations-and-diagnosis?source=search_result&search=diagnostic%20tools%20available%20for%20timely%20diagnosis%20of%20Invasive%20Candidemia&selectedTitle=2~150)

► Bacterial and viral infections are often clinically indistinguishable and cannot be managed appropriately without the aid of diagnostic tests. Rapid diagnostic tests (RDTs) can be used at the point of care to guide appropriate treatment and reduce the risk of antimicrobial resistance (AMR). Developing RDTs that can be used at different levels of the healthcare system for syndromes with multiple aetiologies is complex and challenging, but promising technologies are in the pipeline.


► Accurate identification of persons recently infected with Mycobacterium tuberculosis (MTB) is critical for tuberculosis (TB) control because they are at greatest risk for progression to active disease in 1 to 2 years. Two diagnostic methods exist for latent TB infection (LTBI): the historic and widely used tuberculin skin testing (TST) and the newer interferon-γ release assays (IGRAs). Both tests measure host immunity to MTB antigens, representing an indirect “immunologic footprint” of past infection rather than direct microbial presence; however, neither predicts persons at high risk for progression (1). Current guidelines by the Centers for Disease Control and Prevention consider these tests equivalent for diagnosis of LTBI (2), but several discrepancies challenge whether they can indeed be used interchangeably.Collins, L. F., Geadas, C., &
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:

- Describe and effectively implement evidence-based tools to achieve timely diagnoses of common infectious diseases presenting in the pediatric emergency department.

- Recognize when interferon gamma release assays (IGRA) are indicated to diagnose/rule out Tuberculosis.

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.)

Pablo Marcelo Laufer, M.D.

Pediatric Infectious Diseases Specialist

Baptist Hospital

Nicklaus Children’s Hospital

Miami, Florida

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

Pablo Marcelo Laufer, M.D. indicated that neither he nor his spouse/partner have relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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

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

DATE REVIEWED: May 15, 2019 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

CME ACTIVITY TITLE: Evidence-based Clinical Care: Cesarean Section and Vaginal Delivery

COURSE APPROVED: November 3, 2017
COURSE UPDATED: May 2019

COURSE EXPIRES: May 2022

CREDIT HOUR(S) APPLIED FOR: .50 Cat. 1  

NOTE: May 2019 Credit Revised to .75 Cat 1

TARGET AUDIENCE: Obstetricians and Gynecologists

CONFERENCE DIRECTOR: Jason James, M.D.

CME MANAGER: Marie Vital Acle

EXPECTED NUMBER OF ATTENDEES: 0  

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)

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

This course will address the implementation of Baptist Health standardization efforts for vaginal delivery and Cesarean section. Obstetricians and gynecologists are essential partners to implementing these systemic changes. Processes addressed include the postpartum discharge process, primary elective cesarean section, bishop score screen, labor management protocols and new standardized macrosomia criteria.

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)

► As part of standardization efforts and to eliminate variance in delivery of care throughout Baptist Health vaginal delivery and Caesarean rates have been reviewed and systemwide protocols developed to address these variances. The purpose of this course is to educate practitioners on systemwide, evidenced-based protocols that have been designed to reduce clinical variation and thereby reduce overall cesarean section rate at BHSF. In addition, obstetricians may not be aware that there are new vaginal delivery length of stay protocols that will affect patients stay at Baptist Health facilities.

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)

► Practitioners implement systemwide protocols developed to address variances and deliver optimal patient care consistently throughout Baptist Health.

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): _____________________________
In 2011, one in three women who gave birth in the United States did so by cesarean delivery. Although cesarean delivery can be life-saving for the fetus, the mother, or both in certain cases, the rapid increase in the rate of cesarean births without evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused. These findings suggest that other potentially modifiable factors, such as patient preferences and practice variation among hospitals, systems, and health care providers, likely contribute to the escalating cesarean delivery rates. C-sections save lives — when needed. But the enormous variation in rates, with very little variation in outcomes, shows that a great many of them aren’t necessary. In the last 15 years, the rate of C-section has gone up by 50 percent in the United States. According to Jeffrey Ecker, chairman of the American Congress of Obstetricians and Gynecologists’ committee on obstetric practice, that rise “has not been paralleled by any important fall in rates of things like cerebral palsy” — in other words, outcomes that C-sections are often performed to prevent. C-sections themselves pose some risks to babies, and can create serious complications for mothers, such as hemorrhage, infection and post-partum depression. Having a first baby by C-section leaves a woman with a 90 percent chance that subsequent births will be by C-section as well. And with each C-section, the risk of serious complications rises. Safe prevention of the primary cesarean delivery. American Journal of Obstetrics and Gynecology. 2014; 210(3): 179-193.

Research used by the Evidence Based Clinical Care Team to inform the development of the module.

Evidence Based Research:


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:

- Implement systemwide standardization efforts to improve postpartum discharge process and reduce overall vaginal delivery length of stay while maintaining optimal patient outcomes.
- Educate patients on the risks and benefits of primary elective cesarean section vs. vaginal delivery and consistently complete necessary documentation in Baptist Health electronic medical record.
- Adhere to bishop score screening tool for elective induction in order to schedule patients at Baptist Health facilities.
- Implement consistent labor management protocols to reduce adverse events and likelihood of Cesarean sections.
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.)*

Jason S. James, M.D.
Chief, Dept of Ob/Gyn, Baptist Hospital of Miami
Medical Director, FemCare Ob-Gyn, Miami

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

Jason James, M.D., indicated that neither he nor his spouse/partner have relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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.) Design Committee Disclosures.

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. This course is planning in collaboration with the EBCC department in support of EBCC committee standardization efforts.

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

(Ethos Content) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

Medical Errors
Update on Domestic Violence

<table>
<thead>
<tr>
<th>DATE REVIEWED: November 6, 2017 ; May 2019</th>
<th>REVIEWED BY: ☑ Accelerated Approval ☐ Executive Committee</th>
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<tr>
<td>Continuing Psychology Education Credits: # ☐ N/A</td>
<td>Continuing Dental Education Credits: # ☐ N/A</td>
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Baptist Health South Florida

CONTINUING MEDICAL EDUCATION ACTIVITY APPLICATION

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

CME ACTIVITY TITLE: Hyperglycemic Crisis: What’s New, What’s Not and What’s Next?

COURSE APPROVED: November 2017                COURSE RENEWED: May 2019

COURSE EXPIRES: November 2021

CREDIT HOUR(S) APPLIED FOR: 1.0 Cat. 1

TARGET AUDIENCE: Hospitalists, Internists, Family Practitioners, Emergency Medicine Physicians, Surgeons, Cardiologists, Endocrinologists, Podiatrists, Nurses, Pharmacist, Dietitians and other interested healthcare 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 course provides a review of diabetic ketoacidosis and hyperglycemic hyperosmolar syndrome emphasizing that severity of the hyperglycemic crisis should guide choice of therapy.

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
**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)

Providers may not be aware of the newer hyperglycemic crisis - diabetic ketoacidosis (DKA) and hyperosmolar hyperglycemic state (HHS) guidelines in their care of patients with these conditions in acute care settings. These including changes in dosing recommendations, use of subcutaneous insulin therapy for select patients, and criteria for resolution of DKA. In addition, the challenge of transitioning from intravenous insulin to subcutaneous insulin still exists and new studies support novel approaches to improve this critical period during the care of a patient with insulin deficient diabetes following resolution of ketoacidosis.

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 diagnosis and triage based on severity; proper dosing and titration of insulin infusion therapy; administration of potassium-containing fluids proactively and considering the onset of action and duration of a subcutaneous insulin when transitioning from insulin infusion therapy. Also, it is important to recognize risk factors for recurrent DKA and address them.

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: The hyperglycemic emergencies, diabetic ketoacidosis (DKA) and hyperglycemic hyperosmolar state (HHS) are potentially fatal complications of uncontrolled diabetes mellitus. The incidence of DKA and the economic burden of its treatment continue to rise, but its associated mortality rate which was uniformly high has diminished remarkably over the years. This improvement in outcome is largely due to better understanding of the pathogenesis of hyperglycemic emergencies and the application of evidence-based guidelines in the treatment of 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:

- Apply updated guidelines in the management of patients in a hyperglycemic crisis.
- Utilize a triage system to determine best location of care and therapeutic approach for patients during a hyperglycemic crisis.
- Discuss method to address risk factors for recurrent diabetic ketoacidosis (DKA) prior to discharge.

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.)*

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

Marie E. McDonnell, M.D.
Chief, Diabetes Section, Division of Endocrinology, Diabetes and Hypertension
Harvard Medical School
Director, Diabetes Program
Brigham and Women’s Hospital
Boston, Massachusetts

Marie E. McDonnell, M.D., indicated that neither she nor her spouse/partner have relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).
Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ______________________________________________________

Hospital administration, PI Departments, Hospitalist leadership and BHSF community health education centers continue to wage the battle to control blood sugar in both the inpatient and community settings. This CME Symposium addresses concerns, challenges and goals of these internal stakeholders.

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

DATE REVIEWED: May 15, 2019 REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee
☐ Live Committee

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

Continuing Psychology Education Credits: # ___ ☐ N/A ■ Continuing Dental Education Credits: # ___ ☐ N/A
CME ACTIVITY TITLE: MCI Oncology Academic Educational Series: Pharmacology in Cancer Care

DATE: Saturday, June 8  TIME: 11a.m. – 4p.m.  CREDIT HOUR(S) APPLIED FOR: 4.25 Cat. 1

LOCATION: Miami Cancer Institute – Café

TARGET AUDIENCE: Oncology Nurses, Oncologists, Radiation Oncologists, Hematology Oncologists, Radiation Therapists, Social Workers, Patient Navigators and other interested healthcare providers.

CONFERENCE DIRECTOR: Minesh Mehta, M.D.  CME MANAGER: Eleanor Abreu

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

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

This course is designed to provide evidence-based medication management strategies for antineoplastic, biotherapy, immunotherapy and targeted therapy. The goal of this session is to prepare and reinforce critical information for safe preparation, administration and care management for the patient receiving these therapies.

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 need to have a working knowledge about pharmacology in early-stage cancer to minimize the impact of the impairments on function and quality of life in persons with cancer and cancer survivors.

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.)

DESIRE 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 appropriate pharmacology treatment options for early stage cancer.

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:

Hydromorphone is a more potent opioid analgesic than morphine and is used for moderate to severe pain. It can be administered by injection, by infusion, by mouth, and rectally. Oral bioavailability is low. The kidney excretes hydromorphone and its metabolites. Some metabolites may have greater analgesic activity than hydromorphone itself but
are unlikely to contribute to the pharmacological activity of hydromorphone. With the exception of pruritus, sedation and nausea and vomiting, which may occur less after hydromorphone than after morphine, the side-effects of these drugs are similar. On a milligram basis hydromorphone is five times as potent as morphine when given by the oral route, and 8.5 times as potent as morphine when given intravenously.

Supportive Care in Cancer March 2001, Volume 9, Issue 2, pp 84–96 | Cite as
https://link.springer.com/article/10.1007/s005200000183

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:

- Recite drug class, mechanisms, renal/hepatic, common side effects and major highlights.
- Describe common mechanisms.
- Discuss practical aspects or preparation, dosing, administration, adverse events, precautions and contradictions.

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.)

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

Queen O. Ibekweh, Pharm.D., BCPS, BCOP

Queen O. Ibekweh, Pharm.D., BCPS, BCOP indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Nicholas K. Chow, Pharm.D., BCOP
Nicholas K. Chow, Pharm.D., BCOP indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. 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. ______________________________

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

(EHTOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: _________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee
☐ Live Committee

APPROVED: ☐ YES ☒ NO ■ Credits: AMA/PRA Category Credits: # 1
CME ACTIVITY TITLE: MCI Oncology Academic Educational Series: Pharmacology in Cancer Care

DATE: Saturday, June 8 TIME: 11a.m. – 4p.m. CREDIT HOUR(S) APPLIED FOR: 4.25 Cat. 1

10:30 – 10:50a.m. Registration
10:50 – 11:00 a.m. Introductions
11:00 – 12:30p.m. Pharmacology in Cancer Care, Part I
12:30 – 1:00 p.m. Lunch
1:00 – 2:30 p.m. Pharmacology in Cancer Care, Part II
2:30 – 2:45 p.m. Break
2:45 – 4:00 p.m. Pharmacology in Cancer Care, Part III
4:00 p.m. Adjourn

CME ACTIVITY TITLE: Conversations in Ethics – Ethical and Legal Implications: Appointment of the Wrong Proxy

DATE: Friday, August 16, 2019 TIME: 12 noon – 1 p.m. CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: MH-Main Conference Room
VIDEO CONFERENCED: BHM 5 MCVI Side-A; WKBH Cl. 4 & 5; SMH Cl.-F
LIVE WEBCAST

TARGET AUDIENCE: Physicians, Psychologists, Physician Assistants, Nurse Practitioners, Nurses, Social Workers, Respiratory Therapists, Clinical Chaplains, Pharmacists, Medical Students, Registered Dietitians and other interest healthcare professionals.

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH
CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN, Director, Bioethics Program
CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 50-60 CHARGE: 0

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

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

Healthcare providers are often faced with the appointment of Proxy for a patient, when there is no advance directives completed. Feelings of trepidation is common amongst healthcare providers as many times they are discussing life-saving or end of life decisions with these individuals, without an advance directive. Understanding the appointment of Proxy in the State of Florida will alleviate and ensure that the Florida Statutes are honored and followed. This presentation will provide clarity in the process of the Appointment of Proxy in addition to understanding their breadth and power as it relates to the Healthcare Decision making process within the Acute Care Hospital Setting.

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)

► Prior to the 20th century, healthcare providers could do little to alter the course of many serious diseases or injuries, but people are now able to live for prolonged periods with conditions that would have proven rapidly fatal prior to the advent of modern medical technologies. However, in some cases this means living with disabilities, cognitive deficits, persistent symptoms, and some form of ongoing support. Given that there is no consensus as to when such life-sustaining treatments should be provided, patient preference is an important factor in these medical decision-making situations.1,41 When the patient cannot make decisions, the healthcare provider must discuss end-of-life issues with surrogate decision makers.30 This requires that the healthcare provider identify an appropriate surrogate decision maker. (https://www.consultant360.com/articles/surrogate-decision-making-medical-and-legal-implications-healthcare-providers)

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)

► Healthcare professionals identify appropriate proxy decision makers for incapacitated patients and have effective communications through shared decision-making to provide optimum patient care.

► Effective communication between healthcare providers, individuals, and their surrogates is needed to ensure that individuals’ wishes at the end of life are honored.4 This is a complex process and no one individual can anticipate all of the decisions that will have to be made. A shared decision-making model implemented early in treatment with surrogates and healthcare providers working together to more effectively prepare for and tackle the profound issues surrounding benefits and burdens of treatment on behalf of an individual is important. This entails frequent and open communication that occurs in stages, with the ultimate objective of setting goals of care and determining what aspects of care the individual would feel were acceptable or unacceptable based on expected outcomes.4 It is likely that this process would enhance patient autonomy by increasing the sharing of information about the patient’s desires, the various treatment options, and their potential outcomes. Additionally, it could potentially decrease the risk of liability, as it allows for surrogates and healthcare providers to share decision making around jointly established goals of care. (https://www.consultant360.com/articles/surrogate-decision-making-medical-and-legal-implications-healthcare-providers)

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
☒ Consensus of experts
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:

- Outline the proxy appointment process in accordance with Florida State law.
- Describe the power of the appointed Proxy.
- Recognize the clinical and legal implications of appointing the wrong Proxy.

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

Jennifer Company-Rivero, LCSW, MHSA
Supervisor, Department of Case Management
Baptist Hospital of Miami

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

Due to the non-clinical nature of the content discussed, the speakers have no relevant financial relationships to disclose.

This CME activity will not cover content that would involve products or services of commercial interests. Therefore, no opportunity exists for a conflict of interest based on the financial relationships of faculty and those persons in control of content. Since these relationships are not relevant, no disclosure information was collected.

Non-clinical content: All activities that are considered non-clinical must be vetted by the Department Director. If there is no opportunity to affect the content of CME concerning the products or services of a commercial interest, then there can be no relevant financial relationships or conflicts of interest. Both the following statements must apply. Reference SOP “Disclosures for Activities with Non-Clinical Content” for further instructions and necessary steps to ensure compliance.

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

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. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.
COMMERCIAL SUPPORT: □  Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: ___________  REVIEWED BY:  □  Accelerated Approval  □  Executive Committee  □  Live Committee

APPROVED: □  YES  □  NO  ■  Credits: AMA/PRA Category 1 Credits: # _1
Continuing Psychology Education Credits: # _1  □  N/A  ■  Continuing Dental Education Credits: # ___ □  N/A

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

CME ACTIVITY TITLE: Interstitial Lung Disease Case Review Conference

DATE/TIME:  2019-2020 Dates, Fourth Tuesday of each month, 7:30-8:30 a.m.  LOCATIONS: MCVI Conf. Room at SMH

July 23  January 28  June 23  November 24
August 27  February 25  July 28  December 22
September 24  March 25  August 25
October 22  April 28  September 22
November 26  May 26  October 27

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

CONFERENCE DIRECTOR and Moderator: Jacky Bruce Blank, M.D.  (No Disclosures)
Coordinator: Mikki Thompson, RRT, MHA, FAARC (No Disclosures)
Contact: Michele Dalce

PROMOTION: Include on Calendar, Email Blasts – BHSF Medical Staff and Employees only.

Overview:
The complexities of interstitial lung disease presents challenges to obtain a confident diagnosis. The proper evaluation always requires laboratory, clinical and radiological context for a relevant and clinically useful diagnosis. This activity provides the multidisciplinary team with a discussion forum to review interesting interstitial lung disease cases and formulate optimal patient care strategies by translating evidence into practice.
TARGET AUDIENCE: Pulmonologists, Rheumatologists, Pathologists, Radiologists, Primary Care Physicians, Physician Assistants, Nurse Practitioners, Respiratory Therapists, Nurses, Pharmacists, Occupational Therapist, Radiologic Technologists and other interested healthcare professionals.

EXPECTED NUMBER OF ATTENDEES: 10-15  CHARGE: 0

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

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

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

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

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

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

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

Other: __________________________________________________________________________

PROFESSIONAL PRACTICE GAP (C2)

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

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

Physicians are currently not involved in a “community of practice” activity to discuss new knowledge in the context of previous and current experiences and translate the “new learnings” into clinical practice.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
Baptist Health physicians and healthcare professionals will participate regularly in a clinical review educational activity to remain current with up-to-date information on evidence-based practice and research findings.

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

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

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

► Baptist Health pulmonologists, rheumatologists, pathologists, radiologists, primary Care physicians will formulate new optimal patient care strategies in interstitial lung disease by translating evidence into practice.

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

► Adults learn most effectively when faced with meaningful problems they need to solve. Health professionals reflect on past experiences to frame important personal learning questions, reflection on action. They then seek information, including colleagues' experiences. And think about how to apply it. When subsequently faced with a similar situation, health professionals then consider the applicability of the newly learned information, reflection in action, 3. Constructivist theories posit that learning occurs as individuals actively assimilate new knowledge with previous experience; 4 social learning theories hold that knowledge is shaped by interactions with respected others in similar environments or situations. Therefore it seems that case reviews, structured as social learning activities for discussing new knowledge in the context of previous and current experience, could lead to new learnings that might translate into clinical practice.

Case-based, reflective, interactive sessions are more likely to impact practice than traditional didactic sessions. They allow individuals to share evidence, ideas, tacit (“how to”) knowledge, and practical experience in a safe environment for continuous learning. [http://www.jcehp.com/vol28/2803price.asp](http://www.jcehp.com/vol28/2803price.asp)

South Miami Hospital COPD Committee Assessment of the 2016-2017 Series Impact in Patient Care:
- Started to meet every other month, we meet every month; from 6 times a year to 12 times a year
- Cases started out as 3 per meeting at every other month = 3X6 18 cases presented
- Cases 3/meeting at 12 meetings = 36 cases
- Added an outside physician who oversees Miami Transplant Institute
- Protocols for treatment are discussed and the presenting physician takes this in to account to treat their patient

**EDUCATIONAL OBJECTIVES:**

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

- Review results from various clinical, pathological and radiological interstitial lung disease cases.
- Implement evidence-based strategies into clinical practice to improve care of the lung disease patient.
COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)

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

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

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

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

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

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

Moderator:

Jacky B. Blank, M.D.
Moderator
Critical Care Physician, Pulmonologist and Internal Medicine Specialist
South Miami Hospital

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

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

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

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

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

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

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

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

Explain: _______________________________________________________________________________________

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

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

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

________________________________________

DATE REVIEWED: May 20, 2019 REVIEWED BY: ☒ Executive Committee ☐ Chairman

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

Continuing Psychology Education Credits: # __ ☐ N/A Continuing Dental Education Credits: # ___ ☐ N/A
CME ACTIVITY TITLE: Conversations in Ethics – Ethical and Legal Implications: Appointment of the Wrong Proxy

DATE: Friday, August 16, 2019  TIME: 12 noon – 1 p.m.  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: MH-Main Conference Room
VIDEO CONFERENCED: BHM 5 MCVI Side-A; WKBH Cl. 4 & 5; SMH Cl.-F
LIVE WEBCAST

TARGET AUDIENCE: Physicians, Psychologists, Physician Assistants, Nurse Practitioners, Nurses, Social Workers, Respiratory Therapists, Clinical Chaplains, Pharmacists, Medical Students, Registered Dietitians and other interest healthcare professionals.

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH
CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN, Director, Bioethics Program
CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 50-60  CHARGE: 0

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

- Case Studies  - Live activity
- 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
- 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.

Healthcare providers are often faced with the appointment of Proxy for a patient, when there is no advance directives completed. Feelings of trepidation is common amongst healthcare providers as many times they are discussing life-saving or end of life decisions with these individuals, without an advance directive. Understanding the appointment of Proxy in the State of Florida will alleviate and ensure that the Florida Statutes are honored and followed. This presentation will provide clarity in the process of the Appointment of Proxy in addition to understanding their breadth and power as it relates to the Healthcare Decision making process within the Acute Care Hospital Setting.

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)

► Prior to the 20th century, healthcare providers could do little to alter the course of many serious diseases or injuries, but people are now able to live for prolonged periods with conditions that would have proven rapidly fatal prior to the advent of modern medical technologies. However, in some cases this means living with disabilities, cognitive deficits, persistent symptoms, and some form of ongoing support. Given that there is no consensus as to when such life-sustaining treatments should be provided, patient preference is an important factor in these medical decision-making situations. When the patient cannot make decisions, the healthcare provider must discuss end-of-life issues with surrogate decision makers. This requires that the healthcare provider identify an appropriate surrogate decision maker.

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)

► Healthcare professionals identify appropriate proxy decision makers for incapacitated patients and have effective communications through shared decision-making to provide optimum patient care.

► Effective communication between healthcare providers, individuals, and their surrogates is needed to ensure that individuals’ wishes at the end of life are honored. This is a complex process and no one individual can anticipate all of the decisions that will have to be made. A shared decision-making model implemented early in treatment with surrogates and healthcare providers working together to more effectively prepare for and tackle the profound issues surrounding benefits and burdens of treatment on behalf of an individual is important. This entails frequent and open communication that occurs in stages, with the ultimate objective of setting goals of care and determining what aspects of care the individual would feel acceptable or unacceptable based on expected outcomes. It is likely that this process would enhance patient autonomy by increasing the sharing of information about the patient’s desires, the various treatment options, and their potential outcomes. Additionally, it could potentially decrease the risk of liability, as it allows for surrogates and healthcare providers to share decision making around jointly established goals of 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 and explain below.)

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

- Outline the proxy appointment process in accordance with Florida State law.
- Describe the power of the appointed Proxy.
- Recognize the clinical and legal implications of appointing the wrong Proxy.

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.)

Jennifer Company-Rivero, LCSW, MHSA
Supervisor, Department of Case Management
Baptist Hospital of Miami
Faculty disclosure statement (as it should appear on course shell):

Due to the non-clinical nature of the content discussed, the speakers have no relevant financial relationships to disclose.

This CME activity will not cover content that would involve products or services of commercial interests. Therefore, no opportunity exists for a conflict of interest based on the financial relationships of faculty and those persons in control of content. Since these relationships are not relevant, no disclosure information was collected.

| Non-clinical content: All activities that are considered non-clinical must be vetted by the Department Director. If there is no opportunity to affect the content of CME concerning the products or services of a commercial interest, then there can be no relevant financial relationships or conflicts of interest. Both the following statements must apply. Reference SOP “Disclosures for Activities with Non-Clinical Content” for further instructions and necessary steps to ensure compliance. |
| CME Activity content is not related to products or services of commercial interests. |
| CME Activity content is non-clinical. |

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. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.
<table>
<thead>
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<th>Reviewed By: □ Accelerated Approval □ Executive Committee □ Live Committee</th>
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<tr>
<td>APPROVED:</td>
<td>□ YES □ NO □ Credits: AMA/PRA Category 1 Credits: # 1</td>
</tr>
<tr>
<td>Continuing Psychology Education Credits: # 1 □ N/A □ Continuing Dental Education Credits: # □ N/A</td>
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CME ACTIVITY TITLE: Proton Therapy Cooperative Group North America (PTCOG-NA) Sixth Annual Conference: New Frontiers in Proton Therapy

DATE: October 14-16, 2019    TIME: Schedule below    CREDIT HOUR(S) APPLIED FOR:  16.5 Cat. 1

LOCATION: Hilton Miami Dadeland, Miami, Florida

TARGET AUDIENCE: Radiation oncologists, medical physicists, dosimetrists and radiation therapists.

CONFERENCE DIRECTORS: Michael Chuong, M.D., Minesh Mehta, M.S., Eugen Hug, M.D. (PTCOG-NA Pres.)

CME MANAGERS: Isabel Rodriguez Morgan, Linda Santos

EXPECTED NUMBER OF ATTENDEES: 170

CHARGE: 0

Rates Depend on Registration Dates

- Early Bird Registration Through August 8, 2019
- Regular Registration August 9-September 23, 2019
- Late Registration September 24-October 14, 2019
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 Oral presentations of original contributions

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

PTCOG-NA will explore New Frontiers in Particle Therapy at its Sixth Annual Conference in Miami. The 2019 conference brings together radiation oncologists, medical physicists, dosimetrists and radiation therapists to advance their expertise on the latest clinical applications, outcomes and physics and biology experiences with particle therapy. Internationally renowned experts will discuss best-practice proton therapy approaches and the latest evidence-based proton treatment planning for specific diseases and disease sites.

The setting and format allow physicians, physicists and dosimetrists to learn in a relaxed environment with plenty of opportunity for interaction with faculty, peers, poster presenters and exhibitors to expand the clinical knowledge base of proton therapy for cancer treatment. Attendees will have the opportunity to tour the state-of-the-art Miami Cancer Institute Proton Therapy Center, and a Miami City Night evening option will be provided.

Days one and two (Monday and Tuesday) will consist of morning and afternoon talks with lunches and breaks at the new Hilton Miami Dadeland, adjacent to Miami Cancer Institute. Day three (Wednesday) will be similar, with midday adjournment. The schedule provides attendees with the opportunity to spend a weekend enjoying and exploring Greater Miami and the Beaches prior to the PTCOG-NA opening session. See the Venue section for details about nearby attractions.

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: Limitations on insurance coverage; limitations on trials.
**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 understanding and use of proton therapy continues to evolve as our understanding of patient outcomes increases. Technological advances have allowed more complex treatment planning and delivery.

**Identified Practice and Competency Gaps:**

a. Proton therapy teams must consistently explore new approaches for incorporating the known physical and biological characteristics of proton therapy into advanced radiation treatment planning

b. An assessment of existing proton therapy clinical trials is warranted to determine effectiveness, efficiency and relevance and identify needed improvements.

c. The proton therapy center team needs stay up to date on:
   - New clinical outcomes data to further their competencies about new indications, patient outcomes and toxicities.
   - Recent innovations in treatment delivery as well as medical and accelerator physics.
   - New findings of the biologic underpinnings of particle therapy.

**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)*
Participants will apply best practice in proton therapy candidate selection by recognizing maximum opportunity for toxicity reduction and/or tumor control probability improvement. This will be a result of investigators’ shared experiences surrounding emerging data, new and ongoing initiatives and challenges while focusing on new frontiers in proton 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 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 best practices and/or gaps in practice and/or competencies


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)

As a result of attending this conference, participants should be better able to

- Maintain best practice in proton therapy candidate selection by recognizing maximum opportunity for toxicity reduction and/or tumor control probability improvement.
- Appropriately identify patient candidates for clinical trials and employ resources to overcome barriers to improve enrollment probability.
- Determine where and when to implement advanced treatment planning approaches such as Monte Carlo, relative biological effectiveness (RBE), and linear energy transfer (LET).
- Consider limitations of proton therapy and recognize when applications of dual modality or non-proton therapy are indicated to achieve optimal patient outcomes.

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: See list below

DISCLOSURES: The following individuals are serving in the role(s) of speaker, planner, moderator, content reviewer and/or abstract reviewer.

These individuals have indicated that neither they nor their spouse/partner have relevant financial relationships with commercial interest companies.

William Hartsell, M.D.; Daniel Indelicato, M.D.; Anita Mahajan; R. Charles Nichols, M.D.

These individuals have disclosed the nature of their relevant financial relationships with commercial interest companies as listed below. Baptist Health CME leadership has worked with these individuals to eliminate and/or resolve potential conflicts of interest.

- Chris Beltran, Ph.D. - Grant/Research Support: Varian Medical Systems, Google/Deep Mind
- Michael Chuong, M.D. - Grant/Research Support: AstraZeneca Pharmaceuticals; Speaker’s Bureau: Accuray, Sirtex, ViewRay
- Marcio Fagundes, M.D. - Consultant: Augmenix
- Steven Frank, M.D. - Grant/Research Support: Hitachi, Elekta, Eli Lilly; Consultant: Varian; Employee/Owner: C4 Imaging; Stock Shareholder: Breakthrough Chronic Care; Other Financial/Material Support: Augmenix
- Minesh Mehta, M.D. - Consultant: Celgene, Tocagen, Abbvie, AstraZeneca; Board of Directors: Oncoceutics; Medical Advisory Boards: Colby, Stemina, Procertus
- Charles Simone, M.D. - Speaker’s Bureau: Varian Medical Systems
- Kevin Teo, Ph.D. - Grant/Research Support: Varian Medical Systems

https://www.clinicalkey.com/#/content/playContent/1-s2.0-S0167814018302779?returnurl=null&referrer=null
Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant relationships with commercial interest companies.

**PENDING (do not post – we will update)**

Hesham Gayar, M.D. PENDING
Alonso Gutierrez PENDING
Eugen Hug, M.D. PENDING
Rachel Jimenez, M.D. PENDING
Nancy Mendenhall, M.D. PENDING
Jim Metz, M.D. PENDING
Carl Rossi PENDING

**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, through the Miami Cancer Institute, is collaborating with PTCOG-NA, the North American chapter of the international Particle Therapy Cooperative Group, to enhance collaboration between investigators and practitioners, and provides a platform for scientific exchange and development of treatment guidelines, education and training initiatives for particle therapy.**

**COMMERCIAL SUPPORT:** ☒ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.
(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: ___________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee ☐ Live Committee

APPROVED: ☐ YES ☐ NO ■ Credits: AMA/PRA Category 1 Credits: # 16.5

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

PRELIMINARY SCHEDULE

New Frontiers in Proton Therapy
Monday, October 14 – Wednesday, October 16, 2019 | Hilton Miami Dadeland, Miami, Florida

DAY 1 - Monday, October 14, 2019
07:00  Continental Breakfast - Visit Exhibits & Posters
07:45  Welcome – Opening Remarks
08:00  KEYNOTE LECTURE 1 - GI Oncology: An Emerging Frontier | Michael Chuong
EDUCATIONAL SESSION 1 - Toxicity is the Difference-Maker (08:30-11:00 with break at 09:30)
08:30  Proton Therapy is all about Reducing Late Toxicity
       ▪  The Pediatric Experience | Torunn Yock
       ▪  At the Heart of the Matter | Rachel B. Jimenez
9:30   Break - Visit Exhibits & Posters
10:00  Proton Therapy is all about Reducing Acute Toxicities
       ▪  Head and Neck | Stephen Frank
       ▪  Bowel and GI Toxicities | Chip Nichols
11:00  PANEL SESSION: Challenges of Incorporating Proton Therapy into Cooperative Group
       Clinical Trials and Practical Hurdles of Proton Studies | Bill Hartsell, Nancy Mendenhall, Daniel Ma and Wally Curran invited pending confirmation
12:00  Lunch
*Industry Product Theater One (30 minutes) - Optional session concurrent with lunch*

13:00  Original Contribution Session 1

14:30  KEYNOTE LECTURE 2 – Improving Dosimetric Precision: Clinical Implementation of Dual Energy CT for PT Planning | Kevin Teo

15:00  INVITED LECTURE – Multi-organ toxicity Prediction Approach for Proton Planning | Soren Bentzen

15:30  Adjourn Day 1 Educational Sessions

15:30  Break - Visit Exhibits & Posters

16:00  Mentor-led Poster Walk

17:00  Depart for Miami Cancer Institute (15 minute walk - Please indicate during registration if transportation is needed.)

17:30 – 19:00  Reception and Tour – Miami Cancer Institute Proton Therapy Center
DAY 2 - Tuesday, October 15, 2019

07:00   Continental Breakfast - Visit Exhibits & Posters
        Industry Product Theater Two (30 minutes) - Optional session concurrent with breakfast

07:00   PTCOG-NA Executive Committee Meeting - by invitation

08:00   RBE/LET Planning: A Realistic Assessment, Pros and Cons | Chris Beltran and Daniel Indelicato

08:45   Original Contribution Session 2

10:15   Break - Visit Exhibits & Posters

EDUCATIONAL SESSION 2 - Emerging Clinical Data (10:45-11:45)

10:45   Protons & Cognition | Rupesh Kotecha

11:15   Lung Cancer Conundrum | Charles Simone

11:45   Lunch
        Industry Product Theater Three (30 minutes) - Optional session concurrent with lunch

12:45   Original Contribution Session 3

14:15   Challenging Cases with Audience Participation – Miami Cancer Institute: Protons are not a Panacea | Michael Chuong, Marcio Fagundes, Alonso Gutierrez, Minesh Mehta, Fazal Khan

15:00   Break - Visit Exhibits & Posters

15:30   Original Contribution Session 4

17:00   INVITED LECTURE - Hyperthermia and Protons: Is this the safe way to get the “Carbon Effect”? | Zeljko Vujaskovic

17:30   Adjourn Day 2

18:00   Depart - City Night Miami (Optional)

DAY 3 – Wednesday, October 16, 2019

07:00   Continental Breakfast, Visit Exhibits & Posters

07:30   KEYNOTE LECTURE 3 – FLASH | Jim Metz

08:00   PTCOG-NA General Assembly Meeting, All Members

08:45   Original Contribution Session 5

10:15   Break - Visit Exhibits & Posters

10:30   Original Contribution Session 6

12:00   Closing Remarks & Adjourn

12:30   PTCOG-NA Post-Conference Executive Committee Meeting – By Invitation (1 hour)

Faculty

Chris J. Beltran, Ph.D.  Rochester, Maryland
Associate Professor of Medical Physics
Mayo Clinic School of Medicine Rochester, Maryland

Steven J. Frank, M.D.
Professor of Radiation Oncology
University of Texas MD Anderson Cancer Center Houston, Texas

Soren M. Bentzen, Ph.D., DMSc
Medical Director, MD Anderson Proton Therapy Center
Professor, Epidemiology and Public Health
Radiation Oncology
University of Maryland School of Medicine

Walter J. Curran, Jr., MD, FACR, FASCO invited as of 052019
Lawrence W. Davis Chair, Department of Radiation Oncology
Executive Director, Winship Cancer Institute of Emory University
Atlanta, Georgia

Daniel Indelicato, M.D.
Associate Professor
University of Florida Department of Radiation Oncology
Gainesville, Florida

Rachel B. Jimenez, MD
Associate Program Director
Harvard Radiation Oncology Residency Program
Massachusetts General Hospital
Boston, Massachusetts

Fazal Kahn, CMD
Supervisor, Dosimetry
Miami Cancer Institute
Miami, Florida

Rupesh Kotecha, M.D.
Radiation Oncologist
Miami Cancer Institute
Miami, Florida

Daniel J. Ma, M.D.
Radiation Oncologist
Mayo Clinic
Rochester, Maryland

Nancy Mendenhall, M.D., FASTRO
Professor, Department of Radiation Oncology
Associate Chair, Department of Radiation Oncology
Medical Director, University of Florida Proton Therapy Institute
Jacksonville, Florida

James M. Metz, MD
Chair, Radiation Oncology
Henry K Pancoast Professor
Executive Director, OncoLink
Hospital of the University of Pennsylvania
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Philadelphia, Pennsylvania

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New York, New York

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Philadelphia, Pennsylvania

Zeliko Vujaskovic, M.D., Ph.D.
Professor, Radiation Oncology
Director, Division of Translational Radiation Sciences
University of Maryland School of Medicine
Baltimore, Maryland

Torunn I. Yock, M.D., MCH
Professor, Harvard Medical School
Director, Pediatric Radiation Oncology
Department of Radiation Oncology
Massachusetts General Hospital
Boston, Massachusetts

CONFERENCE PLANNING GROUP

Michael D. Chuong M.D.
Radiation/Hematologist Oncologist
Miami Cancer Institute
Miami, Florida

Hesham Gayar, M.D.
Radiation Oncologist
Karmanos Cancer Center, McLaren Cancer Institute Flint
Detroit, Michigan

Alonso N. Gutiérrez, Ph.D., MBA
Asst. Vice President, Chief Physicist
Radiation Oncology Executive Office
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William F. Hartsell, MD, FACR, FACRO
Medical Director, Chicago Proton Center
Radiation Oncologist, Northwestern Medicine
Chicago, Illinois

Prof. Dr. med. Eugen B. Hug

Symposium Director

President, PTCOG-NA
Medical Director, Managing Director
MedAustron Ion Therapy Center
Vienna, Austria

Anita Mahajan, M.D.

Minesh P. Mehta, M.D.
Deputy Director and Chief of Radiation Oncology
Miami Cancer Institute
Miami, Florida

Carl Rossi, M.D.
California Protons Cancer Therapy Center
San Diego, California

Anita Mahajan, M.D.

DATE: Friday, June 7, 2019    TIME: 12 noon – 1 p.m.    CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: TBD


CONFERENCE DIRECTORS: Louis T. Gidel, M.D., Ph.D., FCCP, Donna Lee Armaignac, Ph.D. APRN, CCNS, CCRN-K, & Eduardo Martinez-DuBouchet, M.D.

CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 30    CHARGE: 0

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

☐ ARS  ☑ Live activity
☒ 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
☐ 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.
Don’t miss this exciting opportunity to hear distinguished professor and intensivist Jean-Louis Vincent, M.D., Ph.D., discuss the important role hemodynamic monitoring plays in the management of today’s acutely ill patients. In recent years, interest in alternative monitoring systems have surged and there are now many different systems available to clinicians. Dr. Vincent will discuss an organized approach to the hemodynamic support of the hemodynamically unstable patient and the benefits this approach has to clinical outcomes.

**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)

► Current State includes inconsistent application of best-evidenced based practice and variable severity adjusted outcomes with worse than predicted mortality and length of stay.

► The Baptist Health South Florida Adult Critical Care Committee envisions best practices of evidence-based health care will be applied in a unified, coordinated manner in all BHSF ICUs to provide the highest patient safety and satisfaction, best outcomes, and greatest efficiency of care to all patients and families benefiting from critical care.

► Hemodynamic monitoring plays a fundamental role in the management of acutely ill patients. With increased concerns about the use of invasive techniques, notably the pulmonary artery catheter, to measure cardiac output, recent years have seen an influx of new, less-invasive means of measuring hemodynamic variables, leaving the clinician somewhat bewildered as to which technique, if any, is best and which he/she should use. (https://ccforum.biomedcentral.com/articles/10.1186/cc10291)

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)

► Clinicians utilize an organized, evidence-based, approach to the hemodynamic support of the hemodynamically unstable patient resulting in improved clinical outcomes.

► As a system:

1. Standardization and consistency in practice.
2. Refocus critical care toward patient safety and satisfaction with the care process.
3. Support interdisciplinary, evidence-based critical care practices throughout BHSF.

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

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


- Appropriate monitoring enables patient treatment to be individualized and adapted over time. Critical illness is just one moment on a patient's healthcare trajectory, and the periods before and after the critical illness are considered increasingly important in optimizing long-term outcomes.


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:

- Assess relationship of Mean Arterial Pressure in relationship to the microcirculatory and systemic hemodynamic variables.
- Apply principles of physiology in the management of the micro and macro circulation.
- Explore applicability of non-invasive sublingual microvascularscopy.
- Explore applicability of Pulse Index and other continuous cardiac output methods for systemic monitoring.
- Employ Arterial, Venous, SCVO2, SVO2, MVO2, Venous/arterial difference, lactate clearance for perfusion assessment.
- Define ideal MAP target for titration of adrenergic infusions.

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.)

Jean-Louis Vincent, M.D., PhD
Professor of Intensive Care Medicine
Université Libre de Bruxelles
Dept. of Intensive Care, Erasme Univ Hospital
Brussels, Belgium

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

Jean-Louis Vincent, M.D., PhD, indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. The mission of the Baptist Health South Florida Adult Critical Care Best Practices Committee is to provide the best care to our critically ill patients and families by applying “conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients,” relying on sound wisdom and clinical expertise and patients’ and family’s desires. Application of these practices is aimed at achieving improved clinical outcomes, health and well-being for our patients and families. In addition the Committee is working on a system-wide initiative to accomplish overall mortality, length of stay, and cost reduction. This course is part of that initiative to help the Committee reach its patient care improvement goals.

COMMERCIAL SUPPORT: ☐ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.
You may also be interested in: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: ___________ 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

CME ACTIVITY TITLE: MCI Multispecialty Grand Rounds – Oncodermatology: Cutaneous reaction to new cancer therapy and healing devices after cancer

DATE: Monday, June 10, 2019 TIME: 7:30 – 8:30 a.m. CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: MCI Tumor Board Conference Room – 3N 110

TARGET AUDIENCE: Oncologists, Radiation Oncologists, Hematology Oncologists, Radiation Therapists, General Surgeons, General Practitioners, Obstetrics and Gynecologists, Oncologists, Radiation Oncologists, Nurses, Social Workers, Patient Navigators and all other interested healthcare professionals.

CONFERENCE DIRECTOR: Guillerme Rabinowits, M.D. CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 30-40 CHARGE: 0

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

☐ ARS ☐ Enduring Material (DVD/Booklet)
☒ Case Studies ☐ Internet Activity Enduring Material
☒ Didactic Lecture ☐ Internet Live Course (Live Webcast)
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

Onco-dermatology links the two specialties to focus on the prevention and treatment of the skin, hair and nail problems that often arise as side effects from cancer treatments. Dr. Waibel will assist participants to explore the latest in technological advances for prevention, diagnosis and treatment of cutaneous conditions associated with cancer treatment.

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)

- Cancer therapy is advancing every day for faster, more effective treatments with high remission rates. However, cancer patients undergoing chemotherapy are at a much higher risk of cutaneous events such as skin malignancies and uncomfortable chronic side effects. Even with immunotherapies, which we had touted as the highest efficacy, lowest adverse event new treatment, we are beginning to see cutaneous complications.

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)

- Technology is evolving such that side effects of cancer treatment can be identified early and treated before they have a chance to be devastating. With the latest in imaging technology, we can monitor cutaneous ailments at remarkable precision to identify malignancies in their earliest form. In addition, there are countless emerging devices to restore life after cancer to a level that does not drag the devastation of cancer along with it every day.

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)
- Process improvement initiatives (C16 & 21)
- Other need identified (Explain): _____________________________
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

The complexity of cancer care with new cancer therapies and their associated dermatologic adverse events profiles benefit from a collaborative, inter-professional approach between dermatology and oncology in the care of the patient with cancer.

Seminars in Oncology Nursing. 33(4):393-401, 2017 11.

http://ovidsp.tx.ovid.com/sp-3.33.0b/ovidweb.cgi?&S=FKLHFPEEMFDDDBBPNCDKPAJCBJFJAA00&CompleteReference=S.sh.24%7c6%7c1&Counter5=SS_view_found_complete%7c28943034%7cmedf%7cmedline%7cmed13&Counter5Data=28943034%7cmedf%7cmedline%7cmed13

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:

- Discuss the cutaneous complications associated with common cancer treatments and their impact on daily life.
- Implement the latest in technological advances for prevention, diagnosis and treatment of cutaneous conditions associated with cancer treatment.

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.)

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

Jill S. Waibel, M.D.
Dermatologist
Owner and Medical Director, Miami Dermatology & Laser Institute
Jill S. Waibel, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

**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. ______________________________________________________

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

**(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN:** List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: ___________ REVIEWED BY: ☐ Accelerated Approval  ☐ Executive Committee

☐ Live Committee

APPROVED: ☐ YES  ☒ NO  Credits: AMA/PRA Category 1 Credits: # __1
CME ACTIVITY TITLE: Conversations in Ethics - Caring for the Mentally ILL Patient in an Acute Care Setting

DATE: Friday, June 21, 2019  TIME: 12 noon – 1pm  CREDIT HOUR(S) APPLIED FOR: 1.0 Cat. 1

LOCATION: BHM Auditorium

VIDEO CONFERENCED: HH Mango & Pineapple RM; MH- Exec. Conf. Rm; DH Valencia Side A & B;

LIVE WEBCAST

TARGET AUDIENCE: Physicians, Psychologists, Physician Assistants, Nurse Practitioners, Nurses, Social Workers, Respiratory Therapists, Clinical Chaplains, Pharmacists, Medical Students, Registered Dietitians and other interest healthcare professionals.

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH

CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN, Director, Bioethics Program

CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 50-60  CHARGE: 0

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 & 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 that keyword searches will pull from this description.

The identification and treatment of the mentally ill in an acute care setting frequently presents significant challenges for the provider. Whether the question is to assess the risk to self or to others in an emergency department presentation or the capacity of a patient to make end of life decisions in a critical care unit, the provider is called to make decisions that involve not only clinical issues but also legal and ethical considerations. Unfortunately, our state ranks quite high in the prevalence of mental illness. This makes the presentation of a mentally ill patient to our care a frequent occurrence. Please join us as Dr. Rafael A. Rivas-Vazquez discusses different complex patient care situations and treatments for the psychologically compromised patient.

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)

► Most of the problems that have bedeviled psychiatric epidemiology since its inception remain unresolved. In particular, until epidemiologists develop adequate methods to measure mental illnesses in community populations, the policy contributions of this field will not be fully realized. (https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1468-0009.2011.00645.x)

► Risky behaviors are a leading cause of preventable morbidity and mortality, yet behavioral counseling interventions to address them are underutilized in healthcare settings. Research on such interventions has grown steadily, but the systematic review of this research is complicated by wide variations in the organization, content, and delivery of behavioral interventions and the lack of a consistent language and framework to describe these differences.

Few studies directly address this question, so evidence addressing whether changing individual behavior improves health outcomes and whether behavioral counseling interventions in clinical settings help people change those behaviors must be linked.

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)

► Healthcare professionals utilize behavioral interventions that facilitate the medical treatment of their psychologically compromised patients.

► Health care systems are natural settings for interventions to improve health behaviors for many individuals because repeated contacts typically occur over a number of years. Interventions to help patients change unhealthy behaviors, like treatments for patients with chronic disease, often require repetition for modest effects over time. Continuity of care offers opportunities to sustain individual motivation, assess progress, provide feedback, and adjust behavior change plans. (https://www.sciencedirect.com/science/article/pii/S0749379702004154)

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): Bioethics Committee Requested

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* 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:

- Describe the diagnostic interface between medical conditions and psychiatric illness.
- Utilize an ethical decision-making approach to determining competence.
- Appropriately apply the voluntary and involuntary Baker Act criteria.

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.)

Rafael Rivas-Vazquez, Psy.D.
Baptist Hospital of Miami
Private Practice, First Choice Neurology
Miami, Florida

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

**Pending Disclosure Statement**

**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. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.

**COMMERCIAL SUPPORT:** ☐ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.
(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: 05/08/19  REVIEWED BY: ☑ Accelerated Approval ☐ Executive Committee

☐ Live Committee

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

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

CME ACTIVITY TITLE: Evidence-based Clinical Care: Evaluation of Intracerebral Hematoma

DATE: June 2019  TIME: June __________

CREDIT HOUR(S) APPLIED FOR: ☑ Cat. 1


CONFERENCE DIRECTOR: Felipe de Los Rios, M.D.

CME MANAGER: Marie Vital Acle

CONFERENCE COORDINATOR: Erika Gonzalez/Meagan Rodriguez

EXPECTED NUMBER OF ATTENDEES: 500 annually  CHARGE: 0

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

☐ ARS  ☐ Enduring Material (DVD/Booklet)

☐ Case Studies  ☑ Internet Activity Enduring Material

☐ Didactic Lecture  ☐ Internet Live Course (Live Webcast)
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

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 may not be aware of evidence-based standardization efforts throughout Baptist Health that are impacting algorithms of care. New quality metrics have been identified and physicians will be evaluated regularly based on these metrics.

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 power plans for identification and treatment of intracerebral hematoma as evidenced by utilization metrics.

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

- Incidence: 12 – 31 per 100,000 people
  - Doubles every 10 years after age 35
- Varies by race
  - Asian >> black >> Mexican Americans >> whites
- Incidence decreasing in high income countries, increasing in low to middle income countries (Asia, Sub-Saharan Africa)
- 30 day mortality: 35 to 52%
- Survival:
  - 1 year 46%
  - 5 years 29%
  - 10 years 18%


Hematoma Expansion

- Occurs most frequently in first hours from symptom onset
  - 38% over the first 24 hours
- Associated with worse prognosis
  - Each 10% increase in volume
    - 5% more likely to die
    - 16% more likely to increase one point in the mRS
- Risk factors for expansion:
  - Anti-thrombotics (anticoagulation, anti-platelets?)
    - OAC associated ICH has mortality rate of 52–73% (observational data)
  - Larger intracerebral hematoma volumes
  - Spot sign / contrast extravasation on initial ct angiography

Risk Factors

- Hypertension
- Anti-thrombetics
  - Warfarin: x2-5 fold risk
  - Novel oral anticoagulants
- Anti-platelets:
  - Single anti-platelet: 0.2%
  - Double anti-platelet treatment: 0.4%
- Others:
  - Genetics
  - Microhemorrhages on brain MRI
  - Lower cholesterol levels
  - Medications with caffeine
  - High alcohol intake
  - Phenylpropanolamine

Bibliography and Additional Resources:


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:

- Implement established clinical pathways for intra-cerebral hematoma designed on current, evidence-based best practices.
- Adopt imaging modality protocols to quickly identify mechanism of hemorrhage and begin refined secondary prevention measures.
- Appropriately follow the Baptist Health South Florida power plans available for the management of intra-cerebral hematoma.
- Recognize the metrics that will be evaluated and monitored through the patient’s hospital stay.

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.)

Felipe De Los Rios, M.D.
Medical Director, Baptist Hospital Comprehensive Stroke Center & Baptist Health South Florida Stroke Program
Voluntary Assistant Professor of Neurology
University of Cincinnati Department of Neurology & Rehabilitation Medicine
Florida International University, Herbert Wertheim College of Medicine
Miami, Florida

Felipe De Los Rios, M.D., has indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

All other evidence-based clinical care committee design team members and those involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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.) EBCC Committee (Hip Fracture) design team members.

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: Algorithms of care are

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. _____________________________________________________

COMMERCIAL SUPPORT: □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.
YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

Medical Errors

COURSE HANDOUT PAGE NOTES: Please insert the following text on course handout page.

NOTE: Physicians should bookmark this course to access all protocols, policies and procedures at your convenience via your CME Portal account. All algorithms will be available on CERNER.

External:

Provider:

Course video:

Course handout:

DATE REVIEWED: _________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee ☐ Live Committee

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

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

CONTINUING MEDICAL EDUCATION ACTIVITY APPLICATION

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

CME ACTIVITY TITLE: Advanced Imaging and the Future of Stroke
COURSE APPROVAL      June 2019                     COURSE EXPIRATION: June 2022

CREDIT HOUR(S) APPLIED FOR: TBD


N/A – Doctor only provided 5 questions.

CONFERENCE DIRECTOR: Felipe de los Rios, M.D.

CME MANAGER: Eleanor Abreu (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 0          CHARGE: 0

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 & 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 that keyword searches will pull from this description.

Advanced imaging has revolutionized stroke care over the last few years. This presentation will review these recent advancements and how to best use them in current clinical practice. It will also look into recent developments that may change how we select patients for acute stroke care treatments in the near future. During this lecture Dr. de los Rios will help participants understand currently available advanced imaging tests for acute stroke care.

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)

► Advanced imaging has revolutionized stroke care over the last few years. Physicians may not be aware of recent advancements and how to best use them in current clinical practice. Physicians will learn how to look into recent developments that may change how to select patients for acute stroke care treatments in the near future.

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 treat patients with acute stroke like symptoms present within the last 24 hours to be assessed for eligibility for both endovascular treatment and TPA with advanced imaging.

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 purpose of these guidelines is to provide an up-to-date comprehensive set of recommendations for clinicians caring for adult patients with acute arterial ischemic stroke in a single document. The intended audiences are prehospital care providers, physicians, allied health professionals, and hospital administrators. These guidelines supersede the 2013 guidelines and subsequent updates.

2018 Guidelines for the Early Management of Patients With Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

Originally published 1 Mar 2018 https://doi.org/10.1161/STR.0000000000000158 Stroke. 2018;49:e46–e99

https://www.ahajournals.org/doi/full/10.1161/STR.0000000000000158


Albers GW. Stroke 2018

Bibliography and Additional Resources:

Table 1. Summary of many relevant physiological parameters for assessing tissue ischaemia in stroke.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
<th>Adult healthy norm</th>
<th>Approaches to increasing perfusion</th>
<th>Measurement</th>
<th>Reference</th>
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</thead>
<tbody>
<tr>
<td>CBF</td>
<td>Rate of blood delivery to tissue (ml blood/kg tissue)</td>
<td>35-40 (ml blood/kg tissue)</td>
<td>&gt;90 (ml blood/kg tissue)</td>
<td>ISO-ratio PET CT perfusion, DISC PET CT perfusion, INO MRI</td>
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<tr>
<td>CBV</td>
<td>Volume of blood per volume of brain (ml blood/ml tissue)</td>
<td>3.3-4.4 (ml blood/ml tissue)</td>
<td>&lt;2.5 (ml blood/ml tissue)</td>
<td>ISO-ratio PET CT perfusion, DISC PET CT perfusion, INO MRI</td>
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<td>CBF/MTT</td>
<td>Rate of oxygen consumed to oxygen delivered (ratio)</td>
<td>4.5:4.4 (ratio)</td>
<td>&gt;5.5 (ratio)</td>
<td>ISO-ratio PET CT perfusion, DISC PET CT perfusion, INO MRI</td>
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<td>MPV</td>
<td>Mean platelet volume (pm)</td>
<td>8.35±0.74 (pm)</td>
<td>&gt;9.5 (pm)</td>
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<tr>
<td>pH/F</td>
<td>pH [mmol/L]</td>
<td>7.3-7.4 (mmol/L)</td>
<td>&gt;7.5 (mmol/L)</td>
<td>ISO-ratio PET CT perfusion, DISC PET CT perfusion, INO MRI</td>
<td></td>
</tr>
<tr>
<td>CI/CI</td>
<td>Rate of oxygen consumed to oxygen delivered (ratio)</td>
<td>3.6-5.1 (ratio)</td>
<td>&gt;5.1 (ratio)</td>
<td>ISO-ratio PET CT perfusion, DISC PET CT perfusion, INO MRI</td>
<td></td>
</tr>
<tr>
<td>CI/CI</td>
<td>Rate of glucose consumed to oxygen delivered (ratio)</td>
<td>6.4-8.3 (ratio)</td>
<td>&gt;8.3 (ratio)</td>
<td>ISO-ratio PET CT perfusion, DISC PET CT perfusion, INO MRI</td>
<td></td>
</tr>
</tbody>
</table>

Notes: values represent ranges based on literature studies unless otherwise indicated. Measurement methods: PET, perfusion positron emission tomography; DISC, dual isotope source CT; INO, integrated neuroimaging; CI, cerebral blood flow; CI, cerebral metabolic rate of oxygen consumption; pH, intracellular pH; CI/CI, cerebral metabolic rate of glucose; CI/CI, cerebral metabolic rate of oxygen; CI/CI, cerebral metabolic rate of glucose.
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:

Original objectives (see PPT objectives below)

- Identify currently available advanced imaging tests for acute stroke care.
- Implement a tailored approach to advanced imaging for the selection of candidates to reperfusion therapies.
- Utilize the institutional acute stroke treatment protocol.
- Recognize where the field is moving in regards to advanced imaging in acute stroke care.
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.)

Felipe de los Rios, M.D.

Medical Director

Stroke Program – Baptist Health South Florida

Comprehensive Stroke Center - Baptist Hospital of Miami

Associate Professor of Neurology

University of Cincinnati College of Medicine

Department of Neurology & Rehabilitation Medicine

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

Felipe de los Rios, M.D, indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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

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

**(ETHOS CONTENT)** YOU MAY ALSO BE INTERESTED IN:  *List names of up to two courses with similar target audiences. Please list complete course title.*

YOU MAY ALSO BE INTERESTED IN:  *List names of up to two courses with similar target audiences. Please list complete course title.*

External:

Provider: 2019IEM161

Course video:

Course handout:

**Quiz Questions**

1. Advanced imaging (beyond CTA or MRA) is required to select patients for endovascular treatment if their last seen normal time is between 0 and 6 hours.

   A. True
   
   B. False

2. With perfusion scans the patient could be deemed eligible for endovascular treatment up to how many hours from their last seen normal time?

   A. 4.5
   
   B. 6
3. The advanced imaging modality of choice to select patients for stroke treatment is:

A. CTA and CT perfusion.
B. MRI and MR perfusion.
C. Cerebrovascular reserve study.
D. Cerebrovascular reserve study with Diamox challenge.
E. Conventional cerebral digital subtraction angiography.

4. An acute stroke MRI cannot be obtained if the screening MRI form cannot be filled out by the patient (for example, in aphasia) or by a relative.

A. True
B. False

5. A CTA with perfusion cannot be obtained if the patient has a GFR less than ____ :

A. 40
B. 45
C. Renal function is not an absolute contraindication to CTA with perfusion if the patient is a likely candidate for endovascular treatment.
D. 50
E. GFR does not matter; it is creatinine >1.5.
CME ACTIVITY TITLE: The Epidemic of Thyroid Cancer: Is it Real?

COURSE APPROVAL: June 2019  COURSE EXPIRATION: June 2021

CREDIT HOUR(S) APPLIED FOR: TBD

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

If 10 questions and if 1 Cat 1

CONFERENCE DIRECTOR:  Guilherme Rabinowits, M.D. and Geoffrey Young, M.D.
CME MANAGER: Eleanor Abreu (Live)/Marie Vital Acle (Online)

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.

Physicians and the public are concerned and confused about the epidemic of thyroid cancer. Physicians are frequently uncertain about the appropriate evaluation of thyroid nodules and there is uncertainty about the appropriate extent of thyroid surgery for well-differentiated thyroid cancer. Learn more about this epidemic from Dr. Robert Udelsman, M.D.

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)

► Practitioners may not be familiar with appropriate evaluation of thyroid nodules and may be uncertain of the appropriate extent of thyroid surgery for well-differentiated thyroid cancer.

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.)

DESIRE 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)

► Practitioners are able to explain current incidence rates to patients and their families, preliminarily assess thyroid nodules and initiate the appropriate treatment protocols when nodules require further evaluation. Practitioners are able to explain the appropriate extent of thyroid surgery for well-differentiated thyroid cancer.

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:
Estimated New Cancer Cases* in the US in 2013

Men 854,700

Women 805,500

Prostate 28% 29% Breast
Lung & bronchus 14% 14% Lung & bronchus
Colon & rectum 9% 9% Colon & rectum
Urinary bladder 6% 6% Uterine corpus
Melanoma of skin 5% 6% Thyroid
Kidney & renal pelvis 5% 4% Non-Hodgkin lymphoma
Non-Hodgkin lymphoma 4% 4% Melanoma of skin
Oral cavity 3% 3% Kidney & renal pelvis
Leukemia 3% 3% Pancreas
Pancreas 3% 3% Ovary
All Other Sites 20% 19% All Other Sites

*Excludes basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder.

http://SEER.Cancer.gov

Controversy:
Thyroid Cancer – Rapidly Increasing Incidence

In 2012:
- 56,360 New Cases
- 1,780 Deaths (3.2%)

*Davies and Welch JAMA 2006; 295: 2164 - 2167
Bibliography and Additional Resources:


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:

- Identify which thyroid nodules should be biopsied and recognize the appropriate extent of thyroid surgery.
- Explain the possible causes of the thyroid cancer epidemic.

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.)

Robert Udelsman, M.D., MBA, FACS, FACE
Director of Endocrine Neoplasia Institute
Miami Cancer Institute

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

Robert Udelsman, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Guilherme Rabinowits, M.D., indicated that he is a consultant with Pfizer, Merck, Sanofi, Castel, Lighthouse, EMD Serono and Regeneron and a stock/shareholder with Regeneron and Syros Pharmaceuticals.

Geoffrey Young, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

**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?
The CME Department and the MCI Cancer Data Center collaborate to educate healthcare professionals on best-practice approaches and latest advances in screening, prevention and treatment pathways to improve care of the head and neck cancer patients.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM144

Course video:

Course handout:

Quiz Questions

DATE REVIEWED: __________ REVIEWED BY: □ Accelerated Approval □ Executive Committee □ Live Committee

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

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: MCI Radiation Oncology Grand Rounds – The Evolving Role of Integrative Strategies in Cancer Care

DATE: June 28, 2019  TIME: 12 – 1p.m.  CREDIT HOUR(S) APPLIED FOR: 1 cat. 1

LOCATION: Miami Cancer Institute – Radiation Oncology Conference Room – 1 N 612

TARGET AUDIENCE: Radiation Oncologists, Medical Oncologists, Oncology surgeons and Radiologists  NOTE: Due to limited space, this conference is open to Baptist Health affiliated Medical Staff and Clinical Employees.

CONFERENCE DIRECTOR: Michael D. Chuong, M.D.  CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 0  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)

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

Integrative Strategies for Cancer Patients is the definitive resource on the benefits of integrative therapies during cancer treatment. During this lecture Dr. Kaiser will define integrative services and help participants understand the metabolic derangements caused by cancer and cancer treatments.

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)

► Most cancer patients are not receiving integrative care despite emerging evidence of potential benefits.

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 should consider referral for integrative strategies and clinical trials that are examining the impact of such modalities on cancer outcomes and survivorship.

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:
Complementary integrative therapies (CITs) correspond to growing demand in patients with cancer-related pain. This demand needs to be considered alongside pharmaceutical and/or interventional therapies. CITs can be used to cover certain specific pain-related characteristics. The objective of this review is to present the options for CITs that could be used within dynamic, multidisciplinary, and personalized management, leading to an integrative oncology approach.


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:

- Define integrative strategies.
- Describe the metabolic derangements caused by cancer and/or cancer treatments.
- Assess the current state of integrative strategies pertaining to exercise and nutrition.

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.)

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

Adeel Kaiser, M.D.
Assistant Professor of Radiation Oncology
University of Maryland Medical System
Baltimore, Maryland
Adeel Kaiser, M.D. indicated that neither he nor his spouse/partner have relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ___________________________________________________
CME ACTIVITY TITLE: Patient Safety Symposium: Journey to Zero Harm

DATE: June 21, 2019  TIME: 7:30 a.m. – 4:00 p.m.  CREDIT HOUR(S) APPLIED FOR: 5.5 Cat. 1

LOCATION: Hilton Miami Dadeland

TARGET AUDIENCE: Baptist Health Medical Group and Baptist Health Employees

CONFERENCE PLANNING COMMITTEE:

Mark Hauser, M.D.
Yvonne Zawodny, R.N.
BHSF Patient Safety Partnership

CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 150-200  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
The Patient Safety Symposium is designed to prepare Baptist Health employees to effectively manage today’s most crucial patient safety, risk management and quality improvement issues. This year’s symposium will focus on how BHSF’s journey of incorporating various patient safety initiatives over time has improved the quality of patient care and outcomes. Content experts and Keynote speaker will provide innovative practical content and tools in a motivational and productive setting.

Registration is on BHU Only.

**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.

**DESIABLE 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)

► Current physician practice does not consistently include effective communication with patients and caregivers to ensure patient satisfaction and safety.

► In spite of Joint Commission and HHS mandates, the process of care coordination between healthcare providers and between institutions remains problematic.

► Deficits in cultural competency and impact on safety and pt compliance (see cultural diversity application for references).

► Current physician practice does not include consistent identification and reporting of Sentinel Events.

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 and healthcare teams will apply principles of high-reliability healthcare and uphold Joint Commission standards; they will improve patient safety by standardizing processes to improving efficiency with a focus on patient-centered care and culturally competent communication; and they will coordinate care to ensure safe and effective transfers to the next setting. In addition they will apply the principles of a fair and just culture to promote the reporting, discussion, and disclosure of adverse events.

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

☐ Consensus of experts

☑ Joint Commission initiatives (C12)

☑ National Patient Safety Goals

☐ New diagnostic/therapeutic modality (C12)

☐ Patient care data

☑ Process improvement initiatives (C16 & 21)
The Joint Commission views effective communication, cultural competence, and patient-centered care as important elements of providing safe, quality care.

Determining the competency of practitioners to provide high quality, safe patient care is one of the most important and difficult decisions an organization must make. The development and maintenance of a credible process to determine competency requires not only diligent data collection and evaluation, but also the actions by both the governing body and organized medical staff.

The credentialing and privileging process involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner’s professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the medical staff, and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each applicant’s licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established.

The revised credentialing and privileging standards have been informed throughout by the six areas of “General Competencies” developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative. The areas of general competencies include the following: Patient Care Medical/Clinical; Knowledge; Practice-based Learning and Improvement; Interpersonal and Communication Skills; Professionalism and Systems-based Practice.

Integrating these concepts into the standards allows the organized medical staff to expand to a more comprehensive evaluation of a practitioner’s professional practice.

Increasingly there is an interest in extending coordination beyond the individual organization or care provider to encompass the whole episode of care for a given patient. Having some form of external coordination between organizations has become an official mandate. Standards from Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and Condition of Participation from the Department of Health and Human Services hold organizations in which a patient receives care responsible for ensuring safe and effective transfers to the next setting. Despite these mandates, the process of coordination between institutions remains problematic. In a recent study between 15 and 72 percent of physicians reported problems with coordination across settings—lack of treatment follow-up, conflicting information from other care providers, delayed transfer of information following hospital discharge, and unavailability of relevant information during patients’ scheduled visits. Starfield’s review of research on coordination in primary care suggests that such communication breakdowns are not new.

For patients, continuity involves perceptions that providers have enough information about patients and their medical histories to make decisions about care (informational continuity); that providers, whether single or multiple, have a consistent care management plan (management continuity); and that providers who know them will provide care in the future (relational continuity). Poor care coordination may result in conflicting information to patients and caregivers and lead to a loss of confidence in providers. It may also produce confused, underinformed, or noncompliant patients, a particularly troublesome outcome when successful recovery depends upon patient cooperation. Additionally, coordination failures may produce patient dissatisfaction, which may have negative consequences for health care organizations in a competitive environment by reducing repeat business, generating negative word of mouth, or producing low patient care quality ratings.

High-reliability science is the study of organizations in industries like commercial aviation and nuclear power that operate under hazardous conditions while maintaining safety levels that are far better than those of health care. Adapting and applying the lessons of this science to health care offer the promise of enabling hospitals to reach levels of quality and safety that are comparable to those of the best high-reliability organizations.
A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Accredited hospitals are required to define sentinel event for its own purposes and to communicate this definition throughout the organization. While this definition must be consistent with the general definition of sentinel event as published by The Joint Commission, accredited hospitals have some latitude in setting more specific parameters to define unexpected, serious, and the risk thereof.

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:

- Define high-reliability healthcare and identify elements and behaviors that must be considered in an overall plan to achieve high reliability at the front lines of care.
- Implement evidence-based methods to improve safety, including team training, simulation, fatigue management systems, and investment in patient safety infrastructure and technology.
- Positively impact patient safety by utilizing the patient and family-centered care concept and the role of patient/family advisor.
- Practice transformational leadership to standardize processes, improve efficiency and streamline technology in your healthcare organization.
- Apply the principles of a fair and just culture to promote the reporting, discussion, and disclosure of adverse events.

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.)

Keynote Speaker:
Jennifer Arnold, M.D.
Medical Director of Simulation Center & Attending Neonatologist
Johns Hopkins All Children’s Hospital
St. Petersburg, Florida.

Faculty:
Matt Arsenault
Corporate Executive Vice-President/Chief Financial Officer
Baptist Health South Florida

Mark Hauser, M.D.
Corporate President Medical Staff Affairs
Baptist Health South Florida

Helen Mule, R.N.
Corporate Director, Risk Management/Patient Safety
Baptist Health South Florida

Faith Solkoff, R.N.
Corporate Vice-President, Quality & Accreditation
Baptist Health South Florida

Sandra Sosa
Patient/Family Advisor
Baptist Health South Florida
Lynne Thompson, R.N.
Corporate Director, Risk Management/Patient Safety
Baptist Health South Florida

Yvonne Zawodny, R.N.
Corporate Vice-President, Risk Management/Patient Safety
Baptist Health South Florida

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

Pending

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. ☒ Risk Management and Patient Safety Partnership.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.
SCHEDULE:

0730 – 0830: Registration & Breakfast

0830 – 0845: Opening & Welcome- Rev. Moon & Bo Boulenger, COO

0845 – 0945: Harm: Historically, Statistically & Personally- Dr. Mark Hauser
   K. Sosa Video/Update/Photos- Yvonne Zawodny, VP

   Grateful Patient Video #1 Immediately Following Presentation

1030 – 1130: Baptist Health South Florida’s Journey to Zero Harm Utilizing Huddles- Reps
   From BHM: Sergio Segarra & Miriam Serrano-Robles, HH: Bill Duquette &
   WKBH: Maria Elena Gauthreaux, Sandra McLean

1130 – 1230: Lunch/Networking

1230 – 1330: Patient Safety Exhibits (12 total) in Main Hall- “Pretty-In-Pink” dessert snacks

1330 – 1430: Key Note Speaker Presentation- Dr. Jennifer Arnold

1430 – 1500: Medication Safety- Madeline Camejo
   Grateful Patient Video #2 Immediately Following Presentation

1500 – 1530: The Value of Quality Patient Care- Matt Arsenault, CFO
   Grateful Patient Video #3 Immediately Following Presentation
1530 – 1600: Closing: Connecting to Symposium Purpose & Next Steps- Bo Boulenger, COO

Recognition of 2019 IHI DAISY Award for Extraordinary Nurse- Jobic Butao, RN

CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

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

CME ACTIVITY TITLE: Evidence-based Clinical Care: Massive Transfusion Guidelines

COURSE REVISED: June 2019 ○ COURSE EXPIRES: June 2022
Course Original Approval: October 1, 2016; Course Renewed October 8, 2018

CREDIT HOUR(S) APPLIED FOR: 1.25 Cat. 1

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

CONFERENCE COORDINATOR: Teri Llerena (Original)/ Tatiana Posada (EBCC)/Marie Vital Acle (CME)


EXPECTED NUMBER OF ATTENDEES: 100-150 annually ○ 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)
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

This online course helps caregivers manage patients requiring massive transfusions, deliver timely blood component therapy and enhance interdepartmental communication during cases of massive hemorrhage. This a result of system-wide collaborative efforts to develop guidelines that enable healthcare professionals to more easily identify patients requiring massive transfusion, facilitate a timely and coordinated response and provide key resources to the clinical teams. The goal of the Massive Transfusion Guidelines is to stop bleeding and restore circulating blood volume as soon as possible.

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

- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review
FACTORS OUTSIDE OUR CONTROL – List factors outside our control and beyond 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 the current and optimal practices is the “practice gap” – this is what should be addressed or ‘closed’ as a result of this CME activity.

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

► Massive blood loss is a high risk, low frequency event. Early identification of patients who may require massive transfusion and newer transfusion strategies have been associated with improved survival for those patients.

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

► Implement massive transfusion guideline developed to quickly and efficiently provide sufficient amounts and types of blood products to patients with massive hemorrhage.

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

✗ Knowledge (Doctors do not know that they need to be doing something.)
Competence (Doctors do not know how to do it)

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

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

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

► Implement massive transfusion guideline for the adult patient population at BHSF and any other patient for whom it may be deemed appropriate.

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

The purpose of the Massive Transfusion Accelerated Change Team is to introduce a massive transfusion guideline (MTG) at BHSF that will assist with the management of patients requiring massive transfusion, facilitate the timely delivery of blood component therapy, and enhance inter-departmental communication during cases of massive hemorrhage.

4-Factor Prothrombin Complex Concentrate is an effective alternative to plasma for urgent reversal of vitamin K antagonist therapy in major bleeding events, as demonstrated by clinical assessments of bleeding and laboratory measurements of international normalized ratio and factor levels.

(Efficacy and Safety of a 4-Factor Prothrombin Complex Concentrate in Patients on Vitamin K Antagonists Presenting With Major Bleeding A Randomized, Plasma-Controlled, Phase IIb Study Ravi Sarode, MD; et. al Circulation September 10, 2013)

EDUCATIONAL OBJECTIVES

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

Delineate the three hemorrhage levels and clinicians roles at each level.

Recognize the roles of those involved in a level 3 massive hemorrhage.

Implement timely interventions in patients with massive hemorrhage.

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

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

☐ Review of Hospital, Health System or Other Data ☐ Other______________________

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

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

► If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: _______________________________________________________________
FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

None: Transfusion Planning Group developed the flowchart which is animated to create this online course. Massive

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

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

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

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

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

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

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

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

This activity is planned in support of the Massive Transfusion Accelerated Change Team as part of system-wide Patient Safety and Quality initiative. This initiative has evolved to now be a part of the Evidence-based Clinical Care committee standardization efforts and is now part of EMR procedures.

DATE REVIEWED: October 8, 2018 (Renewed); June 2019 REVIEWED BY: ☐ Executive Committee
☐ Chairman

APPROVED: ☐ YES   ☐ NO   ● Credits: AMA/PRA Category 1 Credits: # 1.25

Continuing Psychology Education Credits: #___ ☐ N/A   ● Continuing Dental Education Credits: #___ ☐ N/A
CME ACTIVITY TITLE: Evidence-based Clinical Care: Anesthesia Guidelines

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

DATE/TIME/LOCATION: LUNCH PROVIDED ON ALL DATES/LOCATIONS

Friday, June 28, 2019  Baptist Hospital, 5 MCVI, Side A WEBCAST
Friday, July 12, 2019  Mariners Hospital, Main Conference Room
Monday, July 15, 2019  South Miami Hospital, TBD
Wednesday, July 17, 2019  Doctors Hospital, TBD
Thursday, July 18, 2019  West Kendall Baptist Hospital, Auditorium
Monday, July 29, 2019  Homestead Hospital, Lime Room

TARGET AUDIENCE: Hospitalists, Surgeons, Anesthesiologists and Nurses

CONFERENCE DIRECTOR: Edward Abraham, M.D., Guillermo Pol, M.D., Jose Davila, M.D., Samir Kulkarni, M.D.

CME MANAGER: Marie Vital Acle

EXPECTED NUMBER OF ATTENDEES: 0  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
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

This Evidence-based Clinical Care lunch and learn course will review the new system-wide, pre-anesthesia/sedation testing guidelines developed for planned procedure. Adequate preoperative patient evaluation and preparation may improve patient outcomes, decrease complications, delays, cancellations, costs, length of hospital stay, and mortality.

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.

Practitioners may be hesitate to change their pre-operative testing procedures and this education will provide practitioners with the evidence-based data supporting these behavior changes that will improve 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)

► In current practice BHSF does not have specific pre-procedure testing guidelines. Practitioners may not be aware of the evidenced-based process utilized to transform clinical and operational processes and maximize resources in pre-anesthesia/sedation.

The purpose of this initiative is to design a systematic evidenced-based and system-wide process to transform clinical and operational processes, as well as maximize our resources. Practitioners may not be familiar with testing guidelines developed for the preoperative setting as part of system-wide standardization efforts.

The Pre-Anesthesia/Sedation Testing Guidelines were developed as Evidence-Based practice for the preoperative testing recommendations for planned procedure. Adequate preoperative patient evaluation and preparation may improve patient satisfaction, as well as decrease complications, delays, cancellations, costs, length of hospital stay, and mortality.

Physicians may not be aware of evidence-based standardization efforts throughout Baptist Health that are impacting algorithms of care.

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)

► Practitioners will implement adequate preoperative patient evaluation and preparation to improve delivery of care, decrease complications, delays, cancellations, costs, length of hospital stay, and mortality.

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

Research/literature review

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

3. Evaluation of cardiac risk prior to noncardiac surgery. UpToDate, Jul 2018
5. Cardiac Risk Stratification for Noncardiac Surgery. Cleveland Clinic Journal of Medicine 2009; 76(S4): S9-S15
8. Practice Guidelines for the Perioperative Management of Patients with Obstructive Sleep Apnea, Anesthesiology Feb 2014; 120(2): 1-19
11. 2016 ACC/AHA Guideline Focused Update on Duration of Dual Antiplatelet Therapy in Patients with Coronary Artery Disease. American College of Cardiology 2016; 68(10): 1082-1115

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:

- Explain the evidence-based data supporting standardization efforts to improve pre-surgical planning.
- Utilize pre-procedure testing guidelines successfully for planned procedures.
- Recognize the impact of standardization efforts to decrease unnecessary pre-surgical testing, waste and unnecessary delays due to lack of patient optimization.

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.)

Bianca Capella, APRN-BC, RN-BSN
Corporate Clinical Consultant | Evidence Based Clinical Care

Erika Gonzalez, MSN RN CCRN NE-BC
Director | Evidence Based Clinical Care
Baptist Clinical Enterprise | Baptist Health South Florida

Lellany Ruiz
Project Manager | Evidence Based Clinical Care
Baptist Clinical Enterprise | Baptist Health South Florida

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

Bianca Capella, APRN-BC, RN-BSN, Erika Gonzalez, MSN RN CCRN NE-BC and Lellany Ruiz have indicated that neither they nor their spouse/partner has relevant financial relationships with commercial interest companies, and they will not include off-label or unapproved product usage in their presentation(s) or discussion(s).

**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. 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: This course is part of ongoing efforts by EBCC to educate practitioners, other tools include a resource website available on the intranet, posters, WINKS and newsletter communications.

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 course is planning in collaboration with the Evidence-based Clinical Care department in support of BHSF standardization efforts to improve delivery of care.

COMMERCIAL SUPPORT: ☐ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.
You may also be interested in: List names of up to two courses with similar target audiences. Please list complete course title.

Date Reviewed: __________  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

CME activity title: Measles: Prevention, Detection, Treatment, Current and Future

Course Approval: June 2019  ■ Course Expiration: June 2021

Credit Hour(s) Applied For: TBD- If one hour apply for nursing.

Target Audience: Primary Care Physicians, Emergency Department Physicians, Hospitalists, Pediatricians, Internal Medicine Physicians, Infectious Disease Physicians, Nurse Practitioners, Physician Assistants and Nurses

Conference Director: Agueda Hernandez, M.D.  CME Manager: Marie Vital Acle (Online)

Expected Number of Attendees: 0  ■ Charge: 0

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

□ ARS  □ Internet Live Course (Live Webcast)
□ Case Studies  □ Internet point-of-care activity
□ Didactic Lecture  □ Journal-based CME activity
□ Enduring Material (DVD/Booklet)  □ Learning from Teaching
□ Internet Activity Enduring Material  □ Live activity
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

Many providers have never seen a case of measles in clinical practice. This course provides practitioners with essential information on measles prevention, detection and treatment.

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)

► Practitioners may have never seen measles in clinical practice and are unsure of clinical presentation.

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.)

DESIRMED 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)

► Practitioners are able to quickly identify, confirm diagnosis and triage measles patients in the outpatient and ED setting.

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

REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
Epidemiology of Measles

- Highly contagious infection ($R_0 = 15$ to $18$)
- Before vaccines $90\%$ developed measles by $15$ years of age
- Between $2000$ and $2008$ estimated annual deaths from measles dropped from $733\ 000$ to $164\ 000$.
- In $2009$, worldwide measles vaccination coverage had reached $82\%$,
- $2016$ WHO declared all nations in the Americas free from measles as public health threat.
- **BUT unfortunately Today,**
  - Measles is back in the Americas;
    - Politics, conflict, economic collapse, and ideology brought it back to the Americas; it first reappeared in Venezuela following the breakdown of the Venezuelan government and economy, in the USA and Europe the problem is largely with “Anti-vaxers”
  - Outbreaks wherever there is a significantly under vaccinated population
  - Epidemics every $2$ or $3$ years in areas with low vaccination coverage and areas where only one dose of vaccine (instead of $2$ doses given at least $28$ days apart) is standard.
  - In countries where measles was largely eliminated, importation of measles is a problem

### Differential Diagnosis for Morbilliform Rash (and somewhat similar rashes)

<table>
<thead>
<tr>
<th>Causative agent</th>
<th>Disease entity</th>
<th>Rash Characteristics</th>
<th>Special Aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles/Virus (Rubella virus), a parainfectious</td>
<td>Measles</td>
<td>Morbilliform: pink blotchy maculopapular rash. Start on head near hairline, progresses to neck, trunk, then extremities</td>
<td>Prophylactic treatment includes high fever, Koplik spots (ear rashes), usually precedes rash (exanthem). Cough, Coryza, and Conjunctivitis. Patients are “ill-appearance” Immunosuppressive. Neurotropic</td>
</tr>
<tr>
<td>Rubivirus, a Togaviridae virus</td>
<td>Rubella (German Measles)</td>
<td>Blanche maculopapular pink rash that balances. Start on head and neck, progresses to trunk, then extremities</td>
<td>High fever, pharyngeal rashes and enlarged tonsils, Koplik spots, but &lt;10% have hepatitis or mumps-like illness (Poincheiner spots), cervical lymphadenopathy common</td>
</tr>
<tr>
<td>Adenovirus</td>
<td>Adenoviral infection</td>
<td>&quot;Rubelliform&quot; rash or petechial rash</td>
<td>Cough, Coryza, and Conjunctivitis. Patients are &quot;ill-appearance.&quot; Gastroenteritis, pharyngitis and conjunctivitis</td>
</tr>
<tr>
<td>Epstein-Barr virus, Human gammaherpesvirus 4</td>
<td>Infectious mononucleosis</td>
<td>Non-itchy rash ranges from maculopapular to scarlatiniform, urticarial exanthema—infection occurs in all patients.</td>
<td>Proptosis, palatal petechiae, hepatic, splenic, bone marrow, lymphoid hyperplasia, jaundice, may have splenomegaly</td>
</tr>
<tr>
<td>Human Herpesvirus 6 &amp; ?</td>
<td>Roseola infantum</td>
<td>Pink maculopapular rash start on trunk spreads to neck</td>
<td>Fever, pharyngitis, sudden onset of fever, may be accompanied by headache</td>
</tr>
<tr>
<td>Human parvovirus B19</td>
<td>FIFDH (Fever like illness)</td>
<td>&quot;Slapped cheeks&quot; (malar rash) and maculopapular rash on extremities</td>
<td>Minimal symptoms most common, fever, may have painful symmetrical arthritis and hepatitis</td>
</tr>
<tr>
<td>Rickettsia, Chlamydia, &amp; Anaplasmosis</td>
<td>Rickettsiosis/Feverlike illness</td>
<td>Rickettsiosis: small pink macular rash that gradually becomes macular, lesion on extremities toward center and becomes petechial</td>
<td>Fever, headache, nausea, sometimes with chills and vomiting that can be severe</td>
</tr>
<tr>
<td>Coccidiodomycosis, echo, other granulomasis</td>
<td>Coccidioidomycosis</td>
<td>Petechial rash on extremities</td>
<td>Fever, rash, may have meningitis or encephalitis</td>
</tr>
<tr>
<td>Drug reaction/Allergic reaction</td>
<td>Toxic, Drug</td>
<td>Rash ranges from red maculopapular to petechial, papular purpuric, or desquamative</td>
<td>Fever, rash, may have meningitis or encephalitis</td>
</tr>
</tbody>
</table>

*Other diseases that can cause Morbilliform rash include: Dengue, Chikungunya, West Nile virus infection, Scarlet fever, Kawasaki disease, Lupus erythematosus, Scarlet fever, Kawasaki disease, Lupus erythematosus, Scarlet fever, Kawasaki disease, Lupus erythematosus, Scarlet fever, Kawasaki disease, Lupus erythematosus.*
- **Serology**
  - IgM-EIA
    - Measles specific IgM antibody to Dx acute infection, detectable within 3 days of onset
  - IgM-IFA
    - Measles specific IgG to detect long-term immunity

- **Culture**
  - Several tissue lines support growth of measles virus
  - Virus rapidly inactivated in extremes of pH, heat, & sunlight

- **Nucleic acid amplification tests**
  - Real-time reverse transcription-polymerase chain reaction (RT-PCR)

### Managing Suspected and Confirmed Measles

**WARNING MEASLES**

All persons are forbidden to enter or leave these premises without the permission of the HEALTH OFFICER under PENALTY OF THE LAW.

This notice is posted in compliance with the SANITARY CODE and must not be removed without permission of the HEALTH OFFICER.

Health Sign in use in 1904

- **ISOLATE THE PATIENT!**
  - Patients with suspected measles or confirmed measles should be isolated
  - Otherwise health patient:
    - Isolate for at least 4 days after rash appears
  - Malnourished or immunocompromised:
    - Isolate for ENTIRE time of illness

- Avoid contact with any susceptible healthcare workers
- Immediately report cases to local health departments to ensure a prompt public health response
- Vaccinate anyone 6 months or older without previous immunity who enters a hospital area where a measles patient is held (or a hospital area that held a measles patient within the last 6 hours)

### Bibliography and Additional Resources:


Kristi Koenig, W Alassaf , and Michael J. Burns, MD. West JEM 2015, March, 16(2):

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:

- Identify measles and diagnose measles in clinical practice.
- Implement first line treatment for patients and their families.
- Utilize prevention techniques in clinical practice when a case of measles has been identified.
- Determine when to escalate care to an in-patient setting for measles patients presenting through outpatient setting.
- Implement hospital precautions to prevent spread among hospital workers.

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.)

Prof. Dr. Aileen M. Marty M.D., FCAP
Director, FIU Health Travel Medicine Program and Vaccine Clinic Commander, Emergency Response Team Development
Professor, Infectious Diseases, Dept. of Humanities, Health and Society,
Herbert Wertheim College of Medicine, Florida International University
Miami, Florida

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

Prof. Dr. Aileen M. Marty M.D., FCAP, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ______________________________________________________

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:

Provider:

Course video:

Course handout:

Quiz Questions (not proofed yet) – Martha can you please add feedback based on PowerPoint slides

1. A 28-year old man presents with fever of 104 F, headache, severe body aches, a severe sore throat and dry cough for 2 days and has now noted sore eyes and intense tearing. Which of the following additional findings on physical exam would be the most definitive for identifying this as a case of measles?

a. Corneal clouding or corneal ulcers
b. Desquamative rash on his hands and feet
c. Small white spots on a red base on buccal mucosa
d. Stridor and Rapid breathing with chest indrawing
2. Which of the following findings in a 3-month old child with measles requires immediate hospitalization?
   a. Unable to breast feed
   b. ≥ 40 breaths per minute
   c. Pus draining from eyes
   d. Small white spots on a red base on buccal mucosa

3. A 44-year-old woman presents with fever and chill that had started 5 days previously. A few days after the onset of fever she had noticed a red, nonpruritic, confluent, maculopapular rash which began on her face and descended to her body. She also complained of red eyes, photophobia, dyspnea, and watery diarrhea. On exam she had fever of 38.2°C, Blood pressure of 110/60 mm Hg, Respiratory rate of 28 breaths per minute. Koplik spots are noted. Which of the following laboratory findings would most likely manifest on routine blood work?
   a. Elevated Transaminase
   b. Hyperkalemia
   c. Leukocytosis
   d. Red cell casts in urine

4. Which of the following is a complication which presents about 10 years after a case of acute measles?
   a. Corneal Damage
   b. Hecht pneumonia
   c. Mastoiditis
   d. Subacute sclerosing panencephalitis

5. A family with a 9-month-old baby is moving to the Philippines next month and the parents note there is a measles outbreak where they are moving. Which of the following is best represents the current CDC recommendation to protect their 9-month old from the measles?
   a. The 9-month old should immediately receive two doses of MMR spaced at least 28 days apart
   b. If the parents do not know their vaccination status the parents should be vaccinated with MMR, and they should keep their child away from anyone with a rash.
   c. The 9-month old should immediately receive one dose of MMR, then restart the usual vaccination schedule when the child has his first birthday.
   d. The parents should be told to delay their move until the child is at least 12 months of age at which time he should receive his first does of MMR vaccine.
CME ACTIVITY TITLE: 2019 Radiation Safety Training: CT & Fluoroscopy

Annual requirement, will need to be republished annually.

CREDIT HOUR(S) APPLIED FOR: .50 Cat 1

TARGET AUDIENCE: Physicians, Non-physicians and Ancillary Staff who provide fluoroscopy services for pediatric or adult patients.

CONFERENCE DIRECTOR: Kevin Abrams, M.D.          CME MANAGER: Marie Vital Acle

EXPECTED NUMBER OF ATTENDEES: 75 annually          CHARGE: 0

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 & 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 that keyword searches will pull from this description.

This course fulfills annual Joint Commission training requirements for physicians, non-physicians and ancillary personnel who provide fluoroscopy services.

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)

► Practitioners may not consistently implement exposure reduction strategies when providing fluoroscopy services.

Practitioners may not be aware of new Joint Commission annual education required of education requirements for physicians, non-physicians, and ancillary personnel for organizations providing fluoroscopy services.

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)

► Practitioners adhere to radiation safety protocols and implement dose optimization techniques for pediatric and adult patients when providing fluoroscopy services.

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 Joint Commission Radiation Safety Training Requirements specify that “the hospital verifies and documents that individuals (including
physicians, non-physicians, and ancillary personnel) who use fluoroscopic equipment participate in ongoing education that includes annual training on the following:

- Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® campaign
- Safe procedures for operation of the types of fluoroscopy equipment they will use

Note 1: Information on the Image Gently initiative can be found online at [http://www.imagegently.org](http://www.imagegently.org).

Note 2: This element of performance does not apply to fluoroscopy equipment used for therapeutic radiation treatment planning or delivery.


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:

- Adhere to radiation safety protocols as delineated in The Joint Commission standards for organizations providing fluoroscopy services.
- Implement radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently campaign.
- Utilize safe procedures for operations of the types of fluoroscopy equipment used for therapeutic radiation treatment planning or delivery.
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.)

Alyson N. Cieply, M.S.
Diagnostic Medical Physicist
Baptist Health South Florida

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

Alyson N. Cieply, M.S., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentations or discussions.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: __________ REVIEWED BY: □ Accelerated Approval □ Executive Committee
□ Live Committee

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

CME ACTIVITY TITLE: MCI Informatics Education (CERNER) LIVE TRAINING

CREDIT HOUR(S) APPLIED FOR: up to 7 Cat. 1

TARGET AUDIENCE: MCI Physicians, APRNs and Physician Assistants

CONFERENCE DIRECTOR: Paul Lindemann, M.D.

CME MANAGER: Marie Vital Acle

EXPECTED NUMBER OF ATTENDEES: 262 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)
**COURSE DESCRIPTION:** This short summary will be used on course shell. Please note that keyword searches will pull from this description. Non-published course.

**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)

<table>
<thead>
<tr>
<th>Category</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient:</strong></td>
<td>□ Noncompliance □ Lifestyle □ Resistance to change □ Cost of care/Lack of insurance</td>
</tr>
<tr>
<td><strong>Physician:</strong></td>
<td>□ Noncompliance □ Resistance to change □ Communication skills □ Reimbursement issues</td>
</tr>
<tr>
<td><strong>Resources:</strong></td>
<td>□ Institutional Capabilities □ Physician Practice Limitations □ Community Service Limitations</td>
</tr>
<tr>
<td><strong>State of Science:</strong></td>
<td>□ Limited or no treatment modalities □ Limited or no diagnostic modalities</td>
</tr>
<tr>
<td><strong>Other:</strong></td>
<td>Requirements that institution convert to electronic health records and the adoption of new systems.</td>
</tr>
</tbody>
</table>

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

With the implementation of a new electronic health record throughout Baptist Health many providers will be hesitant to implement changes to their practice. This course address some non compliance and resistance to change issues by making this education accessible online for CME credits to facilitate access for Medical Staff with the added incentive of CME credits.

**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)

► MCI providers are not yet familiar with navigation and utilization of enterprise-level electronic health record platform that is in place at all Baptist Health South Florida hospitals. Providers may not be aware that specific to Oncology patients there are multiple encounter types, because billing is more complex for oncology treatment, orders are more complex, and intricate in relation to chemotherapy; and scheduling is more integrated into the orders.
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.)

**DESIRE 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)

- MCI Providers new to Baptist Health competently utilize the new EHR and are able to transition to the new platform with little impact to delivery of 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 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): System-wide electronic health record.

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

- Cerner's PowerChart Ambulatory EHR ensures the right clinicians have the right information at the right time and place to make the best possible decisions.

*Future state after full implementation of newly purchased EHR system.*

SurgiNet: Ensuring safety requires access to accurate, up-to-date clinical information. Designed on the unified Cerner Millennium® architecture, SurgiNet provides exactly that. The solution shares common data elements among the nursing, intra-anesthesia and the PACU documentation. This helps improve patient handoff and assists in meeting JCAHO compliance. Shared documentation also eliminates duplicate entries and keeps patient data consistent. This, in turn, helps ensure accurate patient records and timely reimbursement while also saving nurses time.

Because the SurgiNet solution operates in the Cerner Millennium® environment, you can access a patient’s complete electronic medical record (EMR). Knowledge of a patient’s health history helps you plan for and handle unforeseen...
complications that may arise during surgery. Access to information is only half of the equation. You must also be able to attach complete perioperative data to a patient’s health record—but not at the expense of time spent caring for patients. The SurgiNet perioperative management system’s intuitive documentation tools provide automatic data deficit checking. That feature helps you ensure a thorough record—the system notes and flags gaps in data. Anesthesia providers can also use predefined and customized macros for easy data entry throughout the perioperative process. The SurgiNet solution also allows you to create long-term chronological record of a patient’s perioperative history, which is especially valuable for long-term care.

SurgiNet perioperative tracking allows you to view up-to-the-minute patient and case status data. Automatic updates show case status information, allowing teams to manage routine and unexpected events centrally. Actual case time information connects with the surgery schedule, enabling more efficient use of available OR time. But not every potential viewer needs to see every piece of information. Multiple encoded views allow you to tailor on-screen information to accommodate the surgical patient’s family, the surgeon, the anesthesiologist or other the staff located throughout the facility. These encoded views help you maintain HIPAA compliance.

The SurgiNet solution provides unprecedented access to clinical, financial and operational data via reporting tools for cost analysis, resource use, volume analysis, operational efficiencies and clinical outcomes.

FirstNet: FirstNet includes a complete set of documentation tools which help physicians create fast and complete documentation. The solution automatically generates the appropriate template based on patient and clinical data. In addition, it prompts physicians to return to areas requiring additional information and automatically incorporates information such as allergies and prior medical history from documentation created by nurses and ancillary areas.

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:

- Navigate and utilize new electronic medical record system ensuring transition to new platform with little impact to delivery of care.
- Reduce redundancy and improve delivery of care throughout Baptist Health South Florida entities utilizing a single centralized system for clinicians to review patients’ progress against expected outcomes, document findings, initiate and update orders and receive important timely notifications which affect patient treatment plans.

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.)

Christine Abbott

Assistant Director of Informatics – Miami Cancer Institute

Cerner Provider Education Management, Training & Support – Miami Cancer Institute
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: ________________________________________________

Non-clinical content: All activities that are considered non-clinical must be vetted by the Department Director. If there is no opportunity to affect the content of CME concerning the products or services of a commercial interest, then there can be no relevant financial relationships or conflicts of interest. Both the following statements must apply. Reference SOP “Disclosures for Activities with Non-Clinical Content” for further instructions and necessary steps to ensure compliance.

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

Disclosure statement to be shared with the learner on Breakaway platform prior to the activity taking place: Due to the non-clinical nature of the content discussed, the speakers have no relevant financial relationships to disclose. This CME activity will not cover content that would involve products or services of commercial interests. Therefore no opportunity exists for a conflict of interest based on the financial relationships of faculty and those persons in control of content. Since these relationships are not relevant, no disclosure information was collected.

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 course is planned in collaboration with the IT Telehealth Systems Department.

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

DATE REVIEWED: July 8, 2016; June 17, 2018 REVIEWED BY: ☑ Accelerated Approval ☐ Executive Committee

☑ Live Committee
SPECIALTY BASED CONTENT

- MCI ambulatory only = 4 hours
- Surgical Oncology, 4 hours, + 1 hour session on inpatient surgeon
- GYO, 4 hours, +1.5-2 hour chemo + 1 hour inpatient surgeon training
- Medical Oncologists, 4 hour customary training + 1.5 – 2 hour chemo.
- Stand alone Chemo session 1.5-2 hour sessions
- Additional Specialty training – 2 hour sessions to go over their specific workflows after initial 4 hour training. (Usually happens after special documents or forms are built for them).
- Radiation Oncology runs short, but is scheduled for 4 hours. This will be increasing since they are transitioning more of their ambulatory work into Cerner. Currently they view only for ambulatory and document inpatient only. (the use Aria for ambulatory but we are transitioning them to Cerner as we speak)
- BMT is in development and will be a very intense training. 4 hours + 2-3 hours BMT.
- Providers moving to Med-Oncology from other specialties need 2 hours. 1 hr for MCI differences, and 1.5 for Chemo.

NOTE: All customary live MCI training sessions will be 4 hours in duration, specialty specific training will be tailored to the specialty and learner usage of Cerner application.

CME ACTIVITY TITLE: Promoting Physician Wellness: Management of Physician's Fatigue, Sleep Deprivation and Other Conditions that Contribute to Physician Impairment

DATE: June 27, 2019

TIME: 4 – 5 p.m.

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

LOCATION: WKBH - Family Medicine Center Conference Room – Medical Arts Building, Suite 200

TARGET AUDIENCE: West Kendall Baptist Hospital GME faculty including: Family medicine practitioners, cardiologists, emergency medicine physicians, surgeons, hospitalists, Ob/Gyn’s, nephrologists, hematologists/oncologists, infectious disease specialists, gastroenterologists, neurologists, ENT’s, ophthalmologists, urologists, pulmonologists, critical care physicians, nurses, medical students, residents, fellows and other interested healthcare professionals.
CONFERENCE DIRECTOR: Agueda Hernandez, M.D.  CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 25 - 30  CHARGE: 0

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

- [ ] ARS
- [ ] Case Studies
- [x] 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: With the growing attention paid to resident duty hours, there is an increasing need for research involving fatigue and practical ways to measure it. This study shows that residents who are measurably fatigued (both objectively and subjectively) may have difficulty utilizing vestibular input during quiet standing but can compensate by means of somatosensory and visual input.

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

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

Physician:  
- [x] Noncompliance  
- [x] 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  
- [x] Medical knowledge  
- [x] Practice-based learning and improvement  
- [ ] Interpersonal and communication skills  
- [x] Professionalism  
- [x] 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 may not be aware of the signs of fatigue and sleep deprivation in residents and fellows.

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 supervising residents and fellows implement appropriate strategies to address issues of fatigue and sleep deprivation.

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:

With the growing attention paid to resident duty hours, there is an increasing need for research involving fatigue and practical ways to measure it. This study shows that residents who are measurably fatigued (both objectively and
subjectively) may have difficulty utilizing vestibular input during quiet standing but can compensate by means of somatosensory and visual input.


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:

- Identify the ACGME duty hour regulations
- Recognize the signs of fatigue, sleep deprivation and other conditions that contribute to physician impairment
- Identify the effect of fatigue, sleep deprivation, and other conditions on physician’s functioning and performance
- Engage in strategies to prevent and reduce the impact of fatigue, sleep deprivation, and other conditions on physician’s functioning and performance.

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.)

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

Susan Chalfin, Ph.D.
Licensed Clinical Psychologist
Child Psychology Associates
Susan Chalfin, Ph.D., indicated that neither she nor her spouse/partner have relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ________________________________________________

This event is in collaboration with the West Kendall Baptist Hospital Graduate Medical Education Program.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.
DATE REVIEWED: 06.19.2019

REVIEWED BY: □ Accelerated Approval  □ Executive Committee
          □ Live Committee

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

Continuing Psychology Education Credits: # 1  □ N/A  □ Continuing Dental Education Credits: #  □ N/A

CME ACTIVITY TITLE: Baker Act & Marchman Act Conference

DATE:  September 12, 2019  TIME: 6:00 p.m. – 9:00 p.m.  CREDIT HOUR(S) APPLIED FOR:  3 Cat. 1

LOCATION: Baptist Hospital, Auditorium

LIVE & RECORDED WEBCAST


CONFERENCE DIRECTOR: Barry Crown, Ph.D.  CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES:  60-65  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
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description. Florida citizens who might harm themselves or others may be held involuntarily for assessment up to 72 hours. The statute for mental illness is called the Baker Act; for substance abuse, the Marchman Act. There are very specific criteria for committing someone under the Baker Act or Marchman Act. Join us as Martha R. Lenderman, MSW, clearly explains how to identify patients legally eligible to implement these statutes and the requirements under the Florida Mental Health Act for appropriate admission and discharge in compliance with the law.

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)

► Many physicians lack knowledge and/or competence regarding Baker Act requirements and their appropriate application to medical decision making.

► Prior to the Baker Act, people who had psychiatric/emotional problems were most often handled by the police and were likely to wind up in jail rather than a treatment facility. Also, relatives or friends of a disturbed person could go to a judge and have a person declared incompetent and dangerous which would lead to their placement in a state mental hospital for an indefinite period of time. At one time, the Florida State Hospital held 10,000 people. (Barry Crown, Ph.D., Director, Continuing Education in Psychology)

**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 consistently and competently apply the Baker Act and Marchman Act admission criteria for compliance with involuntary admissions and medical decision making.

The Baker Act is a Florida Statute that provides strict guidelines and procedures for the determination, processing, and detentions of someone who is dangerous to themselves and/or others. Since this is a legal procedure (and not medical), physicians need to be aware of the requirements of the Act and be able to translate and apply these requirements to their medical decision making.

**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
- Consensus of experts
- Disease prevention (C12)
- Joint Commission initiatives (C12)
- Mortality/morbidity statistics
- National Patient Safety Goals
- National/regional data
- New diagnostic/therapeutic modality (C12)
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

► This program provided participants with an overview of the legal, statutory and regulatory policies that relate to The Baker and Marchman Acts.

In order to properly follow the requirements of The Baker Act and Marchman Act admitting psychologist must be aware of the examination criteria, eligibility, admission compliance, discharge compliance and patient rights. Consistency is essential in applying the federal Emergency Medical Treatment and Active Labor Act and the Florida Baker Act laws.

► A Baker Act is a means of providing individuals with emergency services and temporary detention for mental health evaluation and treatment when required, either on a voluntary or an involuntary basis. (Chapter 394, FS; Chapter 65E-5, FAC; 2006 Baker Act Handbook, Chapter 397, F.S., and model forms)

► The Marchman Act is a single law that clearly spells out legislative intent, licensure of service providers, client rights, voluntary and involuntary admissions, offender and inmate programs, service coordination and children’s substance abuse services. (Hal S. Marchman Alcohol & Other Drug Services Act of 1993)


► 2019 Legislative Summary, Florida Hospital Association

This program is derived from the following works.

ACTIVITY TWO REFERENCES (at least 5):
Voluntary Admission Selected Procedures, 394.4625 FS and 65E-5.270, FAC
Initiating Involuntary Examinations, 384.463(2), FS and 65E-5.280, FAC
Involuntary Examinations Initiated by the Court, 384.463(2)(a)1, FS and 65E-5.280(1), FAC
Involuntary Examination Law Enforcement Officers, 384.463(2)(a)2, FS and 65E-5.280(2), FAC
Minimum Standards for Initial Mandatory Involuntary Examination, 394.463(2)(f), FS 65E-5.2801, FAC
Hal S. Marchman Alcohol & Other Drug Services Act of 1993
The Joint Commission National Patient Safety Goals NPSG.15.01.01

APA Criteria 1.4: Program content is related to ethical, legal, statutory or regulatory policies, guidelines, and standards that impact psychology.
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:

- Implement the Baker Act voluntary and involuntary examination criteria.
- Identify which patients are legally eligible to consent to admission and treatment.
- Discuss requirements under the Florida Mental Health Act including appropriate admission and discharge in compliance with the law.
- Implement the criteria for involuntary admission of persons under Florida’s Marchman Act for substance abuse impairment.
- Consistently comply with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Florida Baker Act laws.

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.)

Former Program Coordinator, Department of Children and Families

Consultant, Lenderman & Associates, Pinellas Park, Florida

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

Martha R. Lenderman, MSW, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentations or discussions.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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. ______________________________________________________

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: __________  REVIEWED BY: ☐ Accelerated Approval  ☐ Executive Committee
                          ☐ Live Committee

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

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

CME ACTIVITY TITLE: 2019 Caring for Kids with Cancer Symposium

DATE: Saturday, October 19, 2019  TIME: 8 a.m. – 1:15 p.m.  CREDIT HOUR(S) APPLIED FOR: 5.5 Cat. 1

LOCATION: Miami Cancer Institute – Café
**TARGET AUDIENCE:** Pediatricians, Pediatric Oncologists, Hematologists/Oncologists, Infectious Disease Pediatricians, Pediatric General Internists, Family Physicians, Neonatologists, ED Physicians, Psychiatrists, Psychologists, Nurses, Social Workers, Respiratory Therapists, Radiation Technologists, Dieticians, Pharmacists, Clinical Lab Personnel and all interested healthcare providers who care for children with cancer.

**SYMPOSIUM DIRECTORS:**

**CME MANAGER:** Eleanor Abreu

**EXPECTED NUMBER OF ATTENDEES:** 150  
**CHARGE:** $35

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

- [ ] ARS  
- [X] Case Studies  
- [X] Didactic Lecture  
- [X] 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  
- [X] Live activity  
- [ ] Manuscript review activity  
- [X] 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.*

This symposium will highlight a spectrum of new developments and innovative advances in current pediatric oncology practice. The faculty — including leading experts from the top local and national cancer care institutions — will review the latest technologies and therapeutic approaches to challenging clinical problems, and will focus on evidence-based approaches to the special physical, emotional and psychological needs of pediatric cancer patients and their families.

Working in partnership to provide the best possible care for the communities they serve, two local leaders in healthcare – **Miami Cancer Institute,** part of Baptist Health South Florida, the area's largest, not-for-profit healthcare provider, and nonprofit **Nicklaus Children's Hospital,** part of Miami Children's Health System and the leading provider of children's healthcare services in South Florida – are collaborating to improve healthcare through continuing 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:**  
- [X] Noncompliance  
- [X] Lifestyle  
- [ ] Resistance to change  
- [X] Cost of care/Lack of insurance

**Physician:**  
- [X] Noncompliance  
- [X] Resistance to change  
- [X] Communication skills  
- [X] 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
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)

► Radiation therapy plays an important role in the management of pediatric malignancies. Physicians may not be aware of the differences in radiation therapy or the benefits of proton therapy. Physicians should assess all forms of radiotherapy in order to modify treatments for the patient specific needs and diagnosis.

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)

► Treating physicians will implement and initiate a multi-specialty treatment team allowing a thorough radiation oncology consultation with a trained physician who has full knowledge of all major radiotherapy modalities in order to appropriately define the right option for a given patient.

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:
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:

Please see below.

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.)

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

SYMPOSIUM DIRECTORS:

Doured Daghistani, M.D.
Symposium Director
Hematology/Oncology
Baptist, Homestead, South Miami Hospitals
Miami, Florida

Doured Daghistani, M.D., has indicated that neither he nor his spouse/partner have relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Ziad Khatib, MD
Director of Medical Neuro-Oncology
Division of Pediatric Hematology Oncology
Ziad Khatib, M.D., has indicated that neither he nor his spouse/partner have relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

**FACULTY:**

Fuad Alkhoury, M.D.
Director, Neonatal General Surgery
Niklaus Children’s Hospital
Miami, Florida

Faud Alkhoury, M.D. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Stephen Gottschalk, M.D.
Chair, Department of Bone Marrow Transplantation and Cellular Therapy
Endowed Chair in Bone Marrow Transplantation and Cellular Therapy
St. Jude’s Children’s Hospital
Memphis, Tennessee

Stephen Gottschalk, M.D. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Paul A. Meyers, M.D.
Pediatric Oncologist
Chief of Sarcoma Service
Vice Chair for Clinical Affairs
Memorial Sloan Kettering
New York, New York
Paul A. Meyers, M.D. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Toba N. Niazi, M.D.
Pediatric Neurosurgeon
Nicklaus Children’s Hospital
Miami, Florida

Toba Niazi, M.D. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Dominique Symonette, M.S., RDN. LDN, CNSC
Clinical Nutritionist Specialist
Miami Cancer Institute
Miami, Florida

Dominique Symonette, M.S., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Michael D. Taylor M.D., Ph.D.
Staff Neurosurgeon, Hospital for Sick Children
Professor, Department of Surgery and,
Department of Laboratory Medicine and Pathobiology
University of Toronto
Toronto, Canada

Michael D. Taylor, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. _____________________________________________________

Working in partnership to provide the best possible care for the communities they serve, two local leaders in healthcare – Baptist Health South Florida, the area’s largest, not-for-profit healthcare provider, and nonprofit Nicklaus Children’s Hospital, part of Miami Children’s Health System and the leading provider of children’s healthcare services in South Florida – are collaborating to improve healthcare through continuing education.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: __________ 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

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:
Stephen Gottschalk, M.D.

**T-cell Therapy for Pediatric Diseases**

- Describe and be familiar with current T-cell therapy approaches.
- Examine and have a better understanding on how T-cells are generated and currently used in the clinic.
- Analyze challenged and opportunities in developing T-cell therapies for pediatric cancer.

Reference:

In a single-center phase 1–2a study, the anti-CD19 chimeric antigen receptor (CAR) T-cell therapy tisagenlecleucel produced high rates of complete remission and was associated with serious but mainly reversible toxic effects in children and young adults with relapsed or refractory B-cell acute lymphoblastic leukemia (ALL).


Paul A. Myers, M.D.

**Osteosarcoma Update**

- Summarize the meaning and use of histologic necrosis following initial chemotherapy in the treatment of osteosarcoma.
- Describe the evolving role of genomic profiling in the diagnosis and treatment of osteosarcoma.

Reference:

Osteosarcoma is a highly aggressive cancer for which treatment has remained essentially unchanged for more than 30 years. Osteosarcoma is characterized by widespread and recurrent somatic copy-number alterations (SCNA) and structural rearrangements. In contrast, few recurrent point mutations in protein-coding genes have been identified, suggesting that genes within SCNAs are key oncogenic drivers in this disease. SCNAs and structural rearrangements are highly heterogeneous across osteosarcoma cases, suggesting the need for a genome-informed approach to targeted therapy. To identify patient-specific candidate drivers, we used a simple heuristic based on degree and rank order of copy-number amplification (identified by whole-genome sequencing) and changes in gene expression as identified by RNA sequencing. Using patient-derived tumor xenografts, we demonstrate that targeting of patient-specific SCNAs leads to significant decrease in tumor burden, providing a road map for genome-informed treatment of osteosarcoma. **SIGNIFICANCE:** Osteosarcoma is treated with a chemotherapy regimen established 30 years ago. Although osteosarcoma is genomically complex, we hypothesized that tumor-specific dependencies could be identified within SCNAs. Using patient-derived tumor xenografts, we found a high degree of response for "genome-matched" therapies, demonstrating the utility of a targeted genome-informed approach.


Toba N. Niazi, M.D.

**Neurosurgical Advances in Pediatric Brain Tumors**

- Implement intraoperative MRI, computed tomography and ultrasound to maximize the extent of tumor resection in a single sitting.
- Describe intraoperative neurophysiological monitoring that has been successful to assist in the safe removal of tumors in eloquent areas of the brain.
Reference:

X-rays and ventriculograms were the first imaging modalities used to localize intracranial lesions including brain tumors as far back as the 1880s. Subsequent advances in preoperative radiological localization included computed tomography (CT; 1971) and MRI (1977). Since then, other imaging modalities have been developed for clinical application although none as pivotal as CT and MRI. Intraoperative technological advances include the microscope, which has allowed precise surgery under magnification and improved lighting, and the endoscope, which has improved the treatment of hydrocephalus and allowed biopsy and complete resection of intraventricular, pituitary and pineal region tumors through a minimally invasive approach. Neuronavigation, intraoperative MRI, CT and ultrasound have increased the ability of the neurosurgeon to perform safe and maximal tumor resection. This may be facilitated by the use of fluorescing agents, which help define the tumor margin, and intraoperative neurophysiological monitoring, which helps identify and protect eloquent brain.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6027926/

Dominique Symonette, M.S., RDN

**Pediatric Nutrition and Oncology**

- Describe selected pediatric cancer diagnosis and associated nutrition risks and complications.
- Identify caregivers who would benefit from nutrition referral to assist with nutrition care planning responsibilities during selected treatment roadmaps.
- Discuss available nutrition guidelines and best practice for the pediatric cancer patient survivor.

Reference:

Oncology nutrition encompasses nutrition care for individuals along the cancer care continuum. Nutrition is a vital component of prevention, treatment, and healthy survivorship. The practice of an oncology registered dietitian nutritionist (RDN) reflects the setting and population served with diverse cancer diagnoses, including expanded roles and responsibilities reflecting the RDN's interests and organization's activities. Provision of nutrition services in oncology requires that RDNs have advanced knowledge in the focus area of oncology nutrition. Thus, the Oncology Nutrition Dietetic Practice Group, with guidance from the Academy of Nutrition and Dietetics Quality Management Committee, has developed Standards of Practice and Standards of Professional Performance as tools for RDNs currently in practice or interested in working in oncology nutrition, to address their current skill level and to identify areas for additional professional development in this practice area. The Standards of Practice address and apply the Nutrition Care Process and workflow elements, which are screening, assessment, diagnosis, intervention, evaluation/monitoring, and discharge planning and transitions of care. The Standards of Professional Performance consist of the following six domains of professionalism including: Quality in Practice, Competence and Accountability, Provision of Services, Application of Research, Communication and Application of Knowledge, and Utilization and Management of Resources. Within each standard, specific indicators provide measurable action statements and describe three skill levels (competent, proficient, and expert) for RDNs working in oncology nutrition.


Michael D. Taylor, M.D., Ph.D.

**Molecular Classification of Brain Tumors**

- Apply tumor precision diagnostics in order to improve patient care.
Assess molecular studies that have led to the identification of distinct tumor subgroups in pediatric brain tumors.

Reference:
Optimal integration of this newly emerging knowledge in a timely and meaningful way into clinical care is a remarkable task and a matter of active debate. The historical morphology-based classification of tumors is being replaced by a genetic-based classification, and the first generation of molecularly informed clinical trials is underway.

https://pdfs.semanticscholar.org/f0fb/ff68523311a505d9d10282279fed9f745902.pdf

Stephen Gottschalk, M.D.

**CAR T Cells for Solid Tumors: What are the challenges?**

- Describe current CD19 CAR T-cell therapy outcomes and limitations.
- Assess and familiarize the onset, optimal management and results of anti-tumor efficacy of CAR T-cell toxicities.

Reference:
A patient with recurrent multifocal glioblastoma received chimeric antigen receptor (CAR)–engineered T cells targeting the tumor-associated antigen interleukin-13 receptor alpha 2 (IL13Ra2). Multiple infusions of CAR T cells were administered over 220 days through two intracranial delivery routes — infusions into the resected tumor cavity followed by infusions into the ventricular system. Intracranial infusions of IL13Ra2-targeted CAR T cells were not associated with any toxic effects of grade 3 or higher. After CAR T-cell treatment, regression of all intracranial and spinal tumors was observed, along with corresponding increases in levels of cytokines and immune cells in the cerebrospinal fluid.


https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5390684/

Paul A. Meyers, M.D.

**Ewing Sarcoma Update**

- Describe the value of dose intensity in the treatment of newly diagnosed EWING sarcoma.
- Analyze the controversy around the use of high dose therapy with autologous stem cell support in the treatment of Ewing sarcoma.

Reference:
Purpose For over 30 years, the place of consolidation high-dose chemotherapy in Ewing sarcoma (ES) has been controversial. A randomized study was conducted to determine whether consolidation high-dose chemotherapy improved survival in patients with localized ES at high risk for relapse. Methods Randomization between busulfan and melphalan (BuMel) or standard chemotherapy (vincristine, dactinomycin, and ifosfamide [VAI], seven courses) was offered to patients if they were younger than 50 years of age with poor histologic response (≥ 10% viable cells) after receiving vincristine, ifosfamide, doxorubicin, and etoposide (six courses); or had a tumor volume at diagnosis ≥ 200 mL if unresected, or initially resected, or resected after radiotherapy. A 15% improvement in 3-year event-free survival (EFS) was sought (hazard ratio [HR], 0.60). Results Between 2000 and 2015, 240 patients classified as high risk (median age, 17.1 years) were randomly assigned to VAI (n = 118) or BuMel (n = 122). Seventy-eight percent entered the trial because of poor histologic response after chemotherapy alone. Median follow-up was 7.8 years. In an intent-to-treat analysis, the risk of event was significantly decreased by BuMel compared with VAI: HR, 0.64 (95% CI, 0.43 to 0.95; P = .026); 3- and 8-year EFS were, respectively, 69.0% (95% CI, 60.2% to 76.6%) versus 56.7% (95% CI, 47.6% to 65.4%) and 60.7% (95% CI, 51.1% to 69.6%) versus 47.1% (95% CI, 37.7% to 56.8%). Overall survival (OS) also favored BuMel: HR, 0.63 (95% CI, 0.41 to 0.95; P = .028); 3- and 8-year OS were, respectively, 78.0% (95% CI, 69.6% to 84.5%) versus 72.2% (95% CI, 63.3% to 79.6%) and 64.5% (95% CI, 54.4% to 73.5%) versus 55.6% (95% CI, 45.8% to 65.1%). Results were
consistent in the sensitivity analysis. Two patients died as a result of BuMel-related toxicity, one after standard chemotherapy. Significantly more BuMel patients experienced severe acute toxicities from this course of chemotherapy compared with multiple VAI courses. Conclusion BuMel improved EFS and OS when given after vincristine, ifosfamide, doxorubicin, and etoposide induction in localized ES with predefined high-risk factors. For this group of patients, BuMel may be an important addition to the standard of care.

Faud Alkhoury, M.D.

**Robotics as enhancement to cancer surgery in children**

- Describe robotic surgery in pediatric cancer care.
- Analyze potential usage of robotic surgery in pediatric cancer.
- Demonstrate pediatric cancer surgery case presentations.

Reference:

Diffuse intrinsic pontine gliomas (DIPG) constitute 10-15% of all brain tumors in the pediatric population; currently prognosis remains poor, with an overall survival of 7-14 months. Recently the indication of DIPG biopsy has been enlarged due to the development of molecular biology and various ongoing clinical and therapeutic trials. Classically a biopsy is performed using a stereotactic frame assisted procedure but the workflow may sometimes be heavy and more complex especially in children. In this study the authors present their experience with frameless robotic-guided biopsy of DIPG in a pediatric population.

Dominique Symonette, M.D. RDN

**Managing Treatment Side Effects and Maintaining Proper Nutrition**

- Identify selected pediatric cancer diagnosis and associated nutrition risks and complications.
- Discuss nutrition risks associated with pediatric cancer.
- Discuss common nutrition diagnosis associated with pediatric cancer treatment modalities.

Reference:

Lack of access to nutrition care in outpatient cancer centers is a critical issue in the US health care system. It is well documented that malnutrition adversely affects key outcomes, including morbidity and mortality, as well as hospitalizations, readmissions, and other variables that may increase cost of oncology care. Based upon this evidence, the Oncology Nutrition Dietetic Practice Group (ON DPG), a practice group of the Academy of Nutrition and Dietetics (Academy), formulated a strategic plan to address nutrition-related gaps in cancer care. The ultimate goal of the strategic plan is to improve patient access to oncology nutrition care from the time of diagnoses, through treatment and into cancer survivorship, for whatever period of time survivorship may encompass.
CME ACTIVITY TITLE: 2019 Caring for Kids with Cancer Symposium

DATE: Saturday, October 19, 2019       TIME: 8 a.m. – 2:05 p.m.       CREDIT HOUR(S) APPLIED FOR: 5.5 Cat. 1

AGENDA

7:30 – 7:50 a.m.   Registration and Breakfast

7:50 a.m.   Welcome and Introductions

8:00 a.m.   Immunotherapy in Pediatric Tumors
            Stephen Gottschalk, M.D.

8:45 a.m.   Osteosarcoma Update
            Paul A. Meyers, M.D.

9:10 a.m.   Questions and Answers
            Stephen Gottschalk, M.D. and Paul A. Meyers, M.D.

9:25 a.m.   Update on Neurosurgical Advances in Pediatric Tumors
            Toba N. Niazi, M.D.

9:50 a.m.   Pediatric Nutrition and Oncology
            Dominique Symonette, M.S., RDN

10:15 a.m.   Questions and Answers
            Toba N. Niazi, M.D. and Dominique Symonette, M.S., RDN

10:30 a.m.   Break and Visit Exhibits

10:50 a.m.   Molecular Classification of Brain Tumors
Michael D. Taylor, M.D., Ph.D.

11:35 a.m.   **CAR T Cells for Solid Tumors: What are the Challenges?**
Stephen Gottschalk, M.D.

12:00 p.m.   **Questions and Answers**
Michael D. Taylor, M.D., Ph.D. and Paul A. Meyers, M.D.

12:15 p.m.   **Break and Exhibits**

12:35 p.m.   **Ewing Sarcoma Update**
Paul A. Meyers, M.D.

1:00 p.m.   **Robotics as enhancement to cancer surgery in children**
Faud Alkhoury, M.D.

1:25 p.m.   **Managing Treatment Side Effects and Maintaining Proper Nutrition**
Dominique Symonette, M.S., RDN

1:50 p.m.   **Questions and Answers**
Paul A. Meyers, M.D., Toba N. Niazi, M.D. and Dominique Symonette, M.S., RDN

2:05 p.m.   Adjourn

**Repubished Annually – Update year and republish January annually**

**CME ACTIVITY TITLE: **2019 Baptist Outpatient Services Infection Control and OSHA Training **

CONTINUING MEDICAL EDUCATION ACTIVITY APPLICATION

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

COURSE APPROVED: June 2019    COURSE EXPIRES: June 2022
CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

TARGET AUDIENCE: Baptist Outpatient Services Contracted Physicians, Physician Assistants, Nurse Practitioners, Nurses, Medical Students and other interested healthcare professionals.

CONFERENCE DIRECTOR: Philip Weimer, M.D. CME MANAGER: Marie Vital Acle

EXPECTED NUMBER OF ATTENDEES: 0 CHARGE: 0

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

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

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

This education is required for the safety of physicians and allied healthcare providers, and will educate them on the highest safety standards for occupational safety and health. Safety is focused on infection prevention and control for both employees and the community.

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.
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)

► OSHA (OSHA CFR 1910.1030) mandates that healthcare workers receive annual education on OSHA standards. Contracted physicians may not be aware of infection prevention and OSHA protocols in place within Baptist Outpatient Services (BOS) facilities. This course meets annual required education.

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.)

DESIRE 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)

► Practitioners will adhere to BOS infection prevention protocols, implement OSHA processes including proper management of needle sticks, eye splashes and adhere to adequate personal protective equipment application.

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): OSHA requirements
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:

- Implement infection control practice when exposed to blood and other body fluids.
- Utilize current Baptist Outpatient Services infection control protocols.
- Adhere to Occupational Safety and Health Administration (OSHA) standards for bloodborne pathogens.
- Utilize personal protective equipment (PPE) appropriately.
- Select appropriate isolation- and transmission-based precautions.
- Implement infection prevention practices supporting hand hygiene.

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.)

Philip C. Weimer, M.D.
Medical Director
Baptist Hospital of Miami Urgent Care Centers

Lis Estevez, R.N., MPH, CIC
Infection Control Prevention Nurse
Baptist Outpatient Services

Liz Marjorie Balda, M.T., B.S., CIC
Infection Control Prevention Coordinator
Baptist Outpatient Services

Philip C. Weimer, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

Lis Estevez, R.N., MPH, CIC, and Liz Marjorie Balda, M.T., B.S., CIC, indicated that neither they nor their spouses/partners have relevant financial relationships with commercial interest companies, and they will not include off-label or unapproved product usage in their presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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.  

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN:  List names of up to two courses with similar target audiences. Please list complete course title.

External:

Provider:

Course video:

Course handout:

Quiz Questions

Routine hand-washing with soap and water must be performed:

a) To removed soiled and transient microorganisms.
b) Before eating and after using the restroom.
c) After contact with a patient with C. difficile.
d) After multiple use of alcohol based hand sanitizer (as indicated).
e) A, b, c, and d.

2) When is it important for physicians to practice proper hand hygiene?

a) Before and after patient care.
b) Before and after donning gloves.
c) After having contact with anything in the patients environment.
d) Wearing gloves replaces the need for hand hygiene.
3) What does OSHA stand for?
   a) Occupational Exposure to Blood.
   b) **Occupational Safety and Health Administration.**
   c) Occupational Bloodborne Pathogen Standard.
   d) Occupational Needle Sticks and other Sharps Injury.

4) What document is required by OSHA to prevent transmission of bloodborne pathogens such as HIV, HBV and HCV in a healthcare facility?
   a) Infection control plan.
   b) **Exposure control plan.**
   c) Emergency preparedness plan.
   d) Safety plan.

5) Name three of OSHA’s engineering and work practice controls:
   a) Personal protective equipment (PPE).
   b) Post-exposure management.
   c) Accessibility of hand-washing facilities.
   d) Procedure involving blood collection.
   e) **A, b and c.**

6) What are the most common bloodborne pathogens? Select all that apply.
   a) MRSA.
   b) Herpes virus.
   c) Hepatitis virus B (HVB).
   d) Human immunodeficiency virus (HIV).
   e) **C and d.**

7) What isolation precaution should be implemented with a patient presenting with signs and symptoms of tuberculosis?
   a) Droplets.
   b) Contact.
   c) **Airborne.**
   d) Positive.
8) Why is it important to follow the sequence of donning and doffing PPE?
   a) To prevent contamination of the environment.
   b) **To avoid the spread of infections to self, other staff members and patients.**
   c) To limit opportunities for touching from contaminated environment and equipment.
   d) To get ready for the next patient.

9) What PPE should be worn by healthcare professionals with a patient needing airborne precautions such as with tuberculosis, measles and chicken pox?
   a) Regular surgical mask.
   b) **N95 respirator.**
   c) No mask is required.
   d) A and b.

10) While taking care of a patient with possible seasonal influenza, you should:
   a) Use an N95 respirator before entering the room.
   b) **Wear a surgical mask and dispose of it after each use.**
   c) Leave the surgical mask around your neck for the next patient encounter.
   d) Place a surgical mask on the patient only.

11) If you have a needle-stick or sharps injury, the first thing you should do is:
   a) Seek medical treatment.
   b) Keep working so you don't lose your job.
   c) Let the patient know immediately.
   d) **Perform first aid (wash with soap and water).**

12) In caring for a patient with C. difficile diarrhea, you must wash your hands with soap and water, dry them and then use alcohol hand rinse:
   a) **After any contact.**
   b) After changing a stretcher.
   c) Before changing a stretcher.
   d) Before any contact.

13) When performing hand hygiene, wet your hands, dispense the soap and lather for:
   a) 1 minute scrub time.
   b) **15-20 seconds.**
   c) The time it takes to sing the “Happy birthday” song twice.
d) Thirty (30) seconds.

14) When is terminal cleaning done?
   a) At the end of the day, even if the room has not been used.
   b) After each case.
   c) Once a week.
   d) When needed.

15) Covering the hair while conducting a sterile procedure is an AORN recommendation to minimize the amount of hair shedding in the environment. Which of the following is a proper way to cover facial hair?
   a) Wearing a surgical mask.
   b) Wearing a facial hair cover under the surgical mask.
   c) Wearing either a surgical mask or a facial hair cover.
   d) Facial hair does not need to be covered while conducting sterile procedures.
TARGET AUDIENCE: Baptist Outpatient Services Contracted Physicians, Physician Assistants, Nurse Practitioners, Nurses, Medical Students and other interested healthcare professionals.

CONFERENCE DIRECTOR: Philip Weimer, M.D.  CME MANAGER: Marie Vital Acle

EXPECTED NUMBER OF ATTENDEES: 0  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)
- [x] 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.

This education is required for the safety of physicians and allied healthcare providers, and will educate them on the highest safety standards for occupational safety and health. Safety is focused on infection prevention and control for both employees and the community.

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)

► OSHA (OSHA CFR 1910.1030) mandates that healthcare workers receive annual education on OSHA standards. Contracted physicians may not be aware of infection prevention and OSHA protocols in place within Baptist Outpatient Services (BOS) facilities. This course meets annual required education.

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)

► Practitioners will adhere to BOS infection prevention protocols, implement OSHA processes including proper management of needle sticks, eye splashes and adhere to adequate personal protective equipment application.

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): OSHA requirements
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* 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:

- Implement infection control practice when exposed to blood and other body fluids.
- Utilize current Baptist Outpatient Services infection control protocols.
- Adhere to Occupational Safety and Health Administration (OSHA) standards for bloodborne pathogens.
- Utilize personal protective equipment (PPE) appropriately.
- Select appropriate isolation- and transmission-based precautions.
- Implement infection prevention practices supporting hand hygiene.

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______________________
Philip C. Weimer, M.D.
Medical Director
Baptist Hospital of Miami Urgent Care Centers

Lis Estevez, R.N., MPH, CIC
Infection Control Prevention Nurse
Baptist Outpatient Services

Liz Marjorie Balda, M.T., B.S., CIC
Infection Control Prevention Coordinator
Baptist Outpatient Services

Philip C. Weimer, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

Lis Estevez, R.N., MPH, CIC, and Liz Marjorie Balda, M.T., B.S., CIC, indicated that neither they nor their spouses/partners have relevant financial relationships with commercial interest companies, and they will not include off-label or unapproved product usage in their presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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. ______________________________________________________

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:

Provider:

Course video:

Course handout:

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b) Before eating and after using the restroom.
c) After contact with a patient with C. difficile.
d) After multiple use of alcohol based hand sanitizer (as indicated).
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   d) Procedure involving blood collection.
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   d) Human immunodeficiency virus (HIV).
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   b) N95 respirator.
   c) No mask is required.
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    b) Wear a surgical mask and dispose of it after each use.
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    d) Place a surgical mask on the patient only.

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    b) Keep working so you don't lose your job.
    c) Let the patient know immediately.
    d) Perform first aid (wash with soap and water).

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    a) After any contact.
    b) After changing a stretcher.
    c) Before changing a stretcher.
    d) Before any contact.

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    a) 1 minute scrub time.
    b) 15-20 seconds.
    c) The time it takes to sing the “Happy birthday” song twice.
d) Thirty (30) seconds.

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   a) Wearing a surgical mask.
   b) Wearing a facial hair cover under the surgical mask.
   c) Wearing either a surgical mask or a facial hair cover.
   d) Facial hair does not need to be covered while conducting sterile procedures.
disease specialists, gastroenterologists, neurologists, ENTs, ophthalmologists, urologists, pulmonologists, critical care physicians, nurses, medical students, residents, fellows and other interested healthcare professionals

CONFERENCE DIRECTOR: A. Hernandez, M.D. CME MANAGER: Eleanor Abreu (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 0 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)

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

Medical and surgical services furnished by an intern or resident within the scope of his or her training program are covered as provider services and Medicare pays for them through Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments. These services may not be billed or paid under the Medicare Physician Fee Schedule (PFS). When interns or residents are in an approved program and training in a nonprovider setting, the services furnished are payable in one of the following ways:

a. Through DGME and IME payments to the hospital(s), if, among other things, he or she: Provides patient care activities and the hospital(s) incur(s) salary and fringe benefits of the resident or intern during the time spent in the nonprovider setting; or

b. For DGME purposes, spends time in certain nonpatient care activities in certain nonprovider settings and the hospital(s) incur(s) salary and fringe benefits of the resident or intern during the time he or she spent in the nonprovider setting; or

c. Through the Medicare PFS if, in part, the regulations concerning the hospital(s) receipt of DGME and IME payments are not met for the time spent in a nonprovider setting, and the time spent in the nonprovider setting is not counted by the hospital(s) for DGME and IME payment purpose.

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)

► Medicare’s teaching physician guidelines are numerous, complicated and rather unwieldy. Without accurate education, teaching physician services may not be billed correctly.

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)

► With accurate education, teaching physicians and residents will consistently document the performance of services in a full and compliant manner.

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

REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
The presence of the teaching physician during procedures may be demonstrated by the notes in the medical records made by a physician, resident, or nurse. In the case of evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical records.


Bibliography and Additional Resources:

**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:

- Apply up-to-date organizational billing requirements.
- Implement up-to-date government payer billing requirements.

**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.)

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

**Seth Canterbury, CPC, CPC-I**

Healthcare Coding and Reimbursement Consultant

**Seth Canterbury, CPC, CPC-1,** has indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he **will not** include off-label or unapproved product usage in his presentation or discussion.

**Conference Director**

**Agueda Hernandez, M.D.,** indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies.
Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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. _____________________________________________________

This event is in collaboration with the West Kendall Baptist Hospital Graduate Medical Education Program.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM163

Course video:
Course handout:

**Quiz Questions**

1. To bill for a minor procedure, a teaching physician must document his or her presence during ____________ of the service.
   a. The key portion(s)
   b. The beginning
   c. The end
   d. The entirety

2. To bill for a major procedure, a teaching physician must document his or her presence during ____________ of the service.
   a. The key portion(s)
   b. The beginning
   c. The end
   d. The entirety

3. To bill for an E/M service, a teaching physician must document his or her presence during ____________ of the service.
   a. The key portion(s)
   b. The beginning
   c. The end
   d. The entirety

4. To bill for a time-based service, a teaching physician must document his or her presence during ____________ of the service.
   a. The key portion
   b. The beginning
   c. The end
   d. The entirety

DATE REVIEWED: __________ REVIEWED BY: □ Accelerated Approval □ Executive Committee

□ Live Committee

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

Continuing Psychology Education Credits: # __ □ N/A  □ Continuing Dental Education Credits: # __ □ N/A
CME ACTIVITY TITLE: Promoting Physician Wellness: Management of Physician’s Fatigue, Sleep Deprivation and Other Conditions that Contribute to Physician Impairment

COURSE APPROVAL: July 2019                     COURSE EXPIRATION: July 2020

CREDIT HOUR(S) APPLIED FOR: TBD

TARGET AUDIENCE: West Kendall Baptist Hospital GME faculty including: Family medicine practitioners, cardiologists, emergency medicine physicians, surgeons, hospitalists, Ob/Gyn’s, nephrologists, hematologists/oncologists, infectious disease specialists, gastroenterologists, neurologists, ENT’s, ophthalmologists, urologists, pulmonologists, critical care physicians, nurses, medical students, residents, fellows and other interested healthcare professionals.

CONFERENCE DIRECTOR: Agueda Hernandez, M.D.

CME MANAGER: Eleanor Abreu (LIVE); Marie Vital Acle (ONLINE)

EXPECTED NUMBER OF ATTENDEES: 25-30                     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)

COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.
With the growing attention paid to resident duty hours, there is an increasing need for research involving fatigue and practical ways to measure it. This study shows that residents who are measurably fatigued (both objectively and subjectively) may have difficulty utilizing vestibular input during quiet standing but can compensate by means of somatosensory and visual input.

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 may not be aware of the signs of fatigue and sleep deprivation in residents and fellows.

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 supervising residents and fellows implement appropriate strategies to address issues of fatigue and sleep deprivation.

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:
Balance as a measurement of fatigue in postcall residents. Cuthbertson DW¹, Bershad EM, Sangi-Haghpeykar H, Cohen HS.


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:

- Identify the ACGME duty hour regulations
- Recognize the signs of fatigue, sleep deprivation and other conditions that contribute to physician impairment
- Identify the effect of fatigue, sleep deprivation, and other conditions on physician’s functioning and performance
- Engage in strategies to prevent and reduce the impact of fatigue, sleep deprivation, and other conditions on physician’s functioning and performance.

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.)

Susan Chaflin, Ph.D.
Licensed Clinical Psychologist
Child Psychology Associates
Director, Behavioral Medicine Training
Florida International University/West Kendall Baptist Hospital Family Medicine Training

Susan Chaflin, Ph.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.
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. ________________________________________________________

This event is in collaboration with the West Kendall Baptist Hospital Graduate Medical Education Program.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM166

Course video:

Course handout:

Quiz Questions
1. Which of the following is not an ACGME limit on duty hours?
   a. 80 hours maximum per week.
   b. 16 hours maximum per shift for all residents with no exceptions.
   c. In-house call every three nights.
   d. 10-hour minimum rest period provided between daily duty periods and after in-house call.
   e. One day in seven free of patient care responsibilities.

2. Which of the following are signs of fatigue?
   a. Involuntary nodding off, waves of sleepiness and lethargy.
   b. Problems focusing, inattentiveness to details and difficulty with short-term recall.
   c. Irritability, poor coordination and missing work.
   d. All of the above.
   e. a and c

3. True or false: A 60-minute nap or 100 mg of caffeine relieves the impact of fatigue and sleep deprivation.

4. Research shows that the impact of a physician missing one night of sleep includes:
   a. 50% decrease in cognitive performance.
   b. Increase in medical errors.
   c. Increase in length of time required to perform surgery/procedures.
   d. All of the above.
   e. b and c

5. Which of the following are effective wellness tools?
   a. Good sleep hygiene.
   b. Deep breathing, mindfulness and regular exercise.
   c. Good work-life balance.
   d. Supportive work and family relations.
   e. All of the above.
CME ACTIVITY TITLE: The Role of Diet in Preventing, Arresting and Reversing the Leading Causes of Death

COURSE APPROVAL: June 2019
COURSE EXPIRATION: June 2022

CREDIT HOUR(S) APPLIED FOR: TBD

TARGET AUDIENCE: Primary Care Physicians, Cardiologists, Internal Medicine Physicians and all other interested healthcare providers

CONFERENCE DIRECTOR: Arturo Fridman, M.D.
CME MANAGER: Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 0
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)

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

Michael Greger, M.D., New York Times best-selling author of How Not to Die, will present the latest research exploring the role diet may play in preventing and even reversing our leading causes of death and disability.
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)

► Practitioners may not be aware of the evidence-based data supporting a plant-based diet to reduce risk for common medical conditions.

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)

► Practitioners consider a plant-based diet for common medical conditions where evidence-based data supports dietary changes as a means to reduce risk.

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
☐ 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:
Serum-cholesterol, diet, and coronary heart-disease in Africans and Asians in Uganda*

In the African population of Uganda coronary heart disease is almost non-existent.

Yams, maize, and millet are also staple commodities in particular of the non-Baganda groups, while pumpkins, tomatoes, and green leafy vegetables are taken by all.

*female) were certified as due to coronary heart disease (“myocardial infarction”, “coronary thrombosis”). Though the errors inherent in certification must be borne in mind, it is noteworthy that 43% of male deaths and 9% female deaths over 30 years group of hills about 4000ft. above sea level, and the temperature varies from 65 to 80°F by day with little seasonal variation. The rainfall is about 50in. a year and the relative humidity is 60–80%.
confirm the capacity of whole-food plant-based nutrition to restore health in “there is nothing further we can do” situations.

The power of nutrition as medicine

The best kept secret in medicine

Although improved treatments have contributed to a more than 40% reduction in cardiovascular disease mortality (Ford et al., 2007), a number of recent studies have pointed to glaring problems with the medical management of this condition. Nicotinic, long regarded as beneficial because of its effect in raising HDL cholesterol, showed no clinical benefit in a major multicenter study (The AIM-HIGH Investigators, 2011). Statin medication use in postmenopausal women was found to be associated with an increased risk for diabetes mellitus (Culver et al., 2012). A large meta-analysis of randomized controlled trials concluded that the routine use of aspirin for primary prevention is not warranted (Seshaasai et al., 2012). In response, physicians and researchers continue to express the need for more clinical trials (Manning and Breslow, 2011).

When it comes to cardiovascular disease, there is no substitute for nutritional excellence. In the Lifestyle Heart Trial, dietary and lifestyle changes alone caused a 37% decrease in LDL cholesterol (Ornish et al., 1990). In a report of 4,587 adults treated with the Pritikin diet, total and LDL cholesterol levels decreased by an average of 23% and triglyceride levels were reduced by 33% (Barnard, 1990). Is the heart healthy? The answer is: yes.

Conflict of interest statement

None.

References


Effects of ranolazine in symptomatic patients with stable coronary artery disease. A systematic review and meta-analysis

Collectively, our meta-analysis demonstrates a significant improvement of exercise parameters in patients treated with Ranolazine compared to placebo, including significant prolongation of exercise duration by 31.9 [CI: 21.0 to 42.8] and **33.5 seconds** [CI: 25.1 to 41.8] at trough and peak doses, respectively.

Keywords:
Ranolazine
Angina
Coronary artery disease

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Low Protein Intake Is Associated with a Major Reduction in IGF-1, Cancer, and Overall Mortality in the 65 and Younger but Not Older Population

Among subjects with no diabetes at baseline, those in the high protein group had a **73-fold** increase in risk (HR: 73.52; 95% CI: 4.47–1,209.70), while those in the moderate protein category had an almost **23-fold** increase in the risk of diabetes mortality (HR: 22.93; 95% CI: 1.31–400.70).

between protein intake and mortality. Respondents aged 50–65 reporting high protein intake had a 75% increase in overall mortality and a 4-fold increase in cancer death risk during the following 18 years. These associations were either abolished or attenuated if the proteins were plant derived. Conversely, high protein intake was associated with reduced cancer and overall mortality in people aged 65 and over. (Fontana et al., 2010; Hauck et al., 2002; Wei et al., 2009). The effect of the insulin/IGF-1 pathway on longevity was first described in C. elegans by showing that mutations in the insulin/IGF-1 receptor or in the downstream age-1 gene caused a several-fold increase in lifespan (Johnson, 1990; Kenyon et al., 1993, Kenyon, 2010). Other studies revealed that mutations in orthologs of genes functioning in insulin/IGF-1 signaling, but also activated independently of insulin/IGF-1, including TOR- 

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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:

- Explain the evidence-based data supporting a plant-based diet to reduce the risk of common medical conditions and identify patients who would benefit from a plant-based diet.

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.)

Michael Greger, M.D., FACLM
Diplomate, American Board of Lifestyle Medicine
Chief Science Officer and Founder, NutritionFacts.org
Faculty disclosure statement (as it should appear on course shell):

Michael Greger, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentations or discussions.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. This activity was planned by the Wellness Advantage department as a live full day event and the CME department’s role was delivering this content in an online format for interested healthcare workers in support for this system-wide initiative. Physician buy-in plays a critical to success of a plant-based diet in support of risk reduction for common medical illnesses.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:

Provider: 2019IEM165
Quiz Questions

DATE REVIEWED: June 17, 2019 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

CME ACTIVITY TITLE: Glucose Management in Noncritical Hospitalized Patients

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

COURSE APPROVAL: December 2016 - December 2018
Course Renewal: December 2018; June 2019
Course Expires: December 2020
TARGET AUDIENCE: Hospitalists, Internists, Family Practitioners, Emergency Medicine Physicians, Surgeons, Cardiologists, Endocrinologists, Podiatrists, Nurses, Pharmacists, Dietitians and other interested healthcare practitioners

CONFERENCE DIRECTOR: Michael Fili, M.D.  CME MANAGER: Eleanor Abreu/ Marie Vital Acle (Online)

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 & 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: Hyperglycemic crisis, which includes diabetic ketoacidosis and a hyperosmolar state, is a common diagnosis in hospitalized patients whose admission rates continue to increase despite preventive strategies. Healthcare providers are encouraged to discuss challenges to glycemic control unique to the hospital setting, and share strategies on implementing current guidelines and glycemic targets for ill patients.

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)

► Hyperglycemia in hospitalized patients is a common and costly health care problem associated with poor hospital outcomes including prolonged hospital stay, infections and death. System improvements and consistent implementation of evidence-based protocols and procedures are required to facilitate the achievement of glycemic goals in patients with hyperglycemia and diabetes.

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 successfully implement evidenced-based assessment and individualized treatment plans targeted at controlling patient’s blood sugar levels, in both the hospital and community setting.

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:
Hyperglycemic crisis, which includes Diabetic Ketoacidosis and Hyperglycemic Hyperosmolar State, is a common diagnosis in high acuity hospital units and admission rates continue to increase despite preventive strategies. While diabetic ketoacidosis remains a common cause of death in children and adolescents with type 1 diabetes, in adults reported mortality is variable and depends on the severity of metabolic derangement and the presence of other acute and chronic conditions. Hyperosmolar hyperglycemic state, and the overlap syndrome of hyperosmolar ketoacidosis, have a higher overall mortality though outcomes are improving.

Bibliography and Resources

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:

- Explain the impact of glycemic control on clinical outcomes for noncritically ill medical and surgical patients.
- Implement current guidelines and glycemic targets for noncritically ill patients.
- Execute strategies for safe and effective glycemic control from admission until discharge.
- Discuss challenges to glycemic control unique to the hospital setting.

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.)

Archana R. Sadhu, M.D., FACE
Department of Medicine
Director, System Diabetes Management Program
Division of Endocrinology, Diabetes and Metabolism
Archana R. Sadhu, M.D., FACE, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentations or discussions.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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. ________________________________________________________

Hospital administration, PI Departments, Hospitalist leadership and BHSF community health education centers continue to wage the battle to control blood sugar in both the inpatient and community settings. This CME Symposium addresses concerns, challenges and goals of these internal stakeholders.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.
Quiz Questions

1. The acute metabolic stress response includes all of the following processes except:
   a. Increased counterregulatory hormones such as cortisol, glucagon and catecholamines.
   b. Decreased insulin secretion and increased insulin resistance.
   c. Increased reactive oxygen species and mediators of inflammation.
   d. Immune cell dysfunction.
   *e. Decreased free fatty acids, ketones and lactate.

2. Inpatient hyperglycemia has been associated with poor outcomes in which of the following conditions:
   a. Critical illness
   b. Post-orthopedic, vascular, colorectal, bariatric and cardiac surgery
   c. Post-CVA and other neurological emergencies
   d. Labor and delivery
   *e. All of the above

3. Which of the following statements is not correct regarding the RABBIT-2 trials in noncritically ill surgical and medical patients?
   *a. The groups were equal in the average daily glucose achieved.
   b. The trials evaluated the difference in glycemic control and patient outcomes using a basal bolus insulin regimen versus the sliding-scale insulin regimen.
   c. Average daily glucose was higher in the patients receiving the sliding-scale insulin.
   d. A statistically significant reduction in composite endpoints of postoperative complications was demonstrated in the patients receiving the basal bolus insulin regimen.
   e. These trials support the use of basal bolus insulin therapy in medical and surgical patients with diabetes in the hospital setting.

4. The key components of a basal bolus insulin regimen are (choose all that apply):
a. Sliding-scale insulin therapy only.
b. An intermediate or long-acting insulin.
c. Scheduled rapid- or short-acting insulin with meals.
d. Correction scale for unexpected hyperglycemia.
*e. b, c and d.

5. Which of the following target glucose levels is generally recommended by the current guidelines from the Endocrine Society for inpatient glucose management?
a. Premeal glucose less than 100 mg/dl and random glucose less than 200 mg/dl.
b. Premeal glucose less than 150 mg/dl and random glucose less than 200 mg/dl.
*c. Premeal glucose less than 140 mg/dl and random glucose less than 180 mg/dl.
d. Premeal glucose less than 80 mg/dl and random glucose less than 140 mg/dl.
e. There are no recommendations for noncritically ill patients.

6. A 73-year-old female is admitted for a hip replacement and is now on the surgical ward postoperatively. She has long-standing type 2 diabetes and has been managed on metformin 500 mg twice daily and glyburide 5 mg twice daily. A1c is not available. Her postoperative glucose is 288 mg/dl, creatinine 1.6 mg/dl with egfr of 32 ml/min/m2. Which of the following is the most appropriate therapy?
a. Continue metformin and glyburide at home dose.
b. Increase metformin to 1000 mg and continue glyburide at home dose.
c. Discontinue both oral hypoglycemic agents and start sliding-scale insulin.
*d. Discontinue oral hypoglycemic agents and start a regimen of long-acting basal insulin and rapid-acting premeal insulin along with correction scale at a dose of 0.2-0.4 units per kg per day.
e. Discontinue oral hypoglycemic agents and start a regimen of long-acting basal insulin and rapid-acting premeal insulin along with correction scale at dose of 0.8-1.0 units per kg per day.

7. A 42-year-old male with type 1 diabetes is now admitted for multilobar pneumonia. His home regimen is glargine 15 units daily and lispro 5 units before each meal. On admission, his A1c is 6.5% and admission glucose is 185 mg/dl. He will be NPO for a bronchoscopy after midnight. Which of the following is the most appropriate therapy?
*a. Continue the home insulin regimen of glargine while NPO and lispro correction scale every 4 hours and add lispro 5 units before meals when eating again.
b. Discontinue glargine and lispro before meals and use lispro correction scale only every 4 hours since he will be NPO.
c. Increase glargine to 20 units due to admission hyperglycemia, and continue lispro 5 units every 4 hours while NPO.
d. Decrease glargine to 5 units daily due to NPO status and add lispro correction scale every 4 hours.

8. A 65-year-old female longtime smoker has been admitted for COPD exacerbation and started on Solu-Medrol 20 mg intravenous every 12 hours. She has a suspicious finding on a chest X-ray and is pending a CT scan of the chest with contrast to evaluate further. Her home insulin regimen is detemir 20 units twice daily, aspart 6-10 units
before each meal and metformin 1000 mg twice daily. A1c is 8.5% and glucose after steroid administration is 350 mg/dl. Her admission creatinine is 0.8 with egr of 70 ml/min/m2. Which of the following is the most appropriate therapy?

a. Continue home doses of detemir, aspart and metformin throughout the hospital stay.

b. Continue home doses of detemir, aspart and metformin and add glyburide.

c. Discontinue the metformin and aspart before meals and continue with the detemir along with an aspart correction scale only.

d. Increase the dose of detemir and aspart by 30% due to hyperglycemia from the steroid therapy, and hold the metformin. Adjust insulin doses daily based on glucose trends.

e. Increase the dose of detemir and aspart by 20%-30% due to hyperglycemia from the steroid therapy, and hold the metformin.

9. Which of the following statements is false regarding the use of diabetes technology, insulin pump therapy (CSII) or continuous glucose monitors (CGM) in the hospital setting?

*a. CSII should never be used in the hospital setting regardless of the situation.

b. Small studies have shown safety in the use of CSII in limited settings.

c. CSII incorporates basal insulin as well as the bolus insulin for prandial and correction for hyperglycemia.

d. CSII is unfamiliar to most clinical staff in the hospital setting and needs to be used with protocols and policies in place.

e. CGM is not approved for inpatient use.
COURSE APPROVAL: August 2017
Course Renewal: August 2019; June 2019
Course Expires: August 2020

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

CME MANAGER: Isabel R. Morgan (Symposium)/ Marie Vital Acle (ONLINE)

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

TARGET AUDIENCE: Family Physicians, General Internists, OB/GYN, Physician Assistants, Nurse Practitioners, Pharmacists and Dietitians

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.

Bio-identical hormone therapy, alternative hormone delivery methods and testosterone use in women have been significantly researched for safety and efficacy. Learn more about the evidence supporting the safe use of these therapies and when to consider these interventions.

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. Primary Care Physician’s limited time and high patient volume.

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

Primary Care Physicians are burdened and challenged with maintaining competencies and adopting best practice models across a variety of medical subspecialty areas. Short of being an expert on everything, there are common knowledge gaps of best practices - resulting in some inconsistencies in quality of care.

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

**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)

► Some physicians are not implementing proper application in the primary care setting because of the broad nature and depth of knowledge required across all medical subspecialties. Physicians need regular educational updates across a variety of medical subspecialties commonly seen in clinical practice in order to improve the quality of patient care.

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.)

DESIRE 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 utilize the latest diagnostic and treatment approaches for common medical conditions and new practice guidelines to maintain and improve his/her ability to implement appropriate evidence-based strategies that lead to optimal patient care and outcomes. And effectively determine when referral to a specialist is necessary.

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): new legislation

in states where medical cannibals is legal to consume

REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
Hormone therapy (HT) involves the administration of synthetic estrogen and progestogen to replace a woman's depleting hormone levels and thus alleviate menopausal symptoms. However, HT has been linked to various risks; debate regarding its risk-benefit ratio continues. Estrogens provide valuable therapy for many women but may pose serious risks. Therefore, physicians should communicate with postmenopausal women who are using or who may be using estrogen or estrogen with progestogen to determine whether the benefits outweigh the risks in their particular case.

► http://emedicine.medscape.com/article/276104-overview#a10

Bibliography and Resources

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.

- Examine the data supporting the use of hormone replacement therapy, and analyze where the negative consumer reaction and clinical bias associated with its use transpired.
- Recognize the rationale behind bio-identical hormone therapy and how it differs from therapies offered in the past.

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:

Randy A. Fink, M.D., FACOG
Obstetrician and Gynecologist
Baptist and Mariners Hospitals
Medical Director
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Randy A. Fink, M.D., FACOG, is a consultant with Biote Medical, Inc., and on the speakers bureau for Cynosure, Inc. and will not include off-label or unapproved product usage in his presentations or discussions.
RELEVANT FINANCIAL RELATIONSHPES: 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:

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. ________________________________________________________

► The Primary Care Focus symposium was planned in collaboration with the Baptist Health Quality Network (BHQN) and Baptist Health Medical Group (BHMG). The groups identified topics of need that are implemented in this year’s programming. This recording took place at the live meeting.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External: 619416
Provider: 2017IEM27

Course video:
https://cdn.baptisthealth.net/cme/vol01/olp/Hormone_Replacement_Fink.mp4

Course handout:

Quiz Questions
1. Which of the following is a criticism of the Women's Health Initiative (WHI) findings?
   a. The combination arm studied orally delivered conjugated equine estrogen and a potent synthetic progestagen.
   b. The average age of the study subjects was 12 years after the onset of menopause.
   c. Women with menopausal symptoms were excluded.
   *d. All of the above.

Slide 12. One of the current problems with treatment today is that decisions are based on results from the WHI, which is different from current practice. Bio-identical hormone therapy with non-oral delivery methods is currently available. Slide 13.


2. Which of the following is TRUE with regard to the use of estradiol and testosterone (E&T) pellets to improve bone mineral density in women with osteoporosis?
   a. E&T pellets have equal efficacy to bisphosphonates.
   *b. E&T pellets have superior efficacy over bisphosphonates.
   c. Bisphosphonates are superior to E&T pellets.
   d. The effects of E&T pellets on bone mineral density have never been studied.

Bisphosphonates improve bone mineral density by 4% per year compared to E&T pellets, which improve bone mineral density by about 8% per year. The mechanism of E&T pellets is that testosterone stimulates the osteoblast, whereas estradiol inhibits the osteoclast. Slide 29.


3. Which of the following statements is FALSE with regard to androgen deficiency syndrome in women?
   *a. Lab reference ranges for testosterone are sufficient for determining androgen deficiency syndrome in women.
   b. There is no FDA-approved androgen therapy for women.
   c. Women with androgen deficiency syndrome should be treated for clinical effect, rather than treating to achieve a predefined level of testosterone.
   d. Some common outcomes of testosterone treatment in women are enhanced libido, increased energy and decreased body fat.

Female androgen deficiency syndrome is difficult to define, and lab reference ranges do not represent age normative values. Slide 21. Other common outcomes of testosterone treatment in women are decreased cholesterol, LDL and triglycerides, increased HDL, enhanced sleep, feelings of well-being, increased lean muscle mass, relieved depression and reduced “brain fog.” Slide 22.

4. What dose of oral micronized progesterone would one expect to be most appropriate for endometrial suppression in a non-hysterectomized woman using estrogen therapy?

a. 50 mg

*b. 200 mg

c. 500 mg

d. None of the above.

Of the answers given, 200 mg is the appropriate dose. 50 mg would not likely be enough to suppress growth of the endometrium, while 500 mg is more than necessary and would increase the risk of side effects. Slide 14.

TARGET AUDIENCE: Hospitalists, Internists, Family Practitioners, Emergency Medicine Physicians, Surgeons, Cardiologists, Endocrinologists, Podiatrists, Nurses, Pharmacists, Dieticians and other interested healthcare practitioners

CONFERENCE DIRECTOR: Michael Fili, M.D.
CME MANAGER: Eleanor Abreau (Live); Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 0  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)
- [x] 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.

Hyperglycemia, a common issue in critically ill patients, is a predictor of adverse outcomes, including mortality. Physicians should implement strategies for achieving reasonable and safe glycemic targets from ICU admission to discharge. During this conference, physicians will discuss emerging evidence that non-insulin regimens may improve glycemic control and reduce the need for insulin administration in hyperglycemic ICU patients.

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)

Resources:   [ ] Institutional Capabilities  [x] 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.
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)*

Hyperglycemia in hospitalized patients is a common and costly health care problem associated with poor hospital outcomes including prolonged hospital stay, infections and death. System improvements and consistent implementation of evidence-based protocols and procedures are required to facilitate the achievement of glycemic goals in patients with hyperglycemia and diabetes.

**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.)
- [x] Competence *and/or* (Doctors do not know how to do it)
- [ ] Performance *and/or* (Doctors know how to do it but are non-compliant - 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 successfully implement evidenced-based assessment and individualized treatment plans targeted at controlling patient’s blood sugar levels, in both the hospital and community setting.

**Indicate what this activity is designed to change.**

- [x] Designed to change competence
- [x] Designed to change performance
- [ ] Designed to change patient outcomes

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

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

**REFERENCES** supporting the current practice and/or the optimal practice and/or practice gap Hyperglycemia in hospitalized patients is a common and costly health care problem associated with poor hospital outcomes including
prolonged hospital stay, infections and death. There is ample evidence that hyperglycemia has short-term adverse effects on the immune system, the vascular system, and wound healing. Similarly, there is evidence that improvement of glycemic control improves outcomes, particularly in the surgical setting. Current guidelines for the management of hyperglycemia in ICU patients recommend the use of intravenous continuous insulin infusion targeting reasonable, achievable and safe glucose target. Increasing evidence suggest that non-insulin regimens (incretin therapy) may improve glycemic control and reduce the need for insulin administration in ICU patients.

Bibliography and Additional Resources:


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 impact of glycemic control on clinical outcomes for surgical patients in the ICU setting.
- Implement strategies for achieving reasonable and safe glycemic targets from ICU admission to discharge.
- Discuss emerging evidence that non-insulin regimens (incretin therapy may improve glycemic control and reduce the need for insulin administration in hyperglycemic ICU 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 2, include list at end of application.)

Archana R. Sadhu, M.D., FACE
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Division of Endocrinology, Diabetes and Metabolism
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Archana R. Sadhu, M.D., FACE, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentations or discussions.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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 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. __________________________________________________________

Hospital administration, PI Departments, Hospitalist leadership and BHSF community health education centers continue to wage the battle to control blood sugar in both the inpatient and community settings. This CME Symposium addresses concerns, challenges and goals of these internal stakeholders.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.
1. In 2001, the Van Den Berghe study of intensive insulin therapy in critically ill surgical patients showed all of the following except:
   a. Reduction in mortality.
   b. Reduction in sepsis.
   c. Reduction in ventilator days.
   d. Reduction in need for dialysis.
   e. Reduction in critical illness-related polyneuropathy.

2. Which of the following statements is most accurate about the NICE-SUGAR trial in 2008?
   a. The NICE-SUGAR trial definitively showed that glucose control is not important in critically ill patients.
   b. It was a small study done at a single center.
   c. Glycemic control in a target range of 80-110 mg/dl has lower mortality than 140-180 mg/dl.
   d. Glycemic control in a target range of 140-180 mg/dl has lower mortality than 110-180 mg/dl.

3. All of the following statements about hypoglycemia are true except:
   a. In critically ill patients, hypoglycemia has not been shown to be associated with increased mortality.
   b. In one study of patients with hypoglycemia during critical illness, approximately 2/3 were spontaneous hypoglycemia and 1/3 were receiving insulin.
   c. Mortality increases with increasing severity of hypoglycemia.
   d. In one study of patients with hypoglycemia and acute myocardial infarction, hypoglycemia was not associated with increased mortality when patients were treated with insulin.

4. Current recommendations for target glucose levels in most critically ill patients are:
   a. 80-110 mg/dl.
   b. 110-140 mg/dl.
   c. 140-180 mg/dl.
   d. 180-250 mg/dl.
5. Which of the following cause acute or stress hyperglycemia in the hospital?

a. Undiagnosed diabetes.
b. Iatrogenic causes, such as medications and enteral/parenteral nutrition.
c. Inappropriate use of sliding-scale insulin as the sole therapy to manage patients with diabetes.
d. Increase in catecholamine and cortisol hormones.
*e. All of the above.

6. Which of the following is not an indication for intravenous insulin therapy?

a. Diabetic ketoacidosis and hyperosmolar hyperglycemia syndrome.
c. During labor and delivery in a patient with type 1 diabetes.
*d. Ambulatory surgical procedure.
e. Critically ill patient with sepsis and multi-organ failure.

7. A 68-year-old female is admitted to the medical intensive care unit with urosepsis and acute kidney injury and is noted to have hyperglycemia with a glucose of 250 mg/dl. There is no prior history of diabetes. Choose the most appropriate therapy:

a. Start regular insulin sliding scale and monitor glucose every 6 hours.
b. Start lispro insulin sliding scale and monitor glucose every 4 hours.
c. Start metformin 500 mg daily and escalate to insulin therapy if needed.
*d. Start intravenous insulin infusion with a target glucose of 140-180 mg/dl.
e. Start intravenous insulin infusion with a target glucose of 80-110 mg/dl.

8. A 53-year-old male with a history of managed type 2 diabetes was admitted with multilobar pneumonia and respiratory failure and managed on intravenous insulin in the ICU. In the previous 24 hours, he required 75 units of insulin and is now ready to transition to the floor. Which of the following is the most appropriate next step:

a. Discontinue all insulin therapy as the hyperglycemia should be resolved now.
b. Discontinue the intravenous insulin therapy and begin a correction scale with rapid-acting insulin every 4-6 hours.
*c. Begin a basal bolus insulin regimen with the basal insulin administration overlapping the intravenous insulin infusion by at least 2 hours before discontinuation.
d. Discontinue his intravenous insulin and start outpatient oral hypoglycemic agents.

9. A 31-year-old female with type 1 diabetes presents to the ED with nausea, vomiting and lethargy. On examination, an insulin pump device is found inserted in her left lower abdomen. She is unable to answer any questions appropriately on your interview.

Initial laboratory evaluation shows a glucose of 485 mg/dl; pH of 7.29; sodium of 134 mEq/L; potassium of 3.8 mEq/L; chloride of 98 mEq/L; and bicarbonate of 16.
Which of the following should be the next step in her therapy?

a. STAT endocrinology consultation to increase the basal rates on her pump settings.
b. Discontinue the insulin pump and start intravenous insulin infusion with a target glucose of 140-180 mg/dl.
c. Discontinue the insulin pump and start intravenous fluids, IV insulin infusion, and electrolyte replacement until glucose is less than 200 mg/dl.
*d. Discontinue the insulin pump and start intravenous fluids, IV insulin infusion, and electrolyte replacement, and follow the anion gap.

Question added by Laura to meet 10 questions:

10. According to the Portland Diabetes Project, what led to a significant reduction in the incidences of deep wound infection?

*a. Continuous intravenous insulin infusion.
b. Intermittent subcutaneous insulin injections.
c. Continuous nasal cannula oxygen.
d. There is no predictive way to reduce the incidences of deep wound infection.
TARGET AUDIENCE: Oncology Nurses, Oncologists, Radiation Oncologists, Hematology Oncologists, Radiation Therapists, Pharmacists, Social Workers, Patient Navigators and other interested healthcare providers.

CONFERENCE DIRECTOR: Minesh Mehta, M.D. CME MANAGER: Eleanor Abreu

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)

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

This course is designed to highlight the advancements in radiation oncology and offers insight towards understanding the benefits and challenges of targeted therapeutics and high-precision radiation therapy.

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 and advanced practice practitioners may not be aware may not have a strong understanding of radiation oncology.

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 and advanced practice practitioners will implement treatment modalities, procedures and processes involved in radiation treatment.

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

REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
Radiation oncology nurses play a key role in patient care; however, exposure to radiation oncology in formal training is often inadequate to prepare nurses for their role in an ever more complex practice environment. We sought to create a formalized curriculum for nursing staff to enhance confidence in managing common clinical scenarios.


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:

Please see below.

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.)

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

Haley R. Appel, P.A.
Physician Assistant
Miami Cancer Institute
Haley R. Appel, P.A., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Allie Garcia-Serra, M.D.
Radiation Oncologist
Miami Cancer Institute

Allie Garcia-Serra, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Joseph Panoff, M.D.
Radiation Oncologist
Miami Cancer Institute

Joseph Panoff, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Lauren Suarez, MSN, R.N.
Miami Cancer Institute

Lauren Suarez, MSN, R.N., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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
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. ________________________________________________________________

Miami Cancer Institute – Department of Radiation Oncology.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: __________  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

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:

Lauren Suarez, MSN

Introduction to Radiation Oncology

- Identify and describe the basic principles of photon and proton radiation therapy.
- Describe the role of the radiation oncology nurse.

Reference:

We have the group interviews from the four members the Certified Nurses in Radiation Therapy Nursing. It was found that Certified Nurses in Radiation Therapy Nursing felt that don't have the information about the patients who receives radiation therapy. In addition, they thought not able to even determine about whether time required, and not provide the professional nursing care practice. They say that we need the time, place and information. They were determined to be there to be necessary in for exhibiting their abilities. In particular, the most important problems that there aren't systematic information of the patients who receives radiation therapy. It's mean that, not have described the information for Radiation Therapy Nursing, and not obviously structure of nursing process or important assessment's, yet.
Haley R. Appel, P-AC

**The Utilization of Proton Therapy in CNS Tumors**

- Identify the different radiation treatment modalities for central nervous system tumors.
- Execute the management of treatment related toxicities.

Reference:

Proton therapy is a form of particle therapy with physical properties that provide a superior dose distribution compared to photons. The ability to spare healthy, developing tissues from low dose radiation with proton therapy is well known. The capability to decrease radiation exposure for children has been lauded as an important advance in pediatric cancer care, particularly for central nervous system (CNS) tumors. Favorable clinical outcomes have been reported and justify the increased cost and burden of this therapy. In this review, we summarize the current literature for proton therapy for pediatric CNS malignancies, with a focus on clinical outcomes to date.


Allie Garcia-Serra, M.D.

**MRI LINAC and Brachtherapy for Gynecologic Malignancies**

- Describe the methodology used to aid applicator placement treatment planning.
- Implement virtual needle trajectory planning in the treatment plans.

Reference:

Gynecologic malignancies are a leading cause of death in women worldwide. Standard treatment for many primary and recurrent gynecologic cancer cases includes a combination of external beam radiation, followed by brachtherapy. Magnetic Resonance Imaging (MRI) is beneficial in diagnostic evaluation, in mapping the tumor location to tailor radiation dose, and in monitoring the tumor response to treatment. Initial studies of MR-guidance in gynecologic brachtherapy demonstrate the ability to optimize tumor coverage and reduce radiation dose to normal tissues, resulting in improved outcomes for patients.


Joseph Panoff, M.D.

**Early Stage Breast Cancer**

- Identify and describe the clinical presentation of breast cancer.
- List common risk factors for breast cancer.

Reference:
Triple-negative breast cancer (TNBC) accounts for 15% of all breast cancers and is associated with poor long-term outcomes compared to other breast cancer subtypes. Currently, chemotherapy remains the main modality of treatment for early-stage TNBC, as there is no approved targeted therapy for this subtype. The biologic heterogeneity of TNBC has hindered the development and evaluation of novel agents, but recent advancements in subclassifying TNBC have paved the way for further investigation of more effective systemic therapies, including cytotoxic and targeted agents. TNBC is enriched for germline BRCA mutation and for somatic deficiencies in homologous recombination DNA repair, the so-called "BRCAness" phenotype. Together, germline BRCA mutations and BRCAness are promising biomarkers of susceptibility to DNA-damaging therapy. Various investigational approaches are consequently being investigated in early-stage TNBC, including immune checkpoint inhibitors, platinum compounds, PI3K pathway inhibitors, and androgen receptor inhibitors. Due to the biological diversity found within TNBC, patient selection based on molecular biomarkers could aid the design of early-phase clinical trials, ultimately accelerating the clinical application of effective new agents. TNBC is an aggressive breast cancer subtype, for which multiple targeted approaches will likely be required for patient outcomes to be substantially improved.

http://ovidsp.dc2.ovid.com/sp-3.33.0/view?S=BFKHFPLLBFEBFOKIPCKMGEHMPEAE00&Complete+Reference=S.sh.24%7c2%7c1&Counter5=SS_view_found_complete%7c29656345%7cmdf%7cmdline%7cmdl&Counter5Data=29656345%7cmdf%7cmdedline%7cmdl

MCI – Oncology Academic Education Series: 2019 Radiation Symposium

9:30 a.m. – 10 a.m. Registration
10 a.m. - 11 a.m. Introduction to Radiation Oncology
11 a.m. – 12 noon The Utilization of Proton Therapy in CNS Tumors
12 noon - 1 p.m. Lunch Break
1 p.m. – 2 p.m. MRI LINAC and Brachytherapy for Gynecologic Malignancies
2 p.m. – 3 p.m. Early Stage Breast Cancer

3 p.m. Adjourn

CONTINUING MEDICAL EDUCATION ACTIVITY APPLICATION

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

CME ACTIVITY TITLE: Evidence-based Clinical Care: Sepsis

COURSE APPROVED: July 2019  COURSE EXPIRES: July 2021

CREDIT HOUR(S) APPLIED FOR: .25 Cat 1
**TARGET AUDIENCE:** Critical Care Physicians, Emergency Department Physicians, Hospitalists, Internal Medicine Physicians, Infectious Disease Physicians, General Surgeons, Oncologists and Obstetricians, Nurses, Nurse Practitioners and Physician Assistants.

**CONFERENCE DIRECTOR:** Eduardo Martinez-DuBouchet, M.D.

**CME MANAGER:** Marie Vital Acle

**CONFERENCE COORDINATOR:** Tatiana Posada

**EXPECTED NUMBER OF ATTENDEES:** 200 annually

**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)
- [x] 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.

Sepsis/Severe Sepsis/Septic Shock is a significant healthcare concern for the U.S. population because of its high prevalence, morbidity, mortality and medical costs. Mortality from sepsis increases 8% for every hour that antibiotic treatment is delayed. Sepsis is a leading cause of death in U.S. hospitals. This course provides a review of the Sepsis Clinical Pathway at Baptist Health South Florida.

**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:**
- [x] Noncompliance
- [x] 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
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 may not be aware of evidence-based standardization efforts throughout Baptist Health that are impacting algorithms of care. This course reviews the sepsis clinical pathway at Baptist Health.

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 power plans for sepsis consistently as evidenced by clinical pathway utilization.

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 system-wide evidence-based clinical care committee is comprised of multidisciplinary stakeholders who have assessed diagnosis related groups (DRGs) to determine new current standard of care and develop treatment algorithms. It is the recommendation of theses committees, based on extensive evidenced-based research, to modify delivery of care to
improve efficiency and ensure all patients receive the same quality care throughout Baptist Health removing variances. These standardization efforts are supported by implementation of Cerner EMS system and monitored by utilization metrics.

**The evidence used to create the algorithms of care for sepsis are as follows:**


**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:

- Explain the evidence-based data supporting standardization efforts to ensure consistent delivery of care in sepsis patients.
- Identify and triage sepsis patients according to clinical pathway and consistently implement appropriate, timely treatment protocols.

**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. EBCC Metrics Data to be provided to CME Department upon request.

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

Content contributors have indicated that neither he nor his spouse/partner have relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

All other team members and those involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.
Others (Conference Coordinator, Planning Group, etc.) EBCC Committee (Hip Fracture) design team members.

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: Algorithms of care are

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 course is planned in collaboration with the evidence-based clinical care committee in support of system-wide standardization efforts.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider:

Course video:

Course handout:

Quiz Questions

COURSE HANDOUT PAGE NOTES: Please insert the following text on course handout page:

NOTE: Physicians should bookmark this course to access all protocols, policies and procedures at your convenience via your CME Portal account. All algorithms will be available on CERNER.

DATE REVIEWED: ___________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee
CME ACTIVITY TITLE: Cultural Perception of Chronic Pain and Illness: A Case-based Discussion

CREDIT HOUR(S) APPLIED FOR: .50 Cat. 1

COURSE APPROVED: September 2017
COURSE RENEWED: July 2019
COURSE EXPIRES: September 2019; September 2020

LOCATION: BaptistHealth.net/CMEonline

TARGET AUDIENCE: All physicians, pharmacists and other interested healthcare professional.

CONFERENCE DIRECTOR: Arturo Fridman, M.D.  CME MANAGER: Marie Vital Acle

EXPECTED NUMBER OF ATTENDEES: 50 annually  CHARGE: 0

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

ARS  Internet point-of-care activity
Case Studies  Journal-based CME activity
Didactic Lecture  Learning from Teaching
Enduring Material (DVD/Booklet)  Live activity
Internet Activity Enduring Material  Manuscript review activity
Internet Live Course (Live Webcast)  Panel
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

Cultural backgrounds can strongly influence a patient's view and treatment of chronic disease. This course will provide strategies for communication with patients to reach consensus on disease management plans and adherence to treatment.

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.

Implicit bias.

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 may not consider how a patient’s culture can affect their perception of pain, willingness to seek medical assistance and compliance.

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.)
- [x] Competence and/or (Doctors do not know how to do it)
- [x] 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)

Cultural competency is critical for ensuring we deliver equitable, high-quality care to our patients. Besides becoming culturally aware, physicians must also become aware of our implicit biases that may limit the quality of treatment provided. Physicians practice active listening with patients and their families to address bias and deliver optimal care.

Indicate what this activity is designed to change.
- [x] Designed to change competence
- [x] 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
- [x] Research/literature review

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

Racial disparity in healthcare is a well-documented phenomenon that has been extensively studied over the last 30 years. We order fewer diagnostic tests for black patients than white patients. In an interesting nationwide study of 500 hospitals and 78 conditions, African Americans were found to receive less major diagnostic procedures than white patients 20% of the time. And minority patients don’t just get less diagnostic tests – they get less interventional treatments – this has been best studied in cardiac catheterization, but black patients have been found time and time again to get less angioplasty, bypass grafts, even aspirin and beta blockers. However, when the decision for interventional treatment in cardiac cases is given to a panel of cardiac interventionists blinded to race, blacks are slightly more likely to receive these treatments than whites.

Minority patients also get less pain medication. In one study, Hispanics with long bone fractures were half as likely as others to get pain medication. In another troubling study, elderly minority patients with cancer were also half as likely to get pain medication as their white counterparts.

Harris et. al. j. Ethn Dis. 1997
Okelo et al. J Am J Cardiology 2001
Peterson et. al. NEJM 1997
Todd et al. JAMA 1993
Bernabei et al. JAMA 1998
Pachter et. al. J Asthma 2002
Juckett G. Am Fam Phys 2005


RESOURCES
CultureClues tip sheet (University of Washington) http://www.depts.washington.edu/pfes/cultureclues.html
Cultural Competence E-Learning modules (Hospital for Sick Children, Canada)
EthnoMed (University of Washington) http://ethnomed.org/
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:

• Consider cultural factors that can influence the management of chronic pain and illness.
• Learn skills to assess a patient’s understanding, interpretation, and actions around health and illness to work better with them on disease 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 2, include list at end of application.)

Ana M. Viamonte Ros, M.D., MPH
Medical Director, Palliative Care and Bioethics Department
Baptist Health South Florida
Associate Dean for Women in Medicine and Science
Associate Professor for Department of Health, Humanities and Society
Herbert Wertheim College of Medicine
Florida International University

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

Due to the non-clinical nature of the content discussed, the speakers, non-faculty contributors and others involved in the planning have no relevant financial relationships to disclose.

This CME activity will not cover content that would involve products or services of commercial interests. Therefore, no opportunity exists for a conflict of interest based on the financial relationships of faculty and those persons in control of content. Since these relationships are not relevant, no disclosure information was collected.

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.
Non-clinical content: All activities that are considered non-clinical must be vetted by the Department Director. If there is no opportunity to affect the content of CME concerning the products or services of a commercial interest, then there can be no relevant financial relationships or conflicts of interest. Both the following statements must apply. Reference SOP "Disclosures for Activities with Non-Clinical Content" for further instructions and necessary steps to ensure compliance.

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

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

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.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External: 594129
Provider: 2017IEM35

Course video: https://cdn.baptisthealth.net/cme/vol01/olp/Cultural_Perception_10262017.mp4

Course handout:

Quiz Questions

1. Which of the following best describes patient experiences with chronic illness?
a. Pain is ultimately a subjective experience.
b. Every patient should be open to taking pain medicine because it can improve function.
c. Although people interpret pain differently, everyone experiences the same amount of objective pain in response to certain stimuli or pathology.
d. If we truly explain the illness clearly to patients, they will be open to our recommended management plan.

Feedback: Cultural perceptions about pain can vary significantly. When in doubt, objective measures of pain, such as vital signs, limited range of movement and grimacing can be useful markers of experienced pain.

2. Which of the following best describes patient perspectives on illness and medical treatment?
   a. Complementary and alternative medicine can be accepted by patients as largely ineffective if they just look at the evidence.
   b. No one believes prayer is truly effective at curing critical illness.
   c. All patients of a cultural group will have a similar understanding of disease causation.
   *d. Different views of disease causation can have a significant impact on treatment adherence.

Feedback: A person’s worldview is closely linked with their cultural and religious background. Simple questions can provide good insight: What do you think is causing the disease? What types of treatment have you tried and do they work? What happens if the disease is not treated?

3. Which of the following best describes patient perspectives on illness and medical treatment?
   *a. A person’s worldview is closely linked with his cultural and religious background.
   b. Fatalism describes people who will closely follow medical treatment for fatal diseases.
   c. Puerto Rican Latinos have a very homogeneous viewpoint on the treatment for common illnesses like asthma.
   d. No one believes that asthma is caused by lack of vitamins.

Feedback: The reasons for beliefs are complex. But we are all shaped, even as medical professionals, by our cultural, religious and social backgrounds, and these backgrounds can vary considerably from those of our patients.

4. What is something that can be followed for those refusing blood transfusion?
   a. Minors cannot make their own decisions about transfusion in any situation.
   *b. Emergency transfusion can be provided without consent if it’s impossible to obtain consent.
   c. If a patient refuses a transfusion and it is administered, the medical team is protected by Good Samaritan laws.
   d. Advance directive cards have no place in the immediate decision making in emergency situations.

Explanation: In the cases where a patient is unable to provide or refuse consent for transfusion, it is lawful to administer a blood transfusion as needed. However, if consent can be obtained, it becomes important to be clear about the patient’s wishes, as providing transfusion in the face of a refusal can lead to criminal and/or civil proceedings.
5. Which of the following can describe parenting dynamics and differences?

a. Collectivistic cultures are those that value independence between parent and child.

b. Individualistic cultures avoid verbal expressions of love, such as saying “I love you.”

*c. Collectivistic cultures may use actions rather than words to express affection.

d. Individualistic cultures believe the community, rather than core parents, are responsible for parenting decisions.

Feedback: Cultures can be broadly classified as individualistic or collectivistic. Individualistic cultures, like Western cultures familiar in Europe and North America, may value independence of the core family unit. Collectivistic cultures, such as those more prominent in Asia, may value the larger community more as an important part of parenting. Collectivistic cultures tend not to verbally express affection, but instead display affection through actions. Parents who never say they love their child may therefore still harbor deep affection for the child.

6. Which of the following is an accurate statement about cultural differences toward vaccination?

*a. Anti-vaccination beliefs can be rooted in historical relationships between cultures.

b. No groups have historical reasons to mistrust vaccines, such as those with a history of colonialism.

c. If someone distrusts vaccinations, there is nothing we can do and we should discharge the patient from our care.

d. In general, all cultures accept the idea of vaccination.

Feedback: Despite good intentions, there are many who distrust or reject vaccination. There are many reasons for this, some with deep historical roots. The history of colonialism, for example, may be a major reason for distrust of “Western” medicine in many parts of the world. It is important to maintain open communication with those who may not share our beliefs about vaccination, and ensure continuity of care.
CME ACTIVITY TITLE: Radiation Safety: Understanding Procedural Radiation Dose and How to Reduce Exposure

RECORDED: Monday, January 9, 2017

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

COURSE APPROVAL: March 2017

Course Renewal: July 2019

Course Expires: December 2019; December 2020

TARGET AUDIENCE: Cardiologists, Interventional Radiologists, Vascular Surgeons, Radiology Technologists, Nurses, and all interested healthcare professionals especially if they use ionizing radiation.

CONFERENCE DIRECTOR: Constantino Peña, M.D.  CME MANAGER: Gabriela Fernandez

EXPECTED NUMBER OF ATTENDEES: 20-30  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)
- [x] 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:

Cardiac interventional radiology (IVR) can cause radiation injury to the staff who administer it as well as to patients. Staff that works on the IVR, including physicians, radiology technologists and nurses may not have sufficient knowledge of radiation safety and should receive appropriate radiation safety training. This course provides discussion relative to the current controversies associated with radiation exposure, as well as the importance of the ALARA principle. The course will discuss the top ten radiation dose reduction techniques, especially in CT and fluoroscopic procedures.

Samaritan Physicians: Successful completion of this activity will qualify Samaritan physicians for annual policy discounts. Upon completion, please print your certificate and submit to Samaritan for consideration.
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)

► Cardiac interventional radiology (IVR) can cause radiation injury to the staff who administer it as well as to patients. Staff that works on the IVR, including physicians, radiology technologists and nurses may not have sufficient knowledge of radiation safety and should receive appropriate radiation safety training. Periodic radiation safety education/training for nurses is essential.

Reference:
Interventional Services at Miami Cardiac and Vascular Institute (MCVI) includes Cardiac Catheterization, Electrophysiology, Interventional Radiology and Interventional Neuroradiology services. These procedure labs are radiology imaging dependent and as such, rely on intravascular contrast agents for diagnosis, guidance for interventions and evaluation of outcomes. The vast majority of patients receive a small to moderate quantity of contrast.

Upon review of the National Cardiac Data Registry Cath-PCI quarterly outcome reports, the proportion of percutaneous coronary intervention cases with acute kidney injury was below the national average for the MCVI Cath Labs. (Baptist Health South Florida System Wide Invasive Radiation and Contrast Reduction and Monitoring Committee)

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)

► The IVR team will be knowledgeable about current controversies associated with radiation exposure, as well as the importance of the ALARA principle. The team will apply radiation dose reduction techniques, especially in CT and fluoroscopic procedures, to reduce risks and improve safety.

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
☑ Consensus of experts
☐ Joint Commission initiatives (C12)
☐ National Patient Safety Goals
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

➤ ALARA represents a practice mandate adhering to the principle of keeping radiation doses to patients and personnel As Low As Reasonably Achievable. This concept is strongly endorsed by the Society for Pediatric Radiology, particularly in the use of procedures and modalities involving higher radiation doses such as CT and fluoroscopic examinations of pediatric patients. There is no doubt that medical imaging, which has undergone tremendous technological advances in recent decades, is integral to patient care. However, these technological advances generally precede the knowledge of end-users concerning the optimal use and correct operation of the resulting imaging equipment, and such knowledge is essential to minimizing potential risks to the patients. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2663649/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2663649/)

Like all medical procedures, computed tomography (CT), fluoroscopy, and nuclear medicine imaging exams present both benefits and risks. These types of imaging procedures have led to improvements in the diagnosis and treatment of numerous medical conditions. At the same time, these types of exams expose patients to ionizing radiation, which may elevate a person’s lifetime risk of developing cancer. As part of a balanced public health approach, the U.S. Food and Drug Administration (FDA) seeks to support the benefits of these medical imaging exams while minimizing the risks. [http://www.fda.gov/Radiation-EmittingProducts/RadiationSafety/RadiationDoseReduction/ucm2007191.htm](http://www.fda.gov/Radiation-EmittingProducts/RadiationSafety/RadiationDoseReduction/ucm2007191.htm)

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:

- Discuss radiation exposure reporting measures.
- Implement radiation reduction techniques to improve testing and reduce risks.
- Apply the ALARA (As Long As Reasonably Achievable) principle to minimize radiation dose to patients and improve their safety.

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.)

Alyson N. Cieply, M.S.
Diagnostic Medical Physicist
Baptist Health South Florida

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

Ms. Alyson N. Cieply has indicated neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in their presentations or discussions:

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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 System Wide Invasive Radiation and Contrast Reduction and Monitoring Committee

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

ETHOS CONTENT
Quiz Questions

1) Where are the correct positions to wear your collar and chest dosimeter badges?
   a. Collar under lead, chest above lead.
   b. Collar under lead, chest under lead.
   c. Collar above lead, chest above lead.
   *d. Collar above lead, chest under lead.

2) What type of risk is associated with occupational Exposure?
   a. Deterministic risk.
   b. Nondeterministic risk.
   *c. Stochastic risk.
   d. Non-stochastic risk.

3) Which of the following was not listed as a Top 10 radiation reduction technique?
   a. Wear your dosimeter badges.
   *b. Face away from the X-ray machine.
   c. Know the scatter fields.
   d. Use collimation.
   e. Time, distance, shielding.

4) What is the current Nuclear Regulatory Commission annual occupational limit for the Deep Dose Equivalent (DDE)?
   a. 2,000 mrem/year.
   *b. 5,000 mrem/year.
   c. 15,000 mrem/year.
   d. 50,000 mrem/year.
5) The highest scatter field is always located:
*a. Toward the side where the X-ray beam enters the patient.
b. Above the patient table when the beam is located beneath the patient.
c. Toward the left of the patient.
d. Toward the right of the patient.

Additional questions provided by Laura -
6. What is a characteristic of radiation-induced cataracts?
a. They occur only in the left eye.
b. They occur only in the right eye.
*c. They generally form on the posterior surface of the lens.
d. They cannot be treated with surgery.

7. Dermal necrosis is an injury associated with what type of risk?
*a. Deterministic risk.
b. Non-deterministic risk.
c. Stochastic risk.
d. Non-stochastic risk.

8. In general, radiation doses to the patient increase:
a. 1.0 to 1.3 times for each magnification position.
b. 1.4 to 2.0 times for each magnification position.
*c. 2.1 to 2.3 times for each magnification position.
d. 2.4 times and greater for each magnification position.

9. What is a benefit of using collimation?
a. It provides a wider picture of the area.
b. It is automatic and requires no maintenance.
*c. It reduces the amount of scatter radiation.
d. It requires less training for the operator.

10. What is a problem with using Air Kerma for doses?
a. There is no way to estimate it.
b. It is not an indicator of deterministic risk.
c. It is not a way to estimate skin dose.

*d. The reference point is accurate only for the average-sized patient.

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

CME ACTIVITY TITLE: Spirituality and Medicine: Preserving Human Dignity at the End of Life – Cultural, Social and Religious Perspectives

COURSE APPROVAL: November 2015

COURSE RENEWED: November 2017; November 2018; July 2019

COURSE EXPIRATION: November 2019; May 2020 (6 month renewal)

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

TARGET AUDIENCE: All Physicians who provide care for dying patients and their families.

CONFERENCE DIRECTOR: Rev. Guillermo Escalona, MDIV, BCC, CT Chairman/Director, Baptist Health Bioethics Department

CME MANAGER: Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 0  CHARGE: 0

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

☐ ARS  ☐ Enduring Material (DVD/Booklet)

☐ Case Studies  ☒ Internet Activity Enduring Material

☐ Didactic Lecture  ☐ Internet Live Course (Live Webcast)
The slogan “Death and Dignity” is frequently used with reference to a human death. Yet it is an ambiguous and often confusing concept. Rabbi David Albert addresses different meanings of human dignity, personhood and the value of life. This course will deepen your bioethical vocabulary and teach practical skills that better support patients to live, and die, with dignity.

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)

► Current physician practice does not include appropriate/consistent use of evidence-based approaches to provide care for patients at the end-of-life. Physicians are not familiar with the Institute of Medicine’s (IOM) recommendations for end-of-life care.

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 consistently apply IOM’s recommendations for end-of-life 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 and explain below.)

☒ Best practice parameters

☒ Consensus of experts

☐ Disease prevention (C12)

☒ Joint Commission initiatives (C12)

☐ Mortality/morbidity statistics

☐ National Patient Safety Goals

☐ National/regional data

☐ New diagnostic/therapeutic modality (C12)

☐ New or updated policy/protocol

☐ Patient care data

☐ Peer review data

☐ Process improvement initiatives (C16 & 21)

☐ Regulatory requirement

☒ Other need identified (Explain): _____________________________

☒ Research/literature review

REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
Clinicians should be prepared to assist families in the dying process. The goal is to provide the patient and family with a quiet, private space devoid of technology and alarms. This may be difficult in units where curtains separate patient beds. When the dying process is prolonged or when demands for an ICU bed cannot be met in other ways, transfer to another area in the hospital may be unavoidable. The transition should occur smoothly with deference to the needs of the patient and family. Every effort should be taken to reassure family members that continuity of clinical care will be maintained.

Even though excellent palliative care can often be provided with no more than attentive and compassionate clinical assessment, there may be a tendency to continue cardiac, pulse oximetry, and even invasive hemodynamic monitoring in the ICU. Since such monitoring does not provide additional comfort to the patient and is not necessary to assess symptoms of distress, providers should critically review whether it should be continued. Family members, particularly those who have spent weeks tracking physiologic markers, may find themselves paying undue attention to the monitor instead of the patient. A specific conversation with the family about the rationale for stopping these forms of monitoring may relieve anxiety.

http://guideline.gov/content.aspx?id=12655

APA Criterion 1.3 reflects program content that has been subjected to mechanisms of external professional peer review. This content can extend beyond empirical research (cf. Criterion 1.2) and may include theoretical, conceptual, case studies or secondary research reviews. Criterion 1.3 emphasizes the acceptability of program content based on peer review in journals, professional conferences, or venues of independent review that support the relevance and acceptability of program content for the discipline of psychology. As an example, a program focused on a new theoretical development concerning borderline personality disorder might use Criterion 1.3 to satisfy Criteria D 1 by citing peer reviewed publications (not necessarily empirical) or presentations that support this program content. Program content has peer reviewed, published support beyond those publications and other types of communications devoted primarily to the promotion of the approach;


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:

- Define the Institute of Medicine’s (IOM) definition of “good death.”
- Analyze the importance of cultural competency when treating a patient at end-of-life.
- Identify steps that help promote human dignity.
- Apply IOM’s evidence-based recommendations for end-of-life care.

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.)

Rabbi David Albert, D.Min. BCC
Senior Staff Chaplain
South Miami Hospital
Pastoral Care Services

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

Rabbi David Albert, D.Min. BCC, indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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)
- [x] Other tools or tactics
  
  Explain: Policies will be distributed as additional reference.

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

- [ ] Yes  
- [x] 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 Baptist Health Bioethics Committee has undertaken an initiative to provide monthly continuing medical education lectures on current medical ethical issues. Topics selected by the Bioethics Committee are influenced by recent confidential ethics consultations.

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

**ETHOS CONTENT**

**YOU MAY ALSO BE INTERESTED IN:** List names of up to two courses with similar target audiences. Please list complete course title.

External: 399346
Provider: 2016IEM20

Course video: [https://cdn.baptisthealth.net/CME/vol01/pastoral_care/Preserving%20Human%20Dignity.mp4](https://cdn.baptisthealth.net/CME/vol01/pastoral_care/Preserving%20Human%20Dignity.mp4)

Course handout:

**Quiz Questions**

1. Examples of “Death with dignity” or a “good death” would include:
   a. Freedom from pain and suffering.
   b. Dying according to one’s wishes.
   c. Being surrounded by loved ones.
   d. Being informed that death is close and being able to prepare.
   e. All of the above.
2. In what ways can healthcare providers honor and respect a dying patient's dignity?
   a. Encourage family members not to disturb the patient and to wait in the waiting room.
   b. Ignore complaints and negative feedback.
   *c. Treat the patient at all times with kindness and respect and from the patient's perspective.
   d. Do whatever can be done to keep the patient alive.

3. In modern history, the concept of human dignity became a fundamental and foundational value in the Universal Declaration of Human Rights (UDHR), which was drafted in the year:
   a. 1928
   *b. 1948
   c. 1950
   d. 1940

4. Regarding contemporary understanding and application of human dignity, which one of the following statements is true:
   a. It’s the same in all cultures.
   b. Academics and bioethicists pretty much agree in its definition and meaning.
   c. It’s easy to define.
   d. Some human beings possess human dignity, while others don’t.
   *e. Theologians, academics and bioethicists agree that all human beings have a basic human dignity (because we are born and are human), which is something that cannot be removed or taken away.

5. Which of the following statements is NOT true of terminally ill (dying) patients?
   *a. They have the same needs as other patients.
   b. They are frequently ignored by healthcare professionals, who are focused on prolonging life.
   c. Dying tends to produce feelings of isolation, fear and dehumanization.
   d. They have an increased need to know they are valued as human beings.

6. According to the Institute of Medicine, a “good death” is defined/described as one in which:
   a. The patient experiences ongoing pain because the doctor is concerned about addiction.
   b. The family visits less and less as the patient becomes increasingly unresponsive.
   c. The patient dies in the hospital, by choice, where more care is available.
   *d. Pain and distress – physical, psychological and spiritual – are alleviated and reduced.
   e. The patient’s doctor makes the decision.
7. With regard to the importance of cultural competency, which of the following statements are true?

a. The desire to provide artificial hydration and nutrition at the end of life is the same in most cultures.

b. All cultures discourage talk about death and displays of emotions such as crying and sadness in the presence of the dying person.

c. People of all cultural backgrounds want to die in peace and dignity, with minimal pain and suffering.

d. When the doctor recommends hospice care to the patient’s family, communicating this to the patient would be appropriate in all cultures.

8. In what ways can we help promote human dignity?

a. Encourage the patient to prepare a living will.

b. Address the patient’s spiritual needs.

c. Fully respect patients and value their opinion.

d. Don’t talk about patient as being a burden.

e. Assist the patient with any needs, especially alleviating pain and discomfort.

f. Withdraw artificial life support, if these are the patient’s wishes.

g. All of the above.
Course expires: November 2019; May 2020 (6 months term)

TARGET AUDIENCE: (gist – Capital letter: ex: Cardiologists, Emergency Medicine Physicians)
Pulmonologist, Internal Medicine Physicians, Cardiologists, Oncologists, Family Medicine Physicians, Thoracic Surgeons, Radiologists and Respiratory Therapists

CONFERENCE DIRECTOR: Arturo Fridman, 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)

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

Recent lung cancer screening guidelines have changed the way we identify and treat lung cancer patients. This course discusses essential guidelines for properly screening patients. Our goal is to catch lung cancer in the early stages so that patients have optimal treatment outcomes. Baptist Health Radiologist, Juan Carlos Batlle, M.D. provides learners with the evidence supporting current screening algorithms.

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
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 may not be aware of current lung cancer screening guidelines.

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 consistently implement current lung cancer screening guidelines to identify patients with lung cancer in earlier stages.

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

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

► National initiative on lung cancer screening guidelines by the National Cancer Institute.  https://www.cancer.gov/types/lung/research/nlst
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:

- Explain the history and evidence supporting current lung cancer screening guidelines.
- Implement current lung cancer screening guidelines and appropriately select candidates for early screening to improve patient outcomes.

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.)

Juan Batlle, M.D.
Diagnostic Radiologist
Baptist Hospital, South Miami, Homestead, Doctors and West Kendall Baptist Hospitals
Baptist Health Quality Network

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

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. ________________________________________________________

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External: 580058
Provider: 2016IEM38

Course video: https://cdn.baptisthealth.net/cme/vol01/olp/LungScreeningbattleOLP.mp4

Course handout:

Quiz Questions

1. Which of the following represents the most commonly accepted pack-year minimum for patients eligible for annual lung cancer screening?
   a. 5 pack-years
   b. 10 pack-years
   c. 20 pack-years
   *d. 30 pack-years

2. The radiation dose from a low-dose CT for lung screening is closest to which of the following?
   a. Screening mammogram
   *b. Routine chest CT
c. Chest X-ray

d. Abdominal CT

3. What is the LUNG-RADS classification for a lesion highly suspicious for lung cancer?
   a. LUNG-RADS 1
   b. LUNG-RADS 2
   c. LUNG-RADS 3
   *d. LUNG-RADS 4

4. Most patients undergoing CT lung screening are reassured and told to come back in one year for their next annual screening. According to Baptist Health data, approximately what percentage of patients does this apply to?
   a. 30%
   b. 50%
   c. 70%
   *d. 90%

DATE REVIEWED: November 1, 2016; October 29, 2018  REVIEWED BY: ☐ Accelerated Approval  ☐ Executive Committee

☐ Live Committee

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

Continuing Psychology Education Credits: # 1 N/A  ■ Continuing Dental Education Credits: # 1 N/A

CONTINUING MEDICAL EDUCATION ACTIVITY APPLICATION

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

CME ACTIVITY TITLE: Medicare's Teaching Physician Billing Guidelines
DATE: July 2019   END DATE: July

CREDIT HOUR(S) APPLIED FOR: 

TARGET AUDIENCE: West Kendall Baptist Hospital GME faculty including: Family medicine practitioners, cardiologists, emergency medicine physicians, surgeons, hospitalists, Ob/Gyns, nephrologists, hematologists/oncologists, infectious disease specialists, gastroenterologists, neurologists, ENTs, ophthalmologists, urologists, pulmonologists, critical care physicians, nurses, medical students, residents, fellows and other interested healthcare professionals

CONFERENCE DIRECTOR: A. Hernandez, M.D.   CME MANAGER: Eleanor Abreu (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 0   CHARGE: 0

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 & 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 that keyword searches will pull from this description.

Medical and surgical services furnished by an intern or resident within the scope of his or her training program are covered as provider services and Medicare pays for them through Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments. These services may not be billed or paid under the Medicare Physician Fee Schedule (PFS). When interns or residents are in an approved program and training in a nonprovider setting, the services furnished are payable in one of the following ways:

a. Through DGME and IME payments to the hospital(s), if, among other things, he or she: Provides patient care activities and the hospital(s) incur(s) salary and fringe benefits of the resident or intern during the time spent in the nonprovider setting; or

b. For DGME purposes, spends time in certain nonpatient care activities in certain nonprovider settings and the hospital(s) incur(s) salary and fringe benefits of the resident or intern during the time he or she spent in the nonprovider setting; or
c. Through the Medicare PFS if, in part, the regulations concerning the hospital(s) receipt of DGME and IME payments are not met for the time spent in a non provider setting, and the time spent in the nonprovider setting is not counted by the hospital(s) for DGME and IME payment purpose.

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)

► Medicare’s teaching physician guidelines are numerous, complicated and rather unwieldy. Without accurate education, teaching physician services may not be billed correctly.

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)

► With accurate education, teaching physicians and residents will consistently document the performance of services in a full and compliant manner.

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

REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
The presence of the teaching physician during procedures may be demonstrated by the notes in the medical records made by a physician, resident, or nurse. In the case of evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical records.


Bibliography and Additional Resources:

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:

- Apply up-to-date organizational billing requirements.
- Implement up-to-date government payer billing requirements.

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.)

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

Seth Canterbury, CPC, CPC-I
Healthcare Coding and Reimbursement Consultant

Seth Canterbury, CPC, CPC-I, has indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

Conference Director

Agueda Hernandez, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies.
Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

**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. ________________________________

This event is in collaboration with the West Kendall Baptist Hospital Graduate Medical Education Program.

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

**ETHOS CONTENT**

**YOU MAY ALSO BE INTERESTED IN:** List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM163

Course video:
Quiz Questions

2. To bill for a minor procedure, a teaching physician must document his or her presence during ________________ of the service.
   
   e. The key portion(s)
   f. The beginning
   g. The end
   h. The entirety

2. To bill for a major procedure, a teaching physician must document his or her presence during ________________ of the service.
   
   e. The key portion(s)
   f. The beginning
   g. The end
   h. The entirety

3. To bill for an E/M service, a teaching physician must document his or her presence during ________________ of the service.
   
   e. The key portion(s)
   f. The beginning
   g. The end
   h. The entirety

4. To bill for a time-based service, a teaching physician must document his or her presence during ________________ of the service.
   
   e. The key portion
   f. The beginning
   g. The end
   h. The entirety

DATE REVIEWED: ___________ REVIEWED BY: □ Accelerated Approval □ Executive Committee
               □ Live Committee

APPROVED: □ YES □ NO □ Continuing Psychology Education Credits: #____ □ N/A □ Continuing Dental Education Credits: #____ □ N/A

Credits: AMA/PRA Category 1 Credits: #___
CME ACTIVITY TITLE: Promoting Physician Wellness: Management of Physician’s Fatigue, Sleep Deprivation and Other Conditions that Contribute to Physician Impairment

COURSE APPROVAL: July 2019  COURSE EXPIRATION: July 2020

CREDIT HOUR(S) APPLIED FOR: TBD

TARGET AUDIENCE: West Kendall Baptist Hospital GME faculty including: Family medicine practitioners, cardiologists, emergency medicine physicians, surgeons, hospitalists, Ob/Gyn’s, nephrologists, hematologists/oncologists, infectious disease specialists, gastroenterologists, neurologists, ENT’s, ophthalmologists, urologists, pulmonologists, critical care physicians, nurses, medical students, residents, fellows and other interested healthcare professionals.

CONFERENCE DIRECTOR: Agueda Hernandez, M.D.

CME MANAGER: Eleanor Abreu (LIVE); Marie Vital Acle (ONLINE)

EXPECTED NUMBER OF ATTENDEES: 25-30  CHARGE: 0

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

- [ ] ARS
- [ ] Case Studies
- [ ] Didactic Lecture
- [ ] 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.
With the growing attention paid to resident duty hours, there is an increasing need for research involving fatigue and practical ways to measure it. This study shows that residents who are measurably fatigued (both objectively and subjectively) may have difficulty utilizing vestibular input during quiet standing but can compensate by means of somatosensory and visual input.

**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 may not be aware of the signs of fatigue and sleep deprivation in residents and fellows.

**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 supervising residents and fellows implement appropriate strategies to address issues of fatigue and sleep deprivation.

**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:
Bibliography and Additional Resources:

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:

- Identify the ACGME duty hour regulations
- Recognize the signs of fatigue, sleep deprivation and other conditions that contribute to physician impairment
- Identify the effect of fatigue, sleep deprivation, and other conditions on physician’s functioning and performance
- Engage in strategies to prevent and reduce the impact of fatigue, sleep deprivation, and other conditions on physician’s functioning and performance.

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.)

Susan Chaflin, Ph.D.
Licensed Clinical Psychologist
Child Psychology Associates
Director, Behavioral Medicine Training
Florida International University/West Kendall Baptist Hospital Family Medicine Training

Susan Chaflin, Ph.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.
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. ______________________________________________________

This event is in collaboration with the West Kendall Baptist Hospital Graduate Medical Education Program.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM166

Course video:

Course handout:

Quiz Questions
1. Which of the following is not an ACGME limit on duty hours?
   a. 80 hours maximum per week.
   b. 16 hours maximum per shift for all residents with no exceptions.
   c. In-house call every three nights.
   d. 10-hour minimum rest period provided between daily duty periods and after in-house call.
   e. One day in seven free of patient care responsibilities.

2. Which of the following are signs of fatigue?
   a. Involuntary nodding off, waves of sleepiness and lethargy.
   b. Problems focusing, inattentiveness to details and difficulty with short-term recall.
   c. Irritability, poor coordination and missing work.
   d. All of the above.
   e. a and c

3. True or false: A 60-minute nap or 100 mg of caffeine relieves the impact of fatigue and sleep deprivation.

4. Research shows that the impact of a physician missing one night of sleep includes:
   a. 50% decrease in cognitive performance.
   b. Increase in medical errors.
   c. Increase in length of time required to perform surgery/procedures.
   d. All of the above.
   e. b and c

5. Which of the following are effective wellness tools?
   a. Good sleep hygiene.
   b. Deep breathing, mindfulness and regular exercise.
   c. Good work-life balance.
   d. Supportive work and family relations.
   e. All of the above.
CME ACTIVITY TITLE: Evidence-based Clinical Care: Chronic Obstructive Pulmonary Disease (COPD) and Asthma

COURSE APPROVED: November 2018  COURSE RENEWAL: March 2019

COURSE EXPIRES: November 2019; November 2020

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

TARGET AUDIENCE: Emergency Department Physicians, Hospitalists, Internal Medicine Physicians and Family Medicine Physicians.

CONFERENCE DIRECTOR: Mark Hauser, M.D.  CME MANAGER: Marie Vital Acle

CONFERENCE COORDINATOR: Erika Gonzalez/Lellany Ruiz

EXPECTED NUMBER OF ATTENDEES: 200 annually  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)
- [X] 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)
This course provides evidence-based data supporting the standardization of care throughout Baptist Health for patients with Chronic Obstructive Pulmonary Disease and Asthma. Included in this course are treatment algorithms, physician resources and the new quality metrics by which all medical staff will be evaluated.

Note to Physicians: Be sure to bookmark this course to access all protocols, pathways, policies and procedures at your convenience via your CME Portal account. All power plans are available in Cerner. All EBCC deliverables will be available on the EBCC website.

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 may not be aware of evidence-based standardization efforts throughout Baptist Health that are impacting algorithms of care for COPD and Asthma patients. New quality metrics have been identified and physicians will be evaluated regularly based on these metrics.

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 power plans for craniotomy consistently as evidenced by CareC2 metrics.

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

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

Bibliography and Additional Resources:


The COPD Foundation http://www.copdfoundation.org/

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:

- Implement the new evidence-based clinical pathway for chronic obstructive pulmonary disease (COPD) and asthma created to standardize care throughout Baptist Health South Florida.
- Utilize the current Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines for the management and treatment of COPD.
- Define COPD and asthma clinical goals and discuss the mechanisms in place to measure adherence to clinical pathways.
- Recognize the value of multidisciplinary teams to facilitate transition from emergency department/observation to inpatient care/outpatient care.
- Educate patients and their families on community resources available to maximize accessibility for patient follow-up and to ensure compliance upon discharge.

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.)

**Javier Perez-Fernandez, M.D.**

Pulmonary Disease Specialist
Director of Pulmonary Services at West Kendall Baptist Hospital
Director of Critical Care Services at Baptist Hospital
Associate Clinical Professor at Florida International University

Miami, Florida

**Seema Chandra, M.D.**

Board-certified in Internal Medicine and Pediatrics
Associate Medical Director for Academics,
Baptist Health Medical Group Hospital Medicine Program

Miami, Florida

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

**Javier Perez Fernandez, M.D.,** has indicated he has a speaker role with Boehringer Ingelheim, Sunovion, Astra-Zeneca, Sunovion and Astra-Zeneca. Dr. Perez Fernandez will not include off-label or unapproved product usage in his presentation or discussion.

**Seema Chandra, M.D.,** indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

**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. This course is planned in collaboration with the evidence-based clinical care committee in support of system-wide standardization efforts.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM93

Course video:

Course handout:

Quiz - see edited version sent by DS

1. Effective multidisciplinary rounds help:
   - a. Expedite safe and early discharge.
   - b. Increase overall length of stay.
   - c. Decrease optimal patient outcomes.
   - d. Reduce the amount of phlegm.

2. Who will be alerted upon completion of the smoking cessation screening?
   - a. Respiratory Therapy,
   - b. Charge nurse.
   - c. Case manager.
   - d. Pulmonologist.
3. GOLD guidelines recommend antibiotics for moderate to severely ill patients with two out of three cardinal symptoms. Choose the best two from the list below.
   a. Increased dyspnea, increased purulence.
   b. Decreased sputum, decreased purulence.
   c. Decreased purulence, increased activity.
   d. Increased hunger, increased thirst.

4. Which of the following Power Plans should physicians use when admitting a COPD patient?
   a. MED PULM COPD Exacerbation_B.
   b. MED PULM Asthma_B.
   c. ED ANI – Suspected Asthma/COPD_B.
   d. ED – Asthma/COPD_B.

5. Which is the best choice to differentiate COPD from asthma?
   a. Onset early in life.
   b. Presence of rhinitis, eczema and environmental allergies.
   c. Slow and continuous progression of symptoms.
   d. None of the above.

6. In acute exacerbations of COPD, which of the following statements is TRUE?
   a. Long-acting bronchodilators are recommended as the first line therapy.
   b. Methylxanthines should be used frequently.
   c. Systemic corticosteroids should be used for no more than 5-7 days.
   d. Antibiotics are never indicated.

7. Effective multidisciplinary rounds help:
   a. Expedite safe and early readmission.
   b. Increase overall length of stay.
   c. Increase optimal patient outcomes.
   d. Reduce the amount of teamwork.

8. Which is associated with an increased risk of death related to asthma?
   a. Any history of intubation for asthma.
   b. No prior hospitalizations for asthma.
   c. Having a written asthma action plan.

9. What is the most important reason to be part of the creation of a clinical pathway?
   a. Help design a systematic, evidence-based and standard process to reduce clinical variation in the care of the patient by building standardized best practices among healthcare professionals.
   b. Be part of a great Baptist Health committee.
   c. Opportunity to work with others with a strong commitment to provide the best care to the patients.
   d. The coffee and snacks provided.

10. Long-term oxygen therapy (LTOT) increases survival in patients with COPD who have chronic resting arterial hypoxemia, which is defined as:
    a. Resting O2 Sat<88% in patients without right heart failure.
    b. Resting O2 SAT <92%.
    c. Resting O2 SAT <95%.
    d. Exertional O2 SAT <95%.
CME ACTIVITY TITLE: SIM WARS Competition

DATE: August 27, 2019 CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1

TIME: See Schedule Below

LOCATION: Homestead Hospital, Mango and Lime Rooms

TARGET AUDIENCE: Physicians, Physician Assistants, Nurse Practitioners, Nurses, Respiratory Therapists, Pharmacist, Radiology Technologist, Social Workers and other interested clinicians.

CONFERENCE DIRECTOR: Agueda Hernandez M.D.
CONFERENCE COORDINATOR: John Mouw PBT, (ASCP)
CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 60-80 CHARGE: 0

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

- [ ] ARS
- [ ] Case Studies
- [x] 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
- [x] Live activity
- [ ] Manuscript review activity
- [x] Panel
- [ ] PI CME activity
- [ ] Question & Answer
- [ ] Regularly Scheduled Series
- [x] Simulation
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

The 2019 SIM WARS provides an opportunity for Inter-professional healthcare teams to participate in a simulation competition for the “best team”. Healthcare teams understand the unexpected is inevitable. Clinicians need to recognize symptoms of concern and be able to respond quickly to prevent needless complications. Applied evidence-based practices from simulation-based medical education and training has been shown to improve clinical competence and patient safety. Join us for this teamwork training to gain crisis management techniques to implement into your practice.

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
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)

► Practitioners may not be aware of the simulation capabilities that are available at Baptist Health and how these resources can be utilized to improve individual and team performance, outcomes and safety. Practitioners may not be utilizing effective teamwork and communication skills.

► Failure to rescue is a key concept; doctors and nurses should recognize symptoms of concern and be able to respond quickly to prevent needless complications. Dr. Gaba a pioneer in simulation noted most anesthetic accidents stem from an “evolutionary cascade” of small errors and system failures that interact and result in adverse events (Agency for Healthcare Research and Quality, 2019).

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)

► Practitioners implement crisis management techniques as a tool for improving patient safety.

► Practitioners utilize an evidence-based systematic approach to the treatment for patients who are clinically deteriorating.

► Practitioners demonstrate coordination of effective high-performance team dynamics and mobilization of the recourses in the management of deteriorating patients.

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
☐ Consensus of experts
☐ Disease prevention (C12)
☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics
☐ National Patient Safety Goals
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:


Standardized Orders:

SO-0020 Stroke - (t-PA) Activase Vital Signs & Neurological Check Flowsheet Rev 5/23/18
SO-0021 Emergent Stroke Response Orders (Inpatient only) Rev 8/29/16
SO-0024 Stroke - (t-PA) Alteplase (Activase) Administration Doctors Orders Rev 9/18/18 p2
SO-0026 Stroke - Ischemic CVA (POST - t-PA) Activase Admission Orders Rev. 6/28/17 p3
SO-0131 Acute Cholecystitis Admission Orders rev 7/23/18 p.5

Standardized Forms:

SF-0020 Stroke - (t-PA) Activase Vital Signs & Neurological Check Flowsheet Rev 10/3/18 p3
SF-0021 Stroke Responder Progress Notes Rev 5/1/18
SF-0022 NIH Stroke Scale Rev 8/29/16
SF-0023 Dysphagia Screening Rev 7/20/17
HH0798 Consent for Intravenous Thrombolytic Treatment of Acute Ischemic Stroke with Tissue Plasminogen Activator Rev 11/3/15
BH 4687 Baptist Stroke Program Algorithm Rev 4/2016 p21
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:

- Identify team behaviors that are essential for effective crisis management.
- Assess how simulation is an effective tool for improving patient safety.
- Explain what simulation capabilities are currently available at the Baptist Health Patient Safety Simulation Lab.
- Apply evidence-based practices from simulation-based medical education and training to improve clinical competence and patient safety.

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.)

John Mouw PBT, (ASCP)
Manager Resuscitation & PCS Lab
Baptist Health South Florida

Shamma Legrand MSN, RN, CNL, SCRN, CCRN-CSC
Clinical Risk Manager/Patient Safety Officer
Baptist Health South Florida

Rosy M. Gonzales RN, CHSE
Mgr Patient Safety Simulation Lab
Baptist Health South Florida

Michelle A. Echevarria
Simulation Lab Coordinator
Baptist Health South Florida

Nelson Peña
Human Patient Simulation Lab Coordinator
Baptist Health South Florida

Dennise Haughton
Clinical Learning Educator 2
Baptist Health South Florida

Marrice King MSN, RN-BC, CNOR, CHSE
Clinical Learning Educator 2,
Baptist Health South Florida
Miami, Florida

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

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. This course has been planned in collaboration with the Baptist Health Patient Safety Partnership and the Baptist Health Patient Safety Simulation Lab.

COMMERCIAL SUPPORT:  □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.
You may also be interested in: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: ___________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee
☐ Live Committee

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

SCHEDULE:

Group #1 8:15a-9:15a  HH Mango  Didactic
         9:15a-10:10a  HH Lime  Simulation

Group #2 9:30a-10:30a  HH Mango  Didactic
         10:30a-11:25a  HH Lime  Simulation

Group #3 12:15p-1:15p  HH Mango  Didactic
         1:15p-2:10p  HH Lime  Simulation

Group #4 1:30p-2:30p  HH Mango  Didactic
         2:30p-3:25p  HH Lime  Simulation

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

CME ACTIVITY TITLE: Baker and Marchman Acts

COURSE APPROVED: September 2019
COURSE EXPIRES: September 2022
CREDIT HOUR(S) APPLIED FOR: TBD


CONFERENCE DIRECTOR: Barry Crown, Ph.D.  CME MANAGER: Katie Deane (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 100 annually  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)

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

Florida citizens who might harm themselves or others may be held involuntarily for assessment up to 72 hours. The statute for mental illness is called the Baker Act; for substance abuse, the Marchman Act. There are very specific criteria for committing someone under the Baker Act or Marchman Act. Join us as Martha R. Lenderman, MSW, clearly explains how to identify patients legally eligible to implement these statutes and the requirements under the Florida Mental Health Act for appropriate admission and discharge in compliance with the law.

Samaritan Physicians: Successful completion of this activity will qualify Samaritan physicians for annual policy discounts. Upon completion, please print your certificate and submit to Samaritan for consideration.

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
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)

► Many physicians lack knowledge and/or competence regarding Baker Act requirements and their appropriate application to medical decision making.

► Prior to the Baker Act, people who had psychiatric/emotional problems were most often handled by the police and were likely to wind up in jail rather than a treatment facility. Also, relatives or friends of a disturbed person could go to a judge and have a person declared incompetent and dangerous which would lead to their placement in a state mental hospital for an indefinite period of time. At one time, the Florida State Hospital held 10,000 people. (Barry Crown, Ph.D., Director, Continuing Education in Psychology)

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 consistently and competently apply the Baker Act and Marchman Act admission criteria for compliance with involuntary admissions and medical decision making.

The Baker Act is a Florida Statute that provides strict guidelines and procedures for the determination, processing, and detentions of someone who is dangerous to themselves and/or others. Since this is a legal procedure (and not medical), physicians need to be aware of the requirements of the Act and be able to translate and apply these requirements to their medical decision making.

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 ☑ Consensus of experts
☐ Disease prevention (C12) ☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics ☐ National Patient Safety Goals
This program provided participants with an overview of the legal, statutory and regulatory policies that relate to The Baker and Marchman Acts.

In order to properly follow the requirements of The Baker Act and Marchman Act admitting psychologist must be aware of the examination criteria, eligibility, admission compliance, discharge compliance and patient rights. Consistency is essential in applying the federal Emergency Medical Treatment and Active Labor Act and the Florida Baker Act laws.

A Baker Act is a means of providing individuals with emergency services and temporary detention for mental health evaluation and treatment when required, either on a voluntary or an involuntary basis. (Chapter 394, FS; Chapter 65E-5, FAC; 2006 Baker Act Handbook, Chapter 397, F.S., and model forms)

The Marchman Act is a single law that clearly spells out legislative intent, licensure of service providers, client rights, voluntary and involuntary admissions, offender and inmate programs, service coordination and children's substance abuse services. (Hal S. Marchman Alcohol & Other Drug Services Act of 1993)

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

► This program provided participants with an overview of the legal, statutory and regulatory policies that relate to The Baker and Marchman Acts.

In order to properly follow the requirements of The Baker Act and Marchman Act admitting psychologist must be aware of the examination criteria, eligibility, admission compliance, discharge compliance and patient rights. Consistency is essential in applying the federal Emergency Medical Treatment and Active Labor Act and the Florida Baker Act laws.

A Baker Act is a means of providing individuals with emergency services and temporary detention for mental health evaluation and treatment when required, either on a voluntary or an involuntary basis. (Chapter 394, FS; Chapter 65E-5, FAC; 2006 Baker Act Handbook, Chapter 397, F.S., and model forms)

The Marchman Act is a single law that clearly spells out legislative intent, licensure of service providers, client rights, voluntary and involuntary admissions, offender and inmate programs, service coordination and children's substance abuse services. (Hal S. Marchman Alcohol & Other Drug Services Act of 1993)

This program is derived from the following works.

ACTIVITY TWO REFERENCES (at least 5):

Voluntary Admission Selected Procedures, 394.4625 FS and 65E-5.270, FAC
Initiating Involuntary Examinations, 384.463(2), FS and 65E-5.280, FAC
Involuntary Examinations Initiated by the Court, 384.463(2)(a)1, FS and 65E-5.280(1), FAC
Involuntary Examination Law Enforcement Officers, 384.463(2)(a)2, FS and 65E-5.280(2), FAC
Minimum Standards for Initial Mandatory Involuntary Examination, 394.463(2)(f), FS 65E-5.2801, FAC
Hal S. Marchman Alcohol & Other Drug Services Act of 1993
The Joint Commission National Patient Safety Goals NPSG.15.01.01

APA Criteria 1.4: Program content is related to ethical, legal, statutory or regulatory policies, guidelines, and standards that impact psychology.

Bibliography and Additional Resources:

► Florida Statute 394 is the current Baker Act - The Florida Mental Health Act. (http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0300-0399/0394/0394.html)
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:

- Implement the Baker Act voluntary and involuntary examination criteria.
- Identify which patients are legally eligible to consent to admission and treatment.
- Discuss requirements under the Florida Mental Health Act including appropriate admission and discharge in compliance with the law.
- Implement the criteria for involuntary admission of persons under Florida’s Marchman Act for substance abuse impairment.
- Consistently comply with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Florida Baker Act laws.

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.)

Martha R. Lenderman, MSW
Former Program Coordinator, Department of Children and Families
Consultant, Lenderman & Associates, Pinellas Park, Florida

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

Martha R. Lenderman, MSW, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.
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. __________________________________________________________________________

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:

Provider: (If same amount of time from old video, can keep same PARS #2017IEM49)

Course video:

Course handout:

Quiz Questions –
1. Which of the following is correct with regard to Baker Act patient rights in all hospitals?

   a. A person can be placed under Baker Act involuntary status due to substance abuse intoxication.
b. People who cannot make well-reasoned, willful and knowing decisions about their mental health or medical or substance abuse treatment must be handled as involuntary patients.

c. People on involuntary status lose rights under the federal EMTALA laws.

d. People on voluntary status have the right to an immediate release if they request it.

2. Which of the following is correct with regard to securing the safety of Baker Act patients at hospitals?

   a. Law enforcement officers are responsible for remaining with patients brought to the hospital in order to prevent elopement.

   b. Law enforcement officers under contract with the hospital for security purposes do not need to comply with patient rights under the Baker Act.

   c. Hospital personnel are responsible for ensuring the safety of patients in their care, including prevention of elopement.

   d. Hospital personnel cannot use physical methods to prevent a person from eloping from the hospital.

3. Which of the following is correct with regard to authorizing examination and treatment for medical conditions when a patient has refused or is incapable of giving informed consent?

   a. People held under the Baker Act retain the right to refuse medical testing and treatment, but other medical laws may provide for such medical issues for emergency conditions without consent.

   b. People lose the right to refuse medical examinations under the Baker Act.

   c. Drawing blood and other laboratory procedures can be conducted if provided for in the hospital’s policies and procedures, even over the objections of the patient.

   d. Psychiatric emergencies and substance abuse emergencies are not considered emergency medical conditions under the federal EMTALA law.
4. Which of the following is correct with regard to the direct release of a person from a hospital emergency department?

a. People on involuntary status cannot be released from a hospital ED without an examination of a psychiatrist.

b. An emergency physician is permitted by law to conduct the involuntary Baker Act examination and to authorize the individual’s direct release from the hospital.

c. In a hospital that has not been designated a Baker Act receiving facility, a patient can be held up to 72 hours after stabilization of a medical emergency condition.

d. Additional “BA-52” certificates of a professional can be “stacked” one on top of another to legally extend the length of time a patient can be held in a non-receiving facility.

5. Which of the following is correct with regard to the federal EMTALA law?

a. EMTALA doesn’t apply to persons on involuntary status.

b. Emergency psychiatric and emergency substance abuse conditions are “emergency medical conditions” under EMTALA.

c. Transfers of patients held under the Baker Act to other hospitals can be done without prior approval of the destination hospital.

d. Medical records of persons held under the Baker Act aren’t required to be shared with hospitals to which a patient is being transferred.

6. Which of the following is correct with regard to the Marchman Act?

a. The Marchman Act is Florida’s substance abuse impairment law.

b. The Marchman Act and the Baker Act are interchangeable and have the same provisions, other than that one is for substance abuse and the other is for mental illness.

c. Physicians cannot independently initiate an involuntary assessment of an adult or minor under the Marchman Act.
d. A person can be involuntarily held up to 96 hours for assessment under the Marchman Act Emergency Admission provisions.

DATE REVIEWED: ___________ 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

CONTINUING MEDICAL EDUCATION ACTIVITY APPLICATION

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

CME ACTIVITY TITLE: Building Collaborative Leadership: Baptist Health Clinical Ethics Consultation Training Program

DATE: July 19, 2019 – TBD Six (6) Group Meetings, 1.5 hours each (specific dates listed below)

TIME: 7-8:30 a.m. CREDIT HOUR(S) APPLIED FOR: 9 Cat 1 (1.5 Cat 1 ea. for 6 sessions)

LOCATION: Baptist Hospital of Miami

TARGET AUDIENCE: Nominated participants who are established or emerging Medical Staff leaders practicing in different specialties as well as nursing managers and administrative executives with oversight of the health care service lines who are members of the Ethics Committee.

CONFERENCE DIRECTOR: Ana M. Viamonte-Ros, M.D., Medical Director, Palliative Care & Bioethics

CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 6 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) Integrated format of: a) presenting a concept or practice, b) engaging in group discussion and c) engaging in interactive exercises to apply the educational module presented

COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description. NOTE: there will be no course shell for this training program.

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 are not consistently communicating and collaborating with each other and with associated disciplines in an effective and timely manner to provide optimum care delivery and time-sensitive information that can benefit their patient, their interdisciplinary collaboration, their department or the hospital.

Physicians do not demonstrate that they consistently utilize optimal communication and collaborative skills with each other, between different specialties and/or departments, and with other disciplines. Exchange of important administrative and other information is not always distributed in a reasonable time, resulting in unnecessary delays in project implementation and ineffective conflict management. Collaboration is not optimized.

This initiative was generated by the CEO of Baptist Hospital of Miami (BHM), Bo Boulenger, and Dr. Mark Hauser, VP-MA, and Dr. Tomas Villanueva, Chief, Primary Care and Corporate Medical Director, Employee Health, to engage a group of physician leaders with related nursing and administrative executives in building sound collaborative leadership skills to strengthen performance, leadership effectiveness, and interdisciplinary accountability that will positively impact quality of care, patient safety and patient satisfaction. http://www.jointcommission.org/Physicians/MD_Advisory.htm

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, healthcare professionals, leaders and administrators utilize sound communication and leadership skills to sustain success in working through critical moments of patient-physician interaction. They employ strong interdisciplinary teamwork, productive communication processes all of which contributes to increased and sustained physician and patient satisfaction.

Concurrent leadership development for medical staff, nursing professionals and hospital executives optimizes their collective efforts for a successful integration of the health care service lines. In addition, it provides a shared experience and team-oriented practices that can inform future efforts. The program uses an “Action Learning” methodology, meaning that new skills are practiced by applying them to advance actual objectives established by the group. The program provides tools to develop high performing leaders with strong communication, relationship, meeting facilitation and systemic thinking skills.

Physician engagement with hospital leadership and strategic planning results in improved physician satisfaction, which in turn positively impacts the goals mentioned below.

In recent years, The Joint Commission’s Board of Commissioners has identified enhancing physician engagement in accreditation and other quality improvement initiatives as one of its top strategic priorities. They also include "improve the effectiveness of communication among caregivers" as part of their National Patient Safety Goals. (https://www.jointcommission.org/npsg_presentation/)
Physician leaders will engage with clinical and administrative executives to build sound communication and leadership skills needed to sustain success in working through critical moments of patient-physician interaction, as well as strengthen interdisciplinary teamwork, develop productive communication processes and ultimately positively impact quality of care, patient safety and patient satisfaction.

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
☐ Consensus of experts
☐ Disease prevention (C12)
☑ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics
☑ National Patient Safety Goals
☐ National/regional data
☐ New diagnostic/therapeutic modality (C12)
☑ New or updated policy/protocol
☐ Patient care data
☐ Peer review data
☑ Process improvement initiatives (C16 & 21)
☐ Regulatory requirement
☑ Other need identified (Explain): Needs of newly developed service lines and existing service lines in need of physician leadership development

☐ Research/literature review

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

• See Attached

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
1. Ethics consultation summaries are presented at BHM Ethics Committee meetings and are submitted in the meeting minutes to the BHM Medical Staff on a quarterly basis.

2. Ethics Consultation Feedback Tool is being developed and will be implemented by summer 2017 to obtain feedback from patients, their families and healthcare professionals on the consultation services provided.

3. BHM Administration will receive reports on the trained physicians’ completion of the training and their participation in ethics consultation at BHM.

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

Rose Allen, DNP, MSM/HM, R.N., CHPN,
Director, Bioethics & Palliative Care
Baptist Hospital of Miami

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

Rose Allen, DNP, MSM/HM, R.N., CHPN indicated that neither she nor her spouse/partner have relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentations or discussions.

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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.) ________________________________

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☐ 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. ________________________________________________

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

<table>
<thead>
<tr>
<th>Group Meeting</th>
<th>Topic</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Meeting</td>
<td>OBJECTIVES:</td>
<td>Rose Allen, DNP, RN</td>
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</tbody>
</table>
| July 19, 2019 | • Review and apply three “perceptual positions” to expand strategic thinking and optimize communication skills in conflict resolution.  
• Discuss Baptist Health’s Bioethics Program, and explain the functions of the Clinical Ethics Committees.  
• Effectively apply ethical theories and clinical ethics consultation competencies to carry out the Baptist Health Ethics Consultation Process.  
Prior materials for reading: Hastings Article (2009) – Charting the Future; ASBH Ethics Consultation Guidelines 2nd Ed. (2015); BHM & BHSF Pediatric Ethics Committee Plans, Ethics Consultant Fact Gathering tool; BHM Requesting an Ethics Consultation Policy; Ethics consultation categories; Mapping the Journey – BHSF Ethics Consultation Process (pp)  
Review of three “perceptual positions” to expand strategic thinking and optimize communication skills in conflict resolution  
BHSF Bioethics Program & Functions of the Clinical Ethics Committees. Overview of Ethical Theories. Overview of Clinical Ethics Consultation Competencies. (30-mins)  
Quick Review - Mapping the Journey – BHSF Ethics Consultation Process (10mins)  
(20 mins)  
Case presentation/role-playing (J.B. 89-year old triple vessel bypass surgery) | Training Participants |
<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date TBD</th>
<th>Time TBD</th>
<th>Location TBD</th>
<th>OBJECTIVES:</th>
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<tbody>
<tr>
<td>2nd</td>
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<td>Improve doctor-patient medical decision-making regarding advance directives and hospice care.</td>
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<td>Consider the influence of cultural and racial differences when having advanced directives discussions with patients and/or their surrogates/proxies.</td>
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<td>Recognize the surrogate/proxy's role and burdens in advance directive decision-making.</td>
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<td>Advance Directives, Surrogate and Proxy Decision-Making, Surrogate/Proxy Burdens (30 mins)</td>
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<td>(30 mins): Case presentation with interactive discussions – 69 year-old, morbidly obese woman's valid refusal to be intubated and on a ventilator.</td>
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<td>Distinguish between competence and decision-making capacity, and examine the ethical and practical implications.</td>
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<td>Evaluate and discuss informed consent and valid refusal.</td>
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<td>Apply helpful communication methods when addressing emotional conflict in the clinical encounter.</td>
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<td>Prior materials for reading: Ten myths about decision making capacity; Assessment of patient’s competence to consent to treatment, NEJM (2007); Some limits of informed consent; Informed consent in clinical practice (2011); ASBH Ethics Consultation Guidelines 2nd Ed. (2015), page 22 - 26</td>
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<td>Decision making capacity (10 mins) Informed consent, valid refusal (10 mins)</td>
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<td>Case presentation, interactive discussions or role-playing (Incapacitated patient, questionable valid advance directives, wife’s decision-making in conflict with HCT)</td>
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<td>4th</td>
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<td>Recognized and discuss futile treatment considering the individual patient’s goals and treatment preferences.</td>
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<td>Define and differentiate between brain death, persistent vegetative state and the minimal conscious state.</td>
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<td>Utilize approaches to effective conversations about end-of-life care with patients and families.</td>
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<td>Appropriately manage challenges and requirements for withholding or withdrawing care.</td>
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<td>Prior materials for reading: Are withholding and withdrawing therapies morally equivalent?; Views on EOL medical treatment, PEWS 2013 report; Futility a concept in evolution, Truog; Baptist Hospital and Baptist Childrens Levels of End</td>
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</tbody>
</table>
| 5th Meeting  
Date TBD  
Time TBD  
Location TBD | **OBJECTIVES:**  
- Recognize and appropriately manage ethical issues involving minors with decision-making capacity, newborns and legal decision-makers for children.  
- Identify and address conflicting values that can occur between a healthcare professional and the parents of a terminally ill infant.  
- Discuss Baptist Children’s Levels of EOL Policy and the Baby Jules Lethal Congenital Disorder Policy.  
**Prior materials for reading:**  
- Lethal Congenital Disorder (20 min)  
(30 min): NICU Case presentation and interactive discussion  
Lethal Congenital Disorder Parent/Physician Conflict – Baby Jules Lethal Congenital Disorder Policy (10 min) | Rose Allen, DNP, RN  
Training Participants |
| 6th Meeting  
Date TBD  
Time TBD  
Location TBD | **OBJECTIVES:**  
- Apply skills of listening, being present and exercising empathy.  
- Review and discuss faith, culture and the role of Pastoral Care.  
- Describe and apply the core competencies for ethics consultation based on the American Society for Bioethics and Humanities Ethics Consultation Guidelines 2nd Ed.  
- Successfully complete the ethics consultation proctoring requirements for final credentialing.  
**Prior materials for reading:**  
- ASBH Ethics Consultation Guidelines 2nd Ed. (2015), Power-point presentation and Spiritual Articles  
Faith, culture and the Role of Pastoral Care – Renato Santos Power-point  
General review/discussions during group session  
- Case presentation and discussions (30 minutes) | Rose Allen, DNP, RN  
Training Participants |
Multiple choice questions covering the didactics and skills that were covered in the training. (30 minutes)

CME ACTIVITY TITLE: Promoting Physician Wellness: Management of Physician’s Fatigue, Sleep Deprivation and Other Conditions that Contribute to Physician Impairment

COURSE APPROVAL: July 2019 COURSE EXPIRATION: July 2020

CREDIT HOUR(S) APPLIED FOR: TBD

TARGET AUDIENCE: West Kendall Baptist Hospital GME faculty including: Family medicine practitioners, cardiologists, emergency medicine physicians, surgeons, hospitalists, Ob/Gyn’s, nephrologists, hematologists/oncologists, infectious disease specialists, gastroenterologists, neurologists, ENT’s, ophthalmologists, urologists, pulmonologists, critical care physicians, nurses, medical students, residents, fellows and other interested healthcare professionals.

CONFERENCE DIRECTOR: Agueda Hernandez, M.D.

CME MANAGER: Eleanor Abreu (LIVE); Marie Vital Acle (ONLINE)

EXPECTED NUMBER OF ATTENDEES: 25-30 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
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

With the growing attention paid to resident duty hours, there is an increasing need for research involving fatigue and practical ways to measure it. This study shows that residents who are measurably fatigued (both objectively and subjectively) may have difficulty utilizing vestibular input during quiet standing but can compensate by means of somatosensory and visual input.

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 may not be aware of the signs of fatigue and sleep deprivation in residents and fellows.

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 supervising residents and fellows implement appropriate strategies to address issues of fatigue and sleep deprivation.

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:
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:

- Identify the ACGME duty hour regulations
- Recognize the signs of fatigue, sleep deprivation and other conditions that contribute to physician impairment
- Identify the effect of fatigue, sleep deprivation, and other conditions on physician’s functioning and performance
- Engage in strategies to prevent and reduce the impact of fatigue, sleep deprivation, and other conditions on physician’s functioning and performance.

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.)

Susan Chaflin, Ph.D.
Licensed Clinical Psychologist
Child Psychology Associates
Director, Behavioral Medicine Training
Florida International University/West Kendall Baptist Hospital Family Medicine Training

Susan Chaflin, Ph.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.
RELEVANT FINANCIAL RELATIONS: 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. ________________________________________________________

This event is in collaboration with the West Kendall Baptist Hospital Graduate Medical Education Program.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM166

Course video:

Course handout:

Quiz Questions
1. Which of the following is not an ACGME limit on duty hours?
   a. 80 hours maximum per week.
   b. **16 hours maximum per shift for all residents with no exceptions.**
   c. In-house call every three nights.
   d. 10-hour minimum rest period provided between daily duty periods and after in-house call.
   e. One day in seven free of patient care responsibilities.

2. Which of the following are signs of fatigue?
   a. Involuntary nodding off, waves of sleepiness and lethargy.
   b. Problems focusing, inattentiveness to details and difficulty with short-term recall.
   c. Irritability, poor coordination and missing work.
   d. **All of the above.**
   e. a and c

3. True or false: A 60-minute nap or 100 mg of caffeine relieves the impact of fatigue and sleep deprivation.

4. Research shows that the impact of a physician missing one night of sleep includes:
   a. 50% decrease in cognitive performance.
   b. Increase in medical errors.
   c. Increase in length of time required to perform surgery/procedures.
   d. **All of the above.**
   e. b and c

5. Which of the following are effective wellness tools?
   a. Good sleep hygiene.
   b. Deep breathing, mindfulness and regular exercise.
   c. Good work-life balance.
   d. Supportive work and family relations.
   e. **All of the above.**
CME ACTIVITY TITLE: Evidence-based Clinical Care: Chronic Obstructive Pulmonary Disease (COPD) and Asthma

COURSE APPROVED: November 2018  COURSE RENEWAL: March 2019

COURSE EXPIRES: November 2019; November 2020

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

TARGET AUDIENCE: Emergency Department Physicians, Hospitalists, Internal Medicine Physicians and Family Medicine Physicians.

CONFERENCE DIRECTOR: Mark Hauser, M.D.  CME MANAGER: Marie Vital Acle

CONFERENCE COORDINATOR: Erika Gonzalez/Lellany Ruiz

EXPECTED NUMBER OF ATTENDEES: 200 annually  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
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

This course provides evidence-based data supporting the standardization of care throughout Baptist Health for patients with Chronic Obstructive Pulmonary Disease and Asthma. Included in this course are treatment algorithms, physician resources and the new quality metrics by which all medical staff will be evaluated.

Note to Physicians: Be sure to bookmark this course to access all protocols, pathways, policies and procedures at your convenience via your CME Portal account. All power plans are available in Cerner. All EBCC deliverables will be available on the EBCC website.

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 may not be aware of evidence-based standardization efforts throughout Baptist Health that are impacting algorithms of care for COPD and Asthma patients. New quality metrics have been identified and physicians will be evaluated regularly based on these metrics.

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.)

DESIRE 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 power plans for craniotomy consistently as evidenced by CareC2 metrics.

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

REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
Bibliography and Additional Resources:
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:

- Implement the new evidence-based clinical pathway for chronic obstructive pulmonary disease (COPD) and asthma created to standardize care throughout Baptist Health South Florida.
- Utilize the current Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines for the management and treatment of COPD.
- Define COPD and asthma clinical goals and discuss the mechanisms in place to measure adherence to clinical pathways.
- Recognize the value of multidisciplinary teams to facilitate transition from emergency department/observation to inpatient care/outpatient care.
- Educate patients and their families on community resources available to maximize accessibility for patient follow-up and to ensure compliance upon discharge.

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.)

**Javier Perez-Fernandez, M.D.**

Pulmonary Disease Specialist  
Director of Pulmonary Services at West Kendall Baptist Hospital  
Director of Critical Care Services at Baptist Hospital  
Associate Clinical Professor at Florida International University  
Miami, Florida

**Seema Chandra, M.D.**

Board-certified in Internal Medicine and Pediatrics  
Associate Medical Director for Academics,  
Baptist Health Medical Group Hospital Medicine Program  
Miami, Florida

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

**Javier Perez Fernandez, M.D.,** has indicated he has a speaker role with Boehringer Ingelheim, Sunovion, Astra-Zeneca, Sunovion and Astra-Zeneca. Dr. Perez Fernandez will not include off-label or unapproved product usage in his presentation or discussion.

**Seema Chandra, M.D.,** indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

**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. This course is planned in collaboration with the evidence-based clinical care committee in support of system-wide standardization efforts.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM93

Course video:

Course handout:

Quiz - see edited version sent by DS

11. Effective multidisciplinary rounds help:
   e. Expedite safe and early discharge.
   f. Increase overall length of stay.
   g. Decrease optimal patient outcomes.
   h. Reduce the amount of phlegm.

12. Who will be alerted upon completion of the smoking cessation screening?
   a. Respiratory Therapy.
   b. Charge nurse.
   c. Case manager.
   d. Pulmonologist.
13. GOLD guidelines recommend antibiotics for moderate to severely ill patients with two out of three cardinal symptoms. Choose the best two from the list below.
   a. Increased dyspnea, increased purulence.
   b. Decreased sputum, decreased purulence.
   c. Decreased purulence, increased activity.
   d. Increased hunger, increased thirst.

14. Which of the following Power Plans should physicians use when admitting a COPD patient?
   a. MED PULM COPD Exacerbation_B.
   b. MED PULM Asthma_B.
   c. ED ANI – Suspected Asthma/COPD_B.
   d. ED – Asthma/COPD_B.

15. Which is the best choice to differentiate COPD from asthma?
   a. Onset early in life.
   b. Presence of rhinitis, eczema and environmental allergies.
   c. Slow and continuous progression of symptoms.
   d. None of the above.

16. In acute exacerbations of COPD, which of the following statements is TRUE?
   a. Long-acting bronchodilators are recommended as the first line therapy.
   b. Methylxanthines should be used frequently.
   c. Systemic corticosteroids should be used for no more than 5-7 days.
   d. Antibiotics are never indicated.

17. Effective multidisciplinary rounds help:
   a. Expedite safe and early readmission.
   b. Increase overall length of stay.
   c. Increase optimal patient outcomes.
   d. Reduce the amount of teamwork.

18. Which is associated with an increased risk of death related to asthma?
   e. Any history of intubation for asthma.
   f. No prior hospitalizations for asthma.
   g. Having a written asthma action plan.
   h. Using short-acting beta-agonists (SABA) infrequently.

19. What is the most important reason to be part of the creation of a clinical pathway?
   e. Help design a systematic, evidence-based and standard process to reduce clinical variation in the care of the patient by building standardized best practices among healthcare professionals.
   f. Be part of a great Baptist Health committee.
   g. Opportunity to work with others with a strong commitment to provide the best care to the patients.
   h. The coffee and snacks provided.

20. Long-term oxygen therapy (LTOT) increases survival in patients with COPD who have chronic resting arterial hypoxemia, which is defined as:
   a. Resting O2 Sat<88% in patients without right heart failure.
   b. Resting O2 SAT <92%.
   c. Resting O2 SAT <95%.
   d. Exertional O2 SAT <95%.
CME ACTIVITY TITLE: SIM WARS Competition

DATE: August 27, 2019  CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1

TIME: See Schedule Below

LOCATION: Homestead Hospital, Mango and Lime Rooms

TARGET AUDIENCE: Physicians, Physician Assistants, Nurse Practitioners, Nurses, Respiratory Therapists, Pharmacist, Radiology Technologist, Social Workers and other interested clinicians.

CONFEREEE DIRECTOR: Agueda Hernandez M.D.

CONFERENCE COORDINATOR: John Mouw PBT, (ASCP)

CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 60-80  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
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

The 2019 SIM WARS provides an opportunity for Inter-professional healthcare teams to participate in a simulation competition for the “best team”. Healthcare teams understand the unexpected is inevitable. Clinicians need to recognize symptoms of concern and be able to respond quickly to prevent needless complications. Applied evidence-based practices from simulation-based medical education and training has been shown to improve clinical competence and patient safety. Join us for this teamwork training to gain crisis management techniques to implement into your practice.

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)

► Practitioners may not be aware of the simulation capabilities that are available at Baptist Health and how these resources can be utilized to improve individual and team performance, outcomes and safety. Practitioners may not be utilizing effective teamwork and communication skills.

► Failure to rescue is a key concept; doctors and nurses should recognize symptoms of concern and be able to respond quickly to prevent needless complications. Dr. Gaba a pioneer in simulation noted most anesthetic accidents stem from an “evolutionary cascade” of small errors and system failures that interact and result in adverse events (Agency for Healthcare Research and Quality, 2019).

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.)

DESORED 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)

► Practitioners implement crisis management techniques as a tool for improving patient safety.

► Practitioners utilize an evidence-based systematic approach to the treatment for patients who are clinically deteriorating.

► Practitioners demonstrate coordination of effective high-performance team dynamics and mobilization of the resources in the management of deteriorating patients.

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
☒ Consensus of experts
☐ Disease prevention (C12)
☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics
☐ National Patient Safety Goals
National/regional data

New or updated policy/protocol

Peer review data

Regulatory requirement

Research/literature review

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


Standardized Orders:

SO-0020  Stroke - (t-PA) Activase Vital Signs & Neurological Check Flowsheet Rev 5/23/18
SO-0021  Emergent Stroke Response Orders (Inpatient only) Rev 8/29/16
SO-0024  Stroke -(t-PA) Alteplase (Activase) Administration Doctors Orders Rev 9/18/18 p2
SO-0026  Stroke - Ischemic CVA (POST - t-PA) Activase Admission Orders Rev. 6/28/17 p3
SO-0131  Acute Cholecystitis Admission Orders rev. 7/23/18 p.5

Standardized Forms:

SF-0020  Stroke - (t-PA) Activase Vital Signs & Neurological Check Flowsheet Rev 10/3/18 p3
SF-0021  Stroke Responder Progress Notes Rev 5/1/18
SF-0022  NIH Stroke Scale Rev 8/29/16
SF-0023  Dysphagia Screening Rev 7/20/17
HH0798  Consent for Intravenous Thrombolytic Treatment of Acute Ischemic Stroke with Tissue Plasminogen Activator Rev 11/3/15
BH 4687  Baptist Stroke Program Algorithm Rev 4/2016 p21
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:

- Identify team behaviors that are essential for effective crisis management.
- Assess how simulation is an effective tool for improving patient safety.
- Explain what simulation capabilities are currently available at the Baptist Health Patient Safety Simulation Lab.
- Apply evidence-based practices from simulation-based medical education and training to improve clinical competence and patient safety.

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.)

John Mouw PBT, (ASCP)  
Manager Resuscitation & PCS Lab  
Baptist Health South Florida

Shamma Legrand MSN, RN, CNL, SCRN, CCRN-CSC  
Clinical Risk Manager/Patient Safety Officer  
Baptist Health South Florida

Rosy M. Gonzales RN, CHSE  
Mgr Patient Safety Simulation Lab  
Baptist Health South Florida

Michelle A. Echevarria  
Simulation Lab Coordinator  
Baptist Health South Florida

Nelson Peña
Human Patient Simulation Lab Coordinator
Baptist Health South Florida

Dennise Haughton
Clinical Learning Educator 2
Baptist Health South Florida

Marrice King MSN, RN-BC, CNOR, CHSE
Clinical Learning Educator 2,
Baptist Health South Florida
Miami, Florida

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

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. This course has been planned in collaboration with the Baptist Health Patient Safety Partnership and the Baptist Health Patient Safety Simulation Lab.

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

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**CME ACTIVITY TITLE:**  Baker and Marchman Acts

**COURSE APPROVED:**  September 2019

**COURSE EXPIRES:**  September 2022
CREDIT HOUR(S) APPLIED FOR: TBD


CONFERENCE DIRECTOR: Barry Crown, Ph.D. CME MANAGER: Katie Deane (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 100 annually 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)

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

Florida citizens who might harm themselves or others may be held involuntarily for assessment up to 72 hours. The statute for mental illness is called the Baker Act; for substance abuse, the Marchman Act. There are very specific criteria for committing someone under the Baker Act or Marchman Act. Join us as Martha R. Lenderman, MSW, clearly explains how to identify patients legally eligible to implement these statutes and the requirements under the Florida Mental Health Act for appropriate admission and discharge in compliance with the law.

Samaritan Physicians: Successful completion of this activity will qualify Samaritan physicians for annual policy discounts. Upon completion, please print your certificate and submit to Samaritan for consideration.

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)

► Many physicians lack knowledge and/or competence regarding Baker Act requirements and their appropriate application to medical decision making.

► Prior to the Baker Act, people who had psychiatric/emotional problems were most often handled by the police and were likely to wind up in jail rather than a treatment facility. Also, relatives or friends of a disturbed person could go to a judge and have a person declared incompetent and dangerous which would lead to their placement in a state mental hospital for an indefinite period of time. At one time, the Florida State Hospital held 10,000 people. (Barry Crown, Ph.D., Director, Continuing Education in Psychology)

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 consistently and competently apply the Baker Act and Marchman Act admission criteria for compliance with involuntary admissions and medical decision making.

The Baker Act is a Florida Statute that provides strict guidelines and procedures for the determination, processing, and detentions of someone who is dangerous to themselves and/or others. Since this is a legal procedure (and not medical), physicians need to be aware of the requirements of the Act and be able to translate and apply these requirements to their medical decision making.

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 ☒ Consensus of experts
☐ Disease prevention (C12) ☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics ☐ National Patient Safety Goals
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

► This program provided participants with an overview of the legal, statutory and regulatory policies that relate to The Baker and Marchman Acts.

In order to properly follow the requirements of The Baker Act and Marchman Act admitting psychologist must be aware of the examination criteria, eligibility, admission compliance, discharge compliance and patient rights. Consistency is essential in applying the federal Emergency Medical Treatment and Active Labor Act and the Florida Baker Act laws.

► A Baker Act is a means of providing individuals with emergency services and temporary detention for mental health evaluation and treatment when required, either on a voluntary or an involuntary basis. (Chapter 394, FS; Chapter 65E-5, FAC; 2006 Baker Act Handbook, Chapter 397, F.S., and model forms)

► The Marchman Act is a single law that clearly spells out legislative intent, licensure of service providers, client rights, voluntary and involuntary admissions, offender and inmate programs, service coordination and children's substance abuse services. (Hal S. Marchman Alcohol & Other Drug Services Act of 1993)

This program is derived from the following works.

ACTIVITY TWO REFERENCES (at least 5):

Voluntary Admission Selected Procedures, 394.4625 FS and 65E-5.270, FAC
Initiating Involuntary Examinations, 384.463(2), FS and 65E-5.280, FAC
Involuntary Examinations Initiated by the Court, 384.463(2)(a)1, FS and 65E-5.280(1), FAC
Involuntary Examination Law Enforcement Officers, 384.463(2)(a)2, FS and 65E-5.280(2), FAC
Minimum Standards for Initial Mandatory Involuntary Examination, 394.463(2)(f), FS 65E-5.2801, FAC
Hal S. Marchman Alcohol & Other Drug Services Act of 1993
The Joint Commission National Patient Safety Goals NPSG.15.01.01

APA Criteria 1.4: Program content is related to ethical, legal, statutory or regulatory policies, guidelines, and standards that impact psychology.

Bibliography and Additional Resources:

► Florida Statute 394 is the current Baker Act - The Florida Mental Health Act. (http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0300-0399/0394/0394.html)
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:

- Implement the Baker Act voluntary and involuntary examination criteria.
- Identify which patients are legally eligible to consent to admission and treatment.
- Discuss requirements under the Florida Mental Health Act including appropriate admission and discharge in compliance with the law.
- Implement the criteria for involuntary admission of persons under Florida’s Marchman Act for substance abuse impairment.
- Consistently comply with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Florida Baker Act laws.

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.)

Martha R. Lenderman, MSW
Former Program Coordinator, Department of Children and Families
Consultant, Lenderman & Associates, Pinellas Park, Florida

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

Martha R. Lenderman, MSW, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.
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. ______________________________________________________

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: (If same amount of time from old video, can keep same PARS #2017IEM49)

Course video:

Course handout:

Quiz Questions –
1. Which of the following is correct with regard to Baker Act patient rights in all hospitals?
   e. A person can be placed under Baker Act involuntary status due to substance abuse intoxication.
f. People who cannot make well-reasoned, willful and knowing decisions about their mental health or medical or substance abuse treatment must be handled as involuntary patients.

g. People on involuntary status lose rights under the federal EMTALA laws.

h. People on voluntary status have the right to an immediate release if they request it.

2. Which of the following is correct with regard to securing the safety of Baker Act patients at hospitals?

e. Law enforcement officers are responsible for remaining with patients brought to the hospital in order to prevent elopement.

f. Law enforcement officers under contract with the hospital for security purposes do not need to comply with patient rights under the Baker Act.

g. Hospital personnel are responsible for ensuring the safety of patients in their care, including prevention of elopement.

h. Hospital personnel cannot use physical methods to prevent a person from eloping from the hospital.

3. Which of the following is correct with regard to authorizing examination and treatment for medical conditions when a patient has refused or is incapable of giving informed consent?

e. People held under the Baker Act retain the right to refuse medical testing and treatment, but other medical laws may provide for such medical issues for emergency conditions without consent.

f. People lose the right to refuse medical examinations under the Baker Act.

g. Drawing blood and other laboratory procedures can be conducted if provided for in the hospital’s policies and procedures, even over the objections of the patient.

h. Psychiatric emergencies and substance abuse emergencies are not considered emergency medical conditions under the federal EMTALA law.
4. Which of the following is correct with regard to the direct release of a person from a hospital emergency department?

e. People on involuntary status cannot be released from a hospital ED without an examination of a psychiatrist.

f. An emergency physician is permitted by law to conduct the involuntary Baker Act examination and to authorize the individual’s direct release from the hospital.

g. In a hospital that has not been designated a Baker Act receiving facility, a patient can be held up to 72 hours after stabilization of a medical emergency condition.

h. Additional “BA-52” certificates of a professional can be “stacked” one on top of another to legally extend the length of time a patient can be held in a non-receiving facility.

5. Which of the following is correct with regard to the federal EMTALA law?

e. EMTALA doesn’t apply to persons on involuntary status.

f. Emergency psychiatric and emergency substance abuse conditions are “emergency medical conditions” under EMTALA.

g. Transfers of patients held under the Baker Act to other hospitals can be done without prior approval of the destination hospital.

h. Medical records of persons held under the Baker Act aren’t required to be shared with hospitals to which a patient is being transferred.

6. Which of the following is correct with regard to the Marchman Act?

e. The Marchman Act is Florida’s substance abuse impairment law.

f. The Marchman Act and the Baker Act are interchangeable and have the same provisions, other than that one is for substance abuse and the other is for mental illness.

g. Physicians cannot independently initiate an involuntary assessment of an adult or minor under the Marchman Act.
h. A person can be involuntarily held up to 96 hours for assessment under the Marchman Act Emergency Admission provisions.

DATE REVIEWED: ___________ 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

CME ACTIVITY TITLE: Building Collaborative Leadership: Baptist Health Clinical Ethics Consultation Training Program

DATE: July 19, 2019 – TBD Six (6) Group Meetings, 1.5 hours each (specific dates listed below)

TIME: 7-8:30 a.m. CREDIT HOUR(S) APPLIED FOR: 9 Cat 1 (1.5 Cat 1 ea. for 6 sessions)

LOCATION: Baptist Hospital of Miami

TARGET AUDIENCE: Nominated participants who are established or emerging Medical Staff leaders practicing in different specialties as well as nursing managers and administrative executives with oversight of the health care service lines who are members of the Ethics Committee.

CONFERENCE DIRECTOR: Ana M. Viamonte-Ros, M.D., Medical Director, Palliative Care & Bioethics

CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 6 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) Integrated format of: a) presenting a concept or practice, b) engaging in group discussion and c) engaging in interactive exercises to apply the educational module presented

COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description. NOTE: there will be no course shell for this training program.

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 are not consistently communicating and collaborating with each other and with associated disciplines in an effective and timely manner to provide optimum care delivery and time-sensitive information that can benefit their patient, their interdisciplinary collaboration, their department or the hospital.

Physicians do not demonstrate that they consistently utilize optimal communication and collaborative skills with each other, between different specialties and/or departments, and with other disciplines. Exchange of important administrative and other information is not always distributed in a reasonable time, resulting in unnecessary delays in project implementation and ineffective conflict management. Collaboration is not optimized.

This initiative was generated by the CEO of Baptist Hospital of Miami (BHM), Bo Boulenger, and Dr. Mark Hauser, VP-MA, and Dr. Tomas Villanueva, Chief, Primary Care and Corporate Medical Director, Employee Health, to engage a group of physician leaders with related nursing and administrative executives in building sound collaborative leadership skills to strengthen performance, leadership effectiveness, and interdisciplinary accountability that will positively impact quality of care, patient safety and patient satisfaction. http://www.jointcommission.org/Physicians/MD_Advisory.htm

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, healthcare professionals, leaders and administrators utilize sound communication and leadership skills to sustain success in working through critical moments of patient-physician interaction. They employ strong interdisciplinary teamwork, productive communication processes all of which contributes to increased and sustained physician and patient satisfaction.

Concurrent leadership development for medical staff, nursing professionals and hospital executives optimizes their collective efforts for a successful integration of the health care service lines. In addition, it provides a shared experience and team-oriented practices that can inform future efforts. The program uses an “Action Learning” methodology, meaning that new skills are practiced by applying them to advance actual objectives established by the group. The program provides tools to develop high performing leaders with strong communication, relationship, meeting facilitation and systemic thinking skills.

Physician engagement with hospital leadership and strategic planning results in improved physician satisfaction, which in turn positively impacts the goals mentioned below.
In recent years, The Joint Commission’s Board of Commissioners has identified enhancing physician engagement in accreditation and other quality improvement initiatives as one of its top strategic priorities. They also include "improve the effectiveness of communication among caregivers" as part of their National Patient Safety Goals. ([https://www.jointcommission.org/npsg_presentation/](https://www.jointcommission.org/npsg_presentation/))

► Physician leaders will engage with clinical and administrative executives to build sound communication and leadership skills needed to sustain success in working through critical moments of patient-physician interaction, as well as strengthen interdisciplinary teamwork, develop productive communication processes and ultimately positively impact quality of care, patient safety and patient satisfaction.

**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
- [x] New or updated policy/protocol
- [ ] Peer review data
- [ ] Regulatory requirement
- [x] Other need identified (Explain): Needs of newly developed service lines and existing service lines in need of physician leadership development

- [ ] Research/literature review

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

- See Attached
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

4. Ethics consultation summaries are presented at BHM Ethics Committee meetings and are submitted in the meeting minutes to the BHM Medical Staff on a quarterly basis.

5. Ethics Consultation Feedback Tool is being developed and will be implemented by summer 2017 to obtain feedback from patients, their families and healthcare professionals on the consultation services provided.

6. BHM Administration will receive reports on the trained physicians’ completion of the training and their participation in ethics consultation at BHM.

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

Rose Allen, DNP, MSM/HM, R.N., CHPN,
Director, Bioethics & Palliative Care
Baptist Hospital of Miami

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

Rose Allen, DNP, MSM/HM, R.N., CHPN indicated that neither she nor her spouse/partner have relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentations or discussions.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ____________________________________________________________

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: # 9

Continuing Psychology Education Credits: # 9  ☐N/A  ■ Continuing Dental Education Credits: # ___  ☐N/A

Training Program Overview

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<td>1st Meeting</td>
<td>OBJECTIVES:</td>
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<tr>
<td>July 19, 2019</td>
<td>Review and apply three “perceptual positions” to expand strategic thinking and optimize communication skills in conflict resolution.</td>
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<td>12 noon – 1:30pm</td>
<td>Discuss Baptist Health’s Bioethics Program, and explain the functions of the Clinical Ethics Committees.</td>
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<tr>
<td>Classroom 5</td>
<td>Effectively apply ethical theories and clinical ethics consultation competencies to carry out the Baptist Health Ethics Consultation Process.</td>
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</table>

PRIOR MATERIALS FOR READING: Hastings Article (2009) – Charting the Future; ASBH Ethics Consultation Guidelines 2nd Ed. (2015); BHM & BHSF Pediatric Ethics Committee Plans, Ethics Consultant Fact Gathering tool; BHM Requesting an Ethics Consultation Policy; Ethics consultation categories; Mapping the Journey – BHSF Ethics Consultation Process (pp).

- Review of three “perceptual positions” to expand strategic thinking and optimize communication skills in conflict resolution.
- BHSF Bioethics Program & Functions of the Clinical Ethics Committees. Overview of Ethical Theories. Overview of Clinical Ethics Consultation Competencies. (30-mins)
- Quick Review - Mapping the Journey – BHSF Ethics Consultation Process (10mins)
- (20 mins) Case presentation/role-playing (J.B. 89-year old triple vessel bypass surgery)

<table>
<thead>
<tr>
<th>2nd Meeting</th>
<th>OBJECTIVES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date TBD</td>
<td>Improve doctor-patient medical decision-making regarding advance directives and hospice care.</td>
</tr>
<tr>
<td>Time TBD</td>
<td>Consider the influence of cultural and racial differences when having advanced directives discussions with patients and/or their surrogates/proxies.</td>
</tr>
<tr>
<td>Location TBD</td>
<td>Recognize the surrogate/proxy’s role and burdens in advance directive decision-making.</td>
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</tbody>
</table>


- Advance Directives, Surrogate and Proxy Decision-Making, Surrogate/Proxy Burdens (30 mins)
<table>
<thead>
<tr>
<th>3rd Meeting Date TBD</th>
<th>OBJECTIVES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision making capacity (10 mins)</td>
<td></td>
</tr>
<tr>
<td>Informed consent, valid refusal (10 mins)</td>
<td></td>
</tr>
<tr>
<td>Case presentation, interactive discussions or role-playing (Incapacitated patient, questionable valid advance directives, wife’s decision-making in conflict with HCT)</td>
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</tr>
</tbody>
</table>

Prior materials for reading: Ten myths about decision making capacity; Assessment of patient’s competence to consent to treatment, NEJM (2007); Some limits of informed consent; Informed consent in clinical practice (2011); ASBH Ethics Consultation Guidelines 2nd Ed. (2015), page 22 - 26

<table>
<thead>
<tr>
<th>4th Meeting Date TBD</th>
<th>OBJECTIVES:</th>
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<tbody>
<tr>
<td>Recognized and discuss futile treatment considering the individual patient’s goals and treatment preferences.</td>
<td></td>
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<tr>
<td>Define and differentiate between brain death, persistent vegetative state and the minimal conscious state.</td>
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<tr>
<td>Utilize approaches to effective conversations about end-of-life care with patients and families.</td>
<td></td>
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<tr>
<td>Appropriately manage challenges and requirements for withholding or withdrawing care.</td>
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</tbody>
</table>

Prior materials for reading: Are withholding and withdrawing therapies morally equivalent?; Views on EOL medical treatment, PEWS 2013 report; Futility a concept in evolution, Truog; Baptist Hospital and Baptist Childrens Levels of End of Life Care Policies; Brain Death Policy, Donation After Cardiac Death Policy

Group discussions: re pp Brain death, PVS, Minimally Conscious (15 min)

Withholding and Withdrawing Life Support. Futility, ethics of organ donation (15 mins)

(30 mins):
<table>
<thead>
<tr>
<th>5th Meeting</th>
<th>Date TBD</th>
<th>Time TBD</th>
<th>Location TBD</th>
<th>OBJECTIVES:</th>
</tr>
</thead>
</table>
|             |         |         |              | - Recognize and appropriately manage ethical issues involving minors with decision-making capacity, newborns and legal decision-makers for children.  
- Identify and address conflicting values that can occur between a healthcare professional and the parents of a terminally ill infant.  
- Discuss Baptist Children’s Levels of EOL Policy and the Baby Jules Lethal Congenital Disorder Policy. |
|             |         |         |              |             |
|             |         |         |              |             |
|             |         |         |              | – Lethal Congenital Disorder (20 min) |
|             |         |         |              | (30 min):  
NICU Case presentation and interactive discussion |
|             |         |         |              | Lethal Congenital Disorder Parent/Physician Conflict – Baby Jules Lethal Congenital Disorder Policy (10 min) |

<table>
<thead>
<tr>
<th>6th Meeting</th>
<th>Date TBD</th>
<th>Time TBD</th>
<th>Location TBD</th>
<th>OBJECTIVES:</th>
</tr>
</thead>
</table>
|             |         |         |              | - Apply skills of listening, being present and exercising empathy.  
- Review and discuss faith, culture and the role of Pastoral Care.  
- Describe and apply the core competencies for ethics consultation based on the American Society for Bioethics and Humanities Ethics Consultation Guidelines 2nd Ed.  
- Successfully complete the ethics consultation proctoring requirements for final credentialing. |
|             |         |         |              |             |
|             |         |         |              | Prior materials for reading: ASBH Ethics Consultation Guidelines 2nd Ed. (2015), Power-point presentation and Spiritual Articles |

Rose Allen, DNP, RN  
Training Participants
Faith, culture and the Role of Pastoral Care – Renato Santos

Power-point

General review/discussions during group session

- Case presentation and discussions (30 minutes)
- Multiple choice questions covering the didactics and skills that were covered in the training. (30 minutes)

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

CME ACTIVITY TITLE: UHZ Sports Medicine Conference Series

DATE: August 2019 to June 2020   TIME: 7-8 a.m.   CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 each

Application Expires: June 2020

LOCATION: Doctors Hospital, UHZ Conference Room

TARGET AUDIENCE: Orthopedists, Physician Assistants and Athletic Trainers.

CONFERENCE DIRECTOR: John Zvijac, M.D.   CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 15 - 20   CHARGE: 0

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

☐ ARS  ☐ Internet Activity Enduring Material

☒ Case Studies  ☐ Internet Live Course (Live Webcast)

☒ Didactic Lecture  ☐ Internet point-of-care activity

☐ Enduring Material (DVD/Booklet)  ☐ Journal-based CME activity
CONTINUING MEDICAL EDUCATION
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☐ Learning from Teaching
☒ Live activity
☐ Manuscript review activity
☐ Panel
☐ PI CME activity
☒ Question & Answer

☒ Regularly Scheduled Series
☐ Simulation
☐ Test item writing activity
☐ Other (specify)

Sports Medicine Fellowship Curriculum

COURSE DESCRIPTION: Orthopedic surgeons diagnose and treat conditions of the musculoskeletal system, which includes the bones, joints, ligaments, tendons, muscles and nerves. Orthopedists will discuss the etiology, mechanism of injury and assessment of various common sports-related injuries as well as describe surgical and non-surgical treatment options to injuries and how they relate to return-to-play criteria.

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

Patient: ☐ Non-compliance ☒ Lifestyle ☐ Resistance-to-change ☐ Cost of care/Lack of Insurance
Physician: ☐ Non-compliance ☒ 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 (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)

► The orthopedic sports medicine physician practice involves a wide range of sports-related musculoskeletal injuries, including some conditions not typically seen in everyday practice. Therefore physician practice may not consistently include adequate evaluation, treatment strategies and/or rehabilitation for every condition. Recommending return to play too soon can put patients at risk for re-injury and possible longer down time.

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 non-compliant - 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 appropriately evaluate and treat patients with a variety of sports injuries, confirming adequate healing or recovery has taken place to avoid risk of repeat injury.

Indicated 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
☒ Consensus of experts
☐ Disease prevention (C12)
☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics
☐ National Pt Safety Goals
☐ National/regional data
☐ New diagnostic/therapeutic modality (C12)
☐ New or updated policy/protocol
☐ Patient care data
Returning an athlete to sport participation is a complex and often difficult decision. The return-to-play (RTP) decision-making process within competitive sport is typically referred to as aggressive rehabilitation while avoiding increased risk to the athlete. This subjective description has not been further refined in the literature, and, as a result, there has been little progress toward identifying systematic approaches to clinical decision making in sport.

The clinical decision-making process for RTP is a central component of the work of team clinicians and evidence suggests that reinjury may be 4 times more likely to occur compared with an initial injury. One soccer study found that a previous ankle or knee sprain is associated with a 5-fold greater risk of sustaining a reinjury to one of these sites. Similar results were found in studies of basketball and volleyball athletes where 70% to 80% of the ankle sprains sustained were recurrent injuries.

Return-to-play decision making remains a complicated issue in sports medicine, as it is multifactorial in nature and potentially affects many players, from the athlete, team, coaches, and parents. Although further data are needed to understand RTP clinical decision making, it is likely, at this point, that a more granular definition of “clearance” would be helpful for quantitative analyses. Most sport medicine clinicians currently believe that factors affecting risk of injury are important, but some believe that other factors of potential importance to athletes should not be considered in RTP decision making.

Team Clinician Variability in Return-to-Play Decisions · Rebecca Shultz, PhD, Jennifer Bido, BA, Ian Shrier, MD, PhD, Willem H. Meeuwisse, MD, PhD, Daniel Garza, MD, Gordon O. Matheson, MD, Phd.


**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:

- Discuss the etiology, mechanism of injury and assessment of various common sports related injuries.
- Describe surgical and non-surgical treatment options for these injuries.
Implement new strategies for evaluation and treatment of the sports injury patient.

**EVALUATION METHOD(S):** 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.)

Fellows and Faculty, participating in the Sports Medicine Fellowship Program – To be Determined

**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 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?  
- **Yes**  
- **No**  

If yes, describe the collaborative efforts. ________________________________
The Sports Medicine CME Conference Series supports the Sports Medicine Fellowship Program, a collaborative initiative between UHZ Sports Medicine Institute, Baptist Health South Florida and the Florida International University Herbert Wertheim College of Medicine. Fellows are assigned lecture topics to research and present as part of the series. Medical staff members also lecture as part of the series. The series provides valuable education to the fellows as well as to physicians who may not regularly see these medical conditions in their private practices.

**COMMERCIAL SUPPORT:**  □ Indicate here if support will come from the Foundation general Continuing Medical Education fund.

**CME ACTIVITY TOPICS**

_CME activities may include, but are not limited to, the following topics._

- Ankle Sprain
- Ankle Instability
- Anterior Cruciate Ligament
- Biostatistics
- Bone Biology
- Concussion Assessment and Treatment
- Dislocated Shoulder
- Failed Articular Resurfacing Procedures
- Fluid Assessment and Treatment in Athletes
- Frozen Shoulder
- Knee Arthroplasty
- Lateral Epicondylitis
- Lisfranc Injuries
- Manual Therapy Techniques
- Meniscal Transplant
- MRI Assessment: Foot and Ankle/Shoulder/Spine/Knee
- Muscle Injury and Regeneration
- Nerve Injury and Repair
- Osteochondral Lesions of the Knee
- Partial Rotator Cuff Tears
- Posterior Cruciate Ligament
- Posterolateral Corner
- Principles of Sports Specific Rehabilitation
- Proximal Humerus Fractures
- Rehabilitation of Soft Tissue Injuries
- Rotator Cuff Fixation & Repair
- Scaphoid Fractures and Wrist Instability in Sports
- SLAP Lesions
- Sports Related Eye Injuries
- Therapeutic Modalities in Rehabilitation
CME ACTIVITY TITLE: MCI: Clinical Hematology Oncology Case Review

DATE: July 2019 – July 2020
Weekly – Every Friday

TIME: 12 – 1:30 p.m. CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1 each

LOCATION: MCI – Tumor Board Conference Room – 3N110

TARGET AUDIENCE: Medical Oncologists, Radiation Oncologists, General Surgeons, Pathologists, Radiologists, Pharmacists, Nurses, Social Workers, Radiologic Technologists, Patient Care Facilitators and all Personnel involved in the care of the hematology cancer patient.

CONFERENCE DIRECTOR: Guenther Koehne, M.D. Ph.D. CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 0 CHARGE: 0

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

ARS ☐ Case Studies ☑
Hematologic malignancies have historically been at the vanguard among cancers in the use of genetic analyses for diagnosis, classification, prognostication, and therapeutic decision-making. During these case studies participants will optimize risk stratifications of patients with hematologic malignancies at diagnosis or disease recurrence.

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)

► Current practice lacks general communication and team discussions/review of clinical decisions for optimized care.

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)

► Clinical cases are now reviewed weekly by the team, including consultants; complex clinical managements are discussed. Standard and experimental approaches are reviewed to provide optimal care to the patients.

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
- Consensus of experts
- Disease prevention (C12)
- Joint Commission initiatives (C12)
- Mortality/morbidity statistics
- National Patient Safety Goals
- National/regional data
- New diagnostic/therapeutic modality (C12)
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

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☐ New or updated policy/protocol ☐ Patient care data
☒ Peer review data ☐ Process improvement initiatives (C16 & 21)
☐ Regulatory requirement ☐ Other need identified (Explain): _____________________________
☐ Research/literature review

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

High-quality evidence evaluating the effectiveness of survivor care plans (SCP’s) and treatment summaries (TS’s) on hematologic cancer survivorship follow-up care is lacking. Nurses have established expertise in health promotion, information, support, and resource provision; they can develop and disseminate SCPs and TSs to facilitate communication among the survivor, specialist, and primary care provider.

Oncology Nursing Forum
Issue: Volume 42(3), May 2015, p 283–291

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:

- Analyze risk stratifications in patients with hematologic malignancies at diagnosis or disease recurrence.
- Develop comprehensive care in complex clinical management of patients with hematologic malignancies.
- Discuss clinical decisions and optimize timely referral of patients for potential stem cell transplants.

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.)

Guenther Koehne, M.D.
Chief of Blood & Marrow Transplant and Hematologic Oncology
Miami Cancer Institute
Miami, Florida

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

______________, M.D indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ____________________________________________________________
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

This conference is in collaboration with the Miami Cancer Institute.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: ___________ REVIEWED BY: □ Accelerated Approval □ Executive Committee □ Live Committee

APPROVED: □ YES □ NO ■ Credits: AMA/PRA Category 1 Credits: # 1.5 each
Continuing Psychology Education Credits: # ___ □ N/A ■ Continuing Dental Education Credits: # ___ □ N/A

CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

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

CME ACTIVITY TITLE: Primary Care Sports Medicine Conference Series

DATE: August 2019 – July 2020 TIME: 7-8 a.m. CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 each

LOCATION: Doctors Hospital – UHZ Conference Room

TARGET AUDIENCE: Orthopedists, Team Physicians, Primary Care Physicians, Pediatricians, Physicians in Training, Physician Assistants, Athletic Trainers, Physical Therapists, Exercise Physiologists, Nurses and other interested healthcare providers.
CONFERENCE DIRECTOR: John Uribe, M.D.  CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 15-20  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)

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

Primary care sports medicine physicians are specially trained in the total care of athletes and other active people. They work closely with orthopedic surgeons, athletic trainers and athletes and assist in assessing injuries and determining appropriate return-to-play goals.

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.
DESItable 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)

► In order to meet ACGME Competencies and requirements of a Sports Medicine fellowship program:

► Orthopedic sports medicine fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

► Fellows must demonstrate competence in their knowledge of

• Non-orthopaedic problems that occur in sports medicine and how to deal with those problems or how to refer them appropriately;

• Sports equipment, particularly protective devices intended to allow the athlete to continue to compete, including helmets, protective pads, knee braces, foot orthotics, and others not specifically named.

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.)

DESIRE 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 who have completed the sports medicine fellowship program will competently 1) identify non-orthopaedic “primary care” health conditions that occur in sports medicine and either treat or refer them appropriately; and 2) apply components of ACGME Competencies into the practice of orthopedic sports medicine including the basic sciences, quality improvement and patient safety initiatives and recognition/mitigation of fatigue and sleep deprivation.

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
- Consensus of experts
- Disease prevention (C12)
- Joint Commission initiatives (C12)
- Mortality/morbidity statistics
- National Patient Safety Goals
- National/regional data
- New diagnostic/therapeutic modality (C12)
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Regulatory requirement
- Other need identified (Explain): ACGME Program Requirements for Graduate Medical Education in Orthopedic Sports Medicine.
- Research/literature review

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

► ACGME Competencies - The program must integrate the following ACGME competencies

1. Curriculum/Basic Science
[Program Requirement IV.A.3.b)]
All fellows must participate in didactic sessions devoted to the basic sciences, including anatomy, biomechanics, and biology of healing.

2. Curriculum/Primary Care
[Program Requirement IV.A.3.c)]
Instruction should also be provided in sports medicine issues in the areas of cardiology, dermatology, pulmonology, preventive medicine, pediatric and adolescent medicine, exercise physiology, environmental exposure, athletic populations, team physicians, and protective equipment (including braces).

3. Fellow Participation in Quality Improvement and Patient Safety Program
[Common Program Requirement VI.A.3]
The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

4. Faculty and Resident Education to Recognize Signs of Fatigue and Sleep Deprivation
[Common Program Requirement VI.C.1.a)]
The program must educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation.

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:

- Identify non-orthopedic "primary care" issues that occur in sports medicine specifically in the areas of cardiology, dermatology, pulmonology, preventive medicine, pediatric and adolescent medicine, exercise physiology, environmental exposure, athletic populations, team physicians, and protective equipment (including braces).
- Critically review and discuss treatment indications, clinical outcomes, evidence-based guidelines, complications, morbidity, and mortality.
- Link the pathophysiologic process and findings of clinical disorders to the appropriate diagnosis, treatment and management.
- Determine when to refer to a specialist for follow-up care.
- Explain principles of biomechanics as well as terminology and application to orthopedic sports medicine.
- Apply specific required components of basic sciences to the practice of orthopedic sports medicine, including biochemistry, biomechanics, embryology, immunology, microbiology, pathology, pharmacology, and physiology.
- Integrate interdisciplinary clinical quality improvement and patient safety principles into practice.
- Recognize the signs of fatigue and sleep deprivation and implement fatigue mitigation processes to manage the potential negative effects on patient care.

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.)

TO BE DETERMINED

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

The Primary Care Sports Medicine Series supports the Sports Medicine Fellowship Program. The series provides valuable education to the fellows as well as to physicians who see athletes in their offices and must provide follow up to address any medical conditions.

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

DATE REVIEWED: 07.17.2017 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
CME ACTIVITY TOPICS

Topics for the series from August 2019 – July 2020 will include but are not limited to the following:

- Cardiology
- Dermatology
- Pulmonology
- Preventive Medicine
- Pediatric and Adolescent Medicine
- Exercise Physiology
- Environmental Exposure
- Athletic Populations
- Team Physicians
- Protective Equipment
- Pathology
- Biomechanics
- Basic Sciences – biochemistry, biomechanics, embryology, immunology, microbiology, pathology, pharmacology and physiology
- Braces
- Anatomy

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

CME ACTIVITY TITLE: Gastrointestinal Tumor Board

DATE: Weekly, Wednesday   TIME: 7:30am – 8:30am

Course expires: June 2016 – June 2017
Renewal: June 2017 – 2018
Renewal: June 2018 – June 2019
Renewal: June 2019 – June 2020
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 per tumor board

LOCATION: MCI Conference Room 3N110

TARGET AUDIENCE: Medical Oncologists, Radiation Oncologists, Colorectal Surgeons, Pathologists, Gastroenterologists, Pharmacists, Nurses, Social Workers, Radiologic Technologists and Patient Care Facilitators and all personnel involved in the care of the gastrointestinal cancer patient.

CONFERENCE DIRECTOR: Antonio Ucar, M.D. CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 20-25 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 & Answer ☐ Regularly Scheduled Series
☐ Simulation ☐ Test item writing activity ☐ Other (specify) Tumor Board

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

The Gastrointestinal Cancer Multidisciplinary Tumor Board plays a critical role in the spectrum of cancer management of gastrointestinal malignancies, including diagnosis, staging, treatment and palliative care. The multidisciplinary approach has become crucial recently due to the ever-increasing complexity of medical knowledge and the huge wealth of information that is available to physicians, in addition to the complexity of the various medical procedures and interventions available for cancer care.

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)

► Standard of care may not always include a multidisciplinary team approach to diagnosis and treatment. Gaps in communication between healthcare providers and key specialists can at times delay optimal delivery of care in cancer patients.

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 present cases through the Gastrointestinal Oncology Tumor Board when developing treatment plans for their gastrointestinal oncology patients, collaborating in a multidisciplinary team approach.

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  ☒ Consensus of experts
☐ Disease prevention (C12)  ☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics  ☐ National Patient Safety Goals
☐ National/regional data  ☐ New diagnostic/therapeutic modality (C12)
☐ New or updated policy/protocol  ☐ Patient care data
☐ Peer review data  ☐ Process improvement initiatives (C16 & 21)
The complexity of treating esophageal and gastric cancer necessitates the need for a multimodality approach. In order to appropriately stage and treat these patients, multiple specialists are required including surgeons, medical oncologists, radiation oncologists, gastroenterologists, radiologists, pathologists, and support services. The goal is to offer patients a well-coordinated and individualized treatment plan. This approach improves satisfaction for patients and the providers involved in the patient’s care. Boniface, M. M., Wani, S. B., Schefter, T. E., Koo, P. J., Meguid, C., Leong, S., … & McCarter, M. D. (2016). Multidisciplinary management for esophageal and gastric cancer. Cancer management and research, 8, 39.

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:

- Implement optimal course of treatment for patients with gastrointestinal cancers.
- Utilize multiple disciplinary approaches to determine diagnosis and treatment options, including radiological findings.
- Determine cancer staging using various imaging modalities of gastrointestinal cancers.
- Promote a multidisciplinary team approach by bridging gaps across the continuum of care in order to enhance the overall quality of patient-centered gastrointestinal cancer care.
- Discuss emotional ramifications and psychosocial implications are discussed when appropriate.

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 Quarterly Evaluations

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

- The following questions are included in quarterly evaluations to access impact on performance and patient outcomes.
  - Please describe one or two instances where patient outcomes were influenced by strategies you implemented as a result of the recommendations suggested at the Gastrointestinal Tumor Board.
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

What have you done differently or what do you intend to do differently in the treatment of your patients as a result of what you learned during the Gastrointestinal Conference Series? What new strategies have you or, or will you apply in your practice of patient care?

If applicable, what obstacles prevented you from implementing new strategies learned at the Tumor Board meetings?

If applicable, what has prevented you from presenting cases at the Gastrointestinal Tumor Boards?

Comments about these Tumor Board meetings.

Comments/Suggestions about the OVERALL Baptist Health CME Program.

MONITORING SYSTEM

PROMOTIONAL MATERIALS: Created in compliance with ACCME criteria by Medical Education Department.

MECHANISM FOR VERIFYING PHYSICIAN PARTICIPATION: Attendees are credited based on sign-in sheets provided for each lecture. Attendees are required to sign-in for credit. Disclosures are included on sign-in sheet.

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

Yes ☒ No ☐

CME Program Manager: Marie Vital Acle ☒ Conference Director (see above)

Medical Director ☒ Corporate Director ☒ Medical Education Committee

Others (i.e.: Conference Coordinator, Department representative, etc.) Vanessa Garcia, Secretary

Annual disclosure forms are required from moderators, core group of contributors, CME program manager and on-site coordinator with department. (Criterion 7)

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

MODERATOR: Antonio Ucar, M.D.


Radiologist: Surya Chundru, M.D., Radiation Oncologist: Minesh Mehta, M.D. Colorectal Surgeon: Gustavo Plasencia, M.D., Marcos Szomstein, M.D. Medical Oncologists: Victor Guardiola, M.D., Santiago Aparo, M.D.

Gastroenterologists: Seth Rosen, M.D., Miguel Villalona Calero, M.D.

Faculty disclosure statement (as it should appear on course shell):
Antonio Ucar, M.D.
Moderator, Gastrointestinal Tumor Board
Hematologist/Oncologist
Baptist Health Medical Group, Baptist, Doctors, Homestead, Mariners, South Miami, and West Kendall Baptist Hospitals

Dr. Ucar indicated that neither he nor his spouse/partner have relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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

If yes, describe the collaborative efforts. ____________________________________________________________

Regularly Scheduled Series foster collaboration across multiple specialties treating specific medical conditions. Patient care and interdisciplinary communication are improved through these types of educational meetings.

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

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**DATE REVIEWED:** __________ REVIEWED BY: [ ] Accelerated Approval [ ] Executive Committee

[ ] Live Committee

**APPROVED:** [ ] YES  [ ] NO  ■ Credits: AMA/PRA Category 1 Credits: # 1 Cat. 1 each

Continuing Psychology Education Credits: # __ [ ] N/A  ■ Continuing Dental Education Credits: # ___ [ ] N/A
CME ACTIVITY TITLE: West Kendall Baptist Hospital – Scholarly Showcase: Oncology for the Non-Oncologist: “What do I need to know?” Part One and Part Two

DATE: August 28, 2019    TIME: 12 – 1:30 p.m.    CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1

LOCATION: West Kendall Baptist Hospital West Wing Auditorium

TARGET AUDIENCE: Hospitalists, pulmonologists, internists, residents, nurse practitioners, physician assistants and any other interested healthcare professionals.

CONFERENCE DIRECTOR: Andres Soto, M.D.    CME MANAGER: Eleanor Abreu

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

The number of oncology agents on the market are increasing. During this conference, participants will understand how to screen and apply prevention strategies for cancer patients presenting with disease related symptoms. Participants will be able to recommend appropriate patient-specific therapies to prevent complications.

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)*

- The number of oncology agents on the market are increasing, especially oral formulations. What was once primarily dedicated to the oncologist may now present to the general practitioner. Currently, these practitioners’ may not be aware of the proper prescribing, adverse effects, and monitoring of these agents. Treatment of emergencies and handling of these agents outside of the pharmacy are critical elements of these types of agents.

**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.)

**DESIRE 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)*

- Optimal practice would include having a general knowledge of oncology agents so when presented with such a patient, the prescriber will be aware and how to handle the 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 and explain below.)**

- Best practice parameters
- Consensus of experts
- Disease prevention (C12)
- Joint Commission initiatives (C12)
- Mortality/morbidity statistics
- National Patient Safety Goals
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

Growing increases in current and projected cancer survivors demands a workforce that can safely meet their health care needs spanning a lifetime. The literature lacks sufficient evidence regarding the knowledge needed by non-oncology nurses who care for cancer survivors in settings not designated for cancer care. This study identified this oncology knowledge and perceived barriers.

Journal of Continuing Education in Nursing. 49(1):12-18, 2018 Jan 01.

http://ovidspdc2.ovid.com/sp-3.33.0b/ovidweb.cgi?S=ACOLFPIIADEBANKKJPCKOGBHJJBAAA00&Complete+Reference=S.sh.56%7c20%7c1&Counter5=SS_view_found_complete%7c29384583%7cmedf%7cmedline%7cmed13&Counter5Data=29384583%7cmedf%7cmedline%7cmed13

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:

- Describe the pathophysiology of common oncologic emergencies.
- Identify signs, symptoms, and complications which result from ineffective or delayed therapy.
- Implement prevention strategies for a cancer patient presenting with disease related symptoms.
- Describe targeted IV immunotherapy.
- List the immune Related Adverse Events (IRAE) and monitor patients.
- Implement treatment modalities utilized in patients with IRAE.
- Identify USP requirements on the Receiving, Storage, and Transport of Hazardous drugs.
- List requirements for hazardous spill clean-up.

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.)

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

Alyssa Donadio, Pharm.D., BCPS – Clinical Pharmacy Specialist

Alyssa Donadio, Pharm.D. indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and **her will not include off-label or unapproved product usage in her presentation(s) or discussion(s).**

Mariadela Matute, APRN, MSN, OCN, BMT-CN

Mariadela Matute, APRN indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and **her will not include off-label or unapproved product usage in her presentation(s) or discussion(s).**

Christine Ibarra, Pharm.D., BCPS – Clinical Pharmacy Specialist

Christine Ibarra Pharm.D. indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and **she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).**

Lilit Smith, Pharm.D., MBA – Pharmacy Supervisor

Lilit Smith Pharm.D. indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and **she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).**

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.
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. ______________________________________________

This event is in collaboration with the Graduate Medical Education Program.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.
Applicable Credits: AMA Category 1 □ Continuing Psychology Education □ Continuing Dental Education □

CME ACTIVITY TITLE: Miami Cancer Institute – Hematologic Oncology Grand Rounds

DATE: Monthly- October 2019 – September 2020  TIME: 8-9 a.m.  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: Miami Cancer Institute – Tumor Board Room – 3N110

TARGET AUDIENCE: This educational program is directed toward hematologists, oncologists, pathologists, radiation oncologists, palliative care staff, oncology, hematology nurses, pharmacists and other allied health care team members interested in the treatment of patients with hematologic malignancies.

CONFERENCE DIRECTOR: Guenther Koehne, M.D.  CME MANAGER: Eleanor Abreu

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

Hematologic Oncology Grand Rounds will address the increasing frequency of hematologic malignancies, complexities of treatments with novel agents and particularly with immunotherapeutic approaches. There is a need to provide an opportunity for oncologists, hematologists, oncology nurses and pharmacists to engage in a thoughtful discussions with experts in these fields. In addition, there is emerging data about the biology of these malignancies impacting optimal management of patients with these disorders. Clinical decision making and management therefore has become more complex.

Leaders in the field will be invited to present on recent advances in the treatment of leukemia, lymphoma, multiple myeloma and stem cell transplantation by novel immunotherapies and treatment combinations. Updates on evolving immunologically and molecular based system therapies will be profiled and discussed.

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.

DESI RABLE 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)

► Current practice lacks general communication and team discussions/review of clinical decisions for optimized care.

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)

► Clinical cases are now reviewed monthly by the team, including consultants; complex clinical managements are discussed. Standard and experimental approaches are reviewed to provide optimal care to the patients.

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 ☒ Consensus of experts
☐ Disease prevention (C12) ☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics ☐ National Patient Safety Goals
☐ National/regional data ☐ New diagnostic/therapeutic modality (C12)
☐ New or updated policy/protocol ☐ Patient care data
☒ Peer review data ☐ Process improvement initiatives (C16 & 21)
☐ Regulatory requirement ☐ Other need identified (Explain): _____________________________
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

High-quality evidence evaluating the effectiveness of survivor care plans (SCP’s) and treatment summaries (TS’s) on hematologic cancer survivorship follow-up care is lacking. Nurses have established expertise in health promotion, information, support, and resource provision; they can develop and disseminate SCPs and TSs to facilitate communication among the survivor, specialist, and primary care provider.

Oncology Nursing Forum
Issue: Volume 42(3), May 2015, p 283–291

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:

- Summarize the evolving therapeutic strategies in the treatment of hematologic malignancies.
- Assess and provide updates of new molecular and immunological treatments being developed for these diseases.
- Describe the rationale for new targeted diagnostic and therapeutic strategies for lymphoma, myeloma and leukemia.
- Identify the role and timing of hematopoietic cell transplantation and potential combinations of immunotherapeutic treatment 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.
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

☐ Other ______________________

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

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

Guenther Koehne M.D., Ph.D.
Deputy Director and Chief of Blood & Marrow Transplant,
Hematologic Oncology and Benign Hematology

Guenther Koehne, M.D. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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) 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. ______________________________________________________

The Miami Cancer Institute and the CME department are providing these monthly conferences for the hematology oncology department.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: __________ REVIEWED BY: □ Accelerated Approval □ Executive Committee
□ Live Committee

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

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

CME ACTIVITY TITLE: MCI Oncology Academic Educational Series: Oncology Nursing Fundamentals, Part II

DATE: Tuesday, August 6, 2019 TIME: 10a.m. – 2:30p.m. CREDIT HOUR(S) APPLIED FOR: 4.0 Cat. 1

LOCATION: BHM -Auditorium

TARGET AUDIENCE: Oncology Nurses, Oncologists, Radiation Oncologists, Hematology Oncologists, Radiation Therapists, Social Workers, Patient Navigators and other interested healthcare providers.
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

CONFERENCE DIRECTOR: Minesh Mehta, M.D.  CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 25-50  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)

COURSE DESCRIPTION: Upon completion of this conference, the learner will identify chemotherapy/biotherapy dose-limiting toxicities to include risk factors. Cathy Ollom, R.N. will review the fundamentals of nursing oncology. This short summary will be used on course shell. Please note that keyword searches will pull from this description.

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)

► Oncology nurses are required to have advanced knowledge in order to provide quality care and meet national safety standards.

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)

► Oncology nurses will possess required knowledge and skills and implement safety measures based on evidence-based practices.

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
☑ Consensus of experts
☐ Disease prevention (C12)
☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics
☐ National Patient Safety Goals
☐ National/regional data
☐ New diagnostic/therapeutic modality (C12)
☐ New or updated policy/protocol
☐ Patient care data
☐ Peer review data
☐ Process improvement initiatives (C16 & 21)
☐ Regulatory requirement
☐ Other need identified (Explain): __________________________________________
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

Symptom management during radiation therapy is critical to providing high-quality care for patients receiving treatment. Symptoms are varied and dependent on the site irradiated. Common symptoms associated with radiation therapy include dermatitis, xerostomia, mucositis, and pneumonitis. Treatment strategies include prevention, anticipation, and development of clinical practice enabling rapid identification and management of emerging symptoms. Understanding the spectrum of symptomatology affecting irradiated patients is integral to improved quality of life and treatment efficacy.


http://ovidsp.tx.ovid.com/sp-3.30.0b/ovidweb.cgi?&S=NGGEFPGHAEDDAMPPNCEKIFI8FGCDAA00&CompleteReference=S.sh.56%7c6%7c1

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:

- Review chemotherapy/biotherapy dose-limiting toxicities to include risk factors, presenting signs and symptoms, diagnosis, and treatment.
- Discuss immediate complications of chemotherapy/biotherapy to include hypersensitivity reactions, anaphylaxis, cytokine release syndrome and extravasation.

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.)
Faculty disclosure statement (as it should appear on course shell):
Cathy Ollom R.N., MSN, AOCNS
Clinical Nurse Specialist
Miami Cancer Institute
Miami, Florida

Ms. Ollom indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing-review of the content have no relevant financial relationships to disclose.

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. __________________________________________________________

Miami Cancer Institute – Department of Radiation Oncology.
COMMERCIAL SUPPORT: □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: ____________ REVIEWED BY: □ Accelerated Approval □ Executive Committee □ Live Committee

APPROVED: □ YES □ NO □ Credits: AMA/PRA Category 4.25 Credits: # _1

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

Oncology Nursing Fundamentals: Part II

9:30 - 10 a.m. Registration
10:00 – 11:30 a.m. Dose limiting toxicities
11:30 - 11:45 a.m. Break
11:45 - 1:15 pm Dose limiting toxicities
1:15- 1:30 pm Break
1:30 - 2:30 pm Immediate Complications
2:30 p.m. Evaluations & Adjourn

Applicable Credits: AMA Category 1 ☒ □ Continuing Psychology Education ☒ □ Continuing Dental Education ☐
CME ACTIVITY TITLE: 25th Annual Brain Injury Symposium

DATE: October 12, 2019  TIME:  7:30 a.m. – 4:30 p.m.  CREDIT HOUR(S) APPLIED FOR:  7 Cat. 1

LOCATION: Hilton Miami Dadeland


SYMPOSIUM DIRECTORS: Bradley M. Aiken, M.D. and Richard A. Hamilton, Ph.D.

CONFERENCE COORDINATOR: Judy Kaufman

CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 150  CHARGE: $250 Standard Rate  $150 BHSF Employee Rate

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.
Traumatic brain injury and stroke are public health problems of major proportions. Each year, more than 230,000 people in the United States sustain a traumatic brain injury, resulting in hospitalization and potential lifelong disability due to a complex variety of cognitive, physical and emotional sequelae. There have been many advances in the practice of rehabilitation medicine, psychology, neurology and other clinical specialties that identify and treat patients with brain injury. This symposium will provide practical, evidence-based strategies to accurately diagnose, treat and rehabilitate brain injury survivors.

**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 may not be aware of or may not consistently implement the most current assessment and treatment modalities for patients with traumatic and non-traumatic brain injuries.

► Traumatic brain injury (TBI) is a public health problem of major proportions. Each year, more than 230,000 people in the United States alone sustain a TBI, resulting in hospitalization and potential life-long disability due to a complex variety of cognitive, physical, and emotional sequelae. Despite the social and economic impact of TBI, few treatments have been shown conclusively to ameliorate the adverse outcomes. In recent years, there have been calls for more definitive trials, both to prevent the effects of TBI and to remedy its long-term effects. Such trials must grapple with multiple challenges posed by the diverse effects of TBI along the continuum of severity, as well as the practical constraints of data collection. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2939167/

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 implement evidence-based treatment strategies based on current research for the assessment and treatment of patients with brain injuries.

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

► Traumatic brain injury (TBI) is a public health problem of major proportions. Each year, more than 230,000 people in the United States alone sustain a TBI, resulting in hospitalization and potential life-long disability due to a complex variety of cognitive, physical, and emotional sequelae.


► Traumatic brain injury (TBI) has short- and long-term adverse clinical outcomes, including death and disability. TBI can be caused by a number of principal mechanisms, including motor-vehicle crashes, falls, and assaults. This report describes the estimated incidence of TBI-related emergency department (ED) visits, hospitalizations, and deaths during 2013 and makes comparisons to similar estimates from 2007. ([https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5829835/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5829835/))

CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

☐ 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.)
See Attached

*Faculty disclosure statement (as it should appear on course shell):* 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 (Conference Coordinator, Planning Group, etc.) ______ Conference Coordinator____________________

**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. ____________________________________________________________

**COMMERCIAL SUPPORT:** ☐ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.
(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

► Stroke in the Cancer Patient
► Stroke Online Series (Multiple Modules)

DATE REVIEWED: 06/14/19  REVIEWED BY: ☑ Accelerated Approval  ☐ Executive Committee
☐ Live Committee

APPROVED: ☑ YES  ☐ NO  ■ Credits: AMA/PRA Category 1 Credits: # _7

Continuing Psychology Education Credits: # _7  ☐ N/A  ■ Continuing Dental Education Credits: # ___  ☐ N/A

SCHEDULE

7:00 a.m.  Registration and Continental Breakfast

7:45 a.m.  Opening Remarks and Introduction
Bradley M. Aiken, M.D. and Richard A. Hamilton, Ph.D.

8:00 a.m.  Update on Imaging in Acute Ischemic Stroke
Kevin J. Abrams, M.D.

9:00 a.m.  Redefining concussion in youth: It's all about the neighborhood
Gerald Gioia, Ph.D.  KEYNOTE SPEAKER

10:30 a.m.  Break and Visit Exhibits

10:45 a.m.  An Overview of Life Care Planning for Acquired Brain Injury
Paul Ramos, PT
11:15 a.m.  Managing Maladaptive Behavior Following Post-Acute TBI.
Richard A. Hamilton, Ph.D.

12:15 p.m.  Luncheon and Visit Exhibits

1:15 p.m.  Traumatic Brain Injury: Early Management to Maximize Functional Outcome
Alan Novick, M.D.

2:15 p.m.  Brain Injury Rehabilitation- Evidence Based Clinical Tools for Assessment and Treatment of Severe to Mild Brain Injury
Emily Schultz, PT

3:15 p.m.  Break and Visit Exhibits

3:30 p.m.  “A TBI Survivor Story”
Rehab Team

4:00 p.m.  Be Realistic…accept help and expect miracles
Janel Blanco

4:30 p.m.  Adjourn

FACULTY & FACULTY DISCLOSURE STATEMENTS
Bradley M. Aiken, M.D.
Symposium Co-director
Medical Director, Department of Rehabilitation and Brain Injury Programs
Baptist Hospital of Miami
Miami, Florida
Pending Disclosure

Richard A. Hamilton, Ph.D.
Symposium Co-director
Clinical Director, Baptist Hospital of Miami Brain Injury and Concussion Rehabilitation Programs
Neuropsychologist, Miami Cancer Institute
Miami, Florida

Richard A. Hamilton, Ph.D., has indicated that he has no relevant financial relationships to disclose and that his discussion will not include mention of investigational or off-label usage.

Kevin J. Abrams, M.D.
Chief of Radiology, Baptist Hospital of Miami
Medical Director, Neuroradiology
Miami, Florida

Kevin J. Abrams, M.D., has indicated that he is a consultant for Keystone Hart and a stockholder with Keystone Hart and Cleerly, Inc., and he will not include off-label or unapproved product usage in his presentation or discussion.

Janel Blanco
Community Member
Traumatic Brain Injury Survivor
Miami, Florida

Janel Blanco has indicated that she has no relevant financial relationships to disclose and that her discussion will not include mention of investigational or off-label usage.

Gerard Gioia, Ph.D.
Division Chief, Pediatric Neuropsychology
Children's National Health System
Professor, Departments of Psychiatry/Behavioral Sciences and Pediatrics
George Washington University School of Medicine
Gerard Gioia, Ph.D., has indicated that he is an author and receives royalties from the Psychological Assessment Resource, Inc., and he will not include mention of off-label or unapproved product usage in his presentation or discussion.

Alan Keith Novick, M.D.
Rehabilitation Medical Director
Memorial Rehabilitation Institute
Hollywood, Florida

Alan Keith Novick, M.D., has indicated that he has no relevant financial relationships to disclose and that his discussion will not include mention of investigational or off-label usage.

Paul M. Ramos, P.T.
Physical Therapist
Miami, Florida

Paul M. Ramos, P.T., has indicated that he has no relevant financial relationships to disclose and that his discussion will not include mention of investigational or off-label usage.

Lida Rivera-Perez, PT., DPT
Physical Therapist
Baptist Hospital of Miami

Emily Ann Schultz, P.T., DPT, NCS
Physical Therapist
UHealth Physical Therapy Outpatient Neuro
Miami, Florida
Emily Ann Schultz, P.T., DPT, NCS, has indicated that she has no relevant financial relationships to disclose and that her discussion will not include mention of investigational or off-label usage.

EDUCATIONAL OBJECTIVES

Update on Imaging in Acute Ischemic Stroke

Kevin J. Abrams, M.D.

EDUCATIONAL OBJECTIVES:

- Describe the wide variety of imaging tools and techniques available for assessing stroke patients
- Recognize the limitations and practical challenges of stroke imaging.
- Explain the imaging penumbra in stroke care.

REFERENCES:


Redefining concussion in youth: It’s all about the neighborhood

Gerald Gioia, Ph.D.

EDUCATIONAL OBJECTIVES:

- Utilize best evidence and current guidelines in the evaluation and management of youth concussion.
- Describe an active approach to concussion treatment and rehabilitation.
- Implement best practices to improve the return-to-school process.

REFERENCES:


**An Overview of Life Care Planning for Acquired Brain Injury**

Paul Ramos, PT

**EDUCATIONAL OBJECTIVES:**

- Recognize the important role life care planning has in meeting an acquired brain injured patient’s individual health needs.
- Outline the different components and multidisciplinary teams involved in creating a life care plan.
- Identify areas of a life care plan that are of particular importance in the management of the acquired brain injured patient.

**REFERENCES:**


**Managing Maladaptive Behavior Following Post-Acute TBI.**

Richard A. Hamilton, Ph.D.

**EDUCATIONAL OBJECTIVES:**

- Describe the neuroanatomical substrate of different types of maladaptive behavior.
- Implement behavior modification procedures to decrease maladaptive behavior.
- Identify antecedents to maladaptive behavior.

**REFERENCES:**


**Traumatic Brain Injury: Early Management to Maximize Functional Outcome**

Alan Novick, M.D.

**EDUCATIONAL OBJECTIVES:**

- Explain the risk factors and epidemiology of traumatic brain injury.
- Describe medical complications commonly associated with traumatic brain injuries.
- Outline the different classifications of traumatic brain injuries.
- Recognize functional outcome predictors for traumatic brain injuries.
- Appropriately utilize pharmacologic management for the treatment of Traumatic Brain injuries.

**REFERENCES:**


**Brain Injury Rehabilitation- Evidence Based Clinical Tools for Assessment and Treatment of Severe to Mild Brain Injury**

Emily Schultz, PT

**EDUCATIONAL OBJECTIVES:**

- Identify individuals who qualify for a BalanceWear assessment and list the steps of facilitating a referral to a qualified clinician.
- Determine the most appropriate assessment tools for commonly reported persistent symptoms following concussion.
- Utilize a multifaceted approach for the treatment of individuals with brain injury (severe to moderate) based on Evidence-based practice.
REFERENCES:


“ A TBI Survivor Story”

Rehab Team

EDUCATIONAL OBJECTIVES:

- Describe the emotional sequelae to traumatic brain injury.
- Identify contributions of the rehabilitation team as they relate to treatment planning.

REFERENCES:


Be Realistic…accept help and expect miracles

Janel Blanco

EDUCATIONAL OBJECTIVES:

- Recognize the brain injury recovery process and difficulties from the perspective of a patient.
LOCATION: Hilton Miami Dadeland, Florida  
EXPECTED NUMBER OF ATTENDEES: 130-175

CHARGES:

<table>
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<th></th>
<th>Physicians</th>
<th>BHSF EMP</th>
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<tr>
<td>Entire Course</td>
<td>$295*</td>
<td>$55</td>
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</table>

*Group discounts available for three or more physicians who register together as a group by Friday, November 29. No add-ons. Call for details.  **Registration must be accompanied by a letter from the Fellowship/Residency Director.

TARGET AUDIENCE: Adult and Pediatric Neurologists, Adult and Pediatric Medical Oncologists, Neurosurgeons, Neuro-Oncologists, Medical Oncologists, Neuroradiologists, Diagnostic Radiologists, Radiation Oncologists, Emergency Medicine Physicians, Neuroscience Nurses, Neurosurgery Nurses, Nurse Practitioners, Physical Therapists, Respiratory Therapists, Dietitians, Radiology Technologists, Clinical Pharmacists, Rehabilitation and Pain Management Specialists, Physician Assistants, as well as other specialists interested in the fields of neuro-oncology and neuroscience. In particular, this course will add tremendous value to residents in training as well as fellows in multiple specialties, including family practice, internal medicine, pediatrics, neurology, neurosurgery, medical oncology, radiation oncology, radiology, and pathology.

SYMPOSIUM DIRECTORS: Yazmin Odia, M.D.  Minesh Mehta, M.D.
Rupesh Kotecha, M.D.  Vitali Siomin, M.D.

CREDIT HOUR(S) APPLIED FOR: 7 Cat. 1

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

- [ ] ARS
- [x] 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.

Overview ► The Miami Brain Symposium will focus on state-of-the-art approaches in the management of primary and metastatic brain and spine tumors, along with an understanding of current standards of care as well as a look at future directions. For one full day this symposium will engage participants, as the expert faculty navigate through complex cases and novel treatment strategies and lively panel discussions.

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 in the management of CNS tumors.

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)

The ever-growing practical issues confronting neuro-oncology today creates a gap in multidisciplinary communication and collaboration among the diverse body of physicians and clinicians who interface between the fields of neurological diseases and cancer.

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 and clinicians will ensure a meaningful partnership among neuro specialty groups in order to better characterize the clinical presentation, evaluation, diagnosis, and treatment and continued follow-up of neuro-oncology patients to achieve optimal patient outcomes and exemplary programmatic outcome.

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
- 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): Evidence-based improvements
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.

Miami Brain Global Learning Objectives and References Supporting the Topics

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

• Examine the role of molecular histopathology in the diagnosis, characterization, and management of primary and metastatic brain tumors
• Recognize the strengths and limitations of advanced imaging in the diagnosis and post-treatment follow-up of patients with spine tumors
• Apply advances in systemic therapy, tumor neurosurgery, and radiation therapy to achieve contemporary management of primary brain tumors
• Examine recent breakthroughs in systemic therapy, neurology, and radiotherapeutics which influence management of patients with CNS malignancies
• Evaluate the management of brain and spinal metastasis in the modern era, focusing on the individual and collective roles of radiation therapy, targeted therapy, immunotherapy, and neurosurgery

Individual Learning Objectives and References/Evidence supporting the topics are attached

Miami Brain Impact Assessment Questions:

• I apply molecular histopathology in the diagnosis, characterization, and management of primary and metastatic brain tumors
• I recognize the strengths and limitations of advanced imaging in the diagnosis and post-treatment follow-up of patients with spine tumors
• I apply advances in systemic therapy, tumor neurosurgery, and radiation therapy to achieve contemporary management of primary brain tumors.
• I examine recent breakthroughs in systemic therapy, neurology, and radiotherapeutics which influence management of patients with CNS malignancies.
• I evaluate the management of brain and spinal metastasis in the modern era, focusing on the individual and collective roles of radiation therapy, targeted therapy, immunotherapy, and neurosurgery.

Commitment to Change Test: ☒Yes ☐No
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.
- [ ] Other______________________

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)  [x] Yes  [ ] No

- [x] CME Dept. leadership and staff
- [x] CME Committee
- [x] 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)
- [x] New order sheets
- [x] Other tools or tactics
  
  Explain: Patient information

  ► The neurooncology (brain and spine), meet monthly to review operational, business, research and clinical trials, as well as updates to clinical pathways and guidelines

  ► The neurooncology teams review the brain and spine tumor clinical pathways on an annual basis to update with the latest evidence based clinical guidelines

  ► The neuro tumor board meeting is held weekly to review complex cases, current literature, process improvements, and determine the best care for patients.

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

- [x] 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. ________________________________________________________

- The Miami Brain Symposium is a collaborative project between Miami Cancer Institute (MCI) and the Department of CME to improve patient care via implementation of evidence-based approaches for patients with brain tumors.
- MCI is aligned with Miami Sloan Kettering (MSK). The concept of the alliance emerged out of a growing awareness that community oncologists deliver the vast majority of cancer care in the United States. Standards of Care and Clinical Trials are most important. Also sharing our data, bio specimen repository and clinical trials.
- The Memorial Sloan Kettering Cancer Alliance is a transformative initiative to improve the quality of cancer care and the lives of cancer patients by bringing evidence-based, world-class standards to community healthcare providers. The overarching goal is to improve the lives of cancer patients through dynamic partnerships with local care providers.
- The collaborative partnership between MSK and the Miami Cancer Institute are helping to:
  - Meet a rising need for access to high-quality cancer care & clinical trials
  - Improve patient outcomes
  - Advance cancer treatment and research
  - To foster the rapid adoption of the newest standards of care in the community setting
- 85% of cancer care is provided by community hospitals. Miami was chosen for their diverse culture and population.

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

DATE REVIEWED:  July 25, 2019  REVIEWED BY: □ Accelerated Approval  □ Executive Committee
□ Live Committee

APPROVED: □ YES □ NO  ■ Credits: AMA/PRA Category 7 Credits: 1

■ Continuing Psychology Education Credits Florida Only: □  ■ Continuing Dental Education Credits: N/A

SCHEDULE

Friday, December 6
7:30 a.m.  Continental Breakfast, Visit Posters and Exhibits
7:55 a.m.  Welcome and Introduction
Yazmin Odia, M.D.
Brain Metastases: Once Size Does Not Fit All
Moderator: Rupesh Kotecha, M.D.
8:00 a.m.  Immunotherapy for Melanoma Brain Metastases
Sarah Weiss, M.D.
8:25 a.m.  Targeted Therapy for NSCLC Brain Metastases
Priscilla Brastianos, M.D.
8:50 a.m.  Stereotactic Radiosurgery and Molecular-Based Therapies
Rupesh Kotecha, M.D.
9:15 a.m.  Hippocampal Avoidance Whole-Brain Radiotherapy
Paul D. Brown, M.D.
9:40 a.m.  Visit Posters and Exhibits

Improving Outcomes for Spine Metastases
Moderator: Vitaly Siomin, M.D.
10:00 a.m.  Stereotactic and Conventional Radiation Strategies
Mark Bilsky, M.D.
10:25 a.m.  Improving Outcomes of Spine Surgery
Vitaly Siomin, M.D.
10:50 a.m.  Interventional Radiology Advances
Brian Schiro, M.D.
11:15 a.m.  Spinal Tumor Imaging
Kevin Abrams, M.D.
11:40 a.m.  Case Discussions
Matthew Hall, M.D.
12:05 p.m.  Lunch and Poster Session

Advancing Glioma Management
Moderator: Yazmin Odia, M.D.
1:05 p.m.  Chemotherapy for Glioblastoma: The Empire Strikes Back
Fabio M. Iwamoto, M.D.
1:30 p.m.  TTFields: The Great Debate  
Pro: Nicholas Avgeropoulos, M.D.  
Con: Jaishri Blakeley, M.D.

2:15 p.m.  Role of Immunotherapy in Gliomas  
Linda M. Liau, M.D.

2:40 p.m.  Panel Questions and Answers  
Moderator: Yazmin Odia, M.D.  
Panel: Fabio M. Iwamoto, M.D., Nicholas Avgeropoulos, M.D.,  
Jaishri Blakeley, M.D., Linda M. Liau, M.D.

2:55 p.m.  Visit Posters and Exhibits

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**Hits of 2019**

Moderator: Minesh Mehta, M.D.

3:15 p.m.  Craniopharyngiomas: Revolutionary Advances  
Priscilla Brastianos, M.D.

3:40 p.m.  Neurofibromatosis: Treatment Advances  
Jaishri Blakeley, M.D.

4:05 p.m.  Cognitive Preservation Strategies in Radiation Therapy  
Rakesh Jalali, M.D.

4:30 p.m.  Midline Gliomas: Changing the Landscape  
Yazmin Odia, M.D.

5:00  Adjourn and Closing Remarks  
Minesh Mehta, M.D.
Yazmin Odia, M.D., M.S.
Neuro-Oncologist
Miami Cancer Institute
Miami, Florida

Rupesh Kotecha, M.D.
Radiation Oncologist
Miami Cancer Institute
Miami, Florida

Minesh P. Mehta, M.D.
Deputy Director and Chief of Radiation Oncology
Miami Cancer Institute
Miami, Florida
Vitaly Siomin, M.D. Neurosurgeon and Medical Director
Brain Tumor Program at Baptist Health Neuroscience Center
Miami, Florida

Guest Faculty

Kevin Abrams, M.D.
Medical Director, Neuroradiology and Magnetic Resonance Imaging
Baptist, Homestead and South Miami Hospitals
Miami, Florida

Nicholas G. Avgeropoulos, M.D.
Neuro-Oncologist
Co-director, Brain and Spine Tumor Program
Orlando Health UF Health Cancer Center
Orlando, Florida
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

Mark H. Bilsky, M.D.
William E. Snee Endowed Chair; Vice Chairman of Clinical Affairs, Neurosurgery
Chief, Multi-Disciplinary Spine Tumor Service
Attending Neurosurgeon
Memorial Sloan Kettering
New York, New York

Jaishri O'Neill Blakeley, M.D.
Director, Johns Hopkins Comprehensive Neurofibromatosis Center
Professor of Neurology
Johns Hopkins Hospital
Baltimore, Maryland

Priscilla Kaliopi Brastianos, M.D.
Assistant Professor of Medicine
Harvard Medical School
Assistant Physician in Medicine, Hematology/oncology/Oncology
Massachusetts General Hospital
Boston, Massachusetts

Paul D. Brown, M.D.
Professor, Radiation Oncology
Consultant, Radiation Oncology
Mayo Clinic
Rochester, Minnesota

Matthew Hall, M.D.
Lead Pediatric Radiation Oncologist
Miami Cancer Institute
Miami, Florida

Fabio M. Iwamoto, M.D.
Assistant Professor of Neurology
Columbia University, Department of Neurosurgery
New York, New York

Rakesh Jalali, M.D., DNB, FRCR
Professor of Radiation Oncology
Tata Memorial Hospital
Mumbai, India

Linda M. Liau, M.D., Ph.D., MBA
Professor and W. Eugene Stern Chair
Department of Neurosurgery
Director, UCLA Brain Tumor SPORE
David Geffen School of Medicine at UCLA
Los Angeles, California
Brian Schiro, M.D.
Radiation Oncologist
Miami Cardiac and Vascular Institute
Miami, Florida

Sarah Weiss, M.D.
Assistant Professor, Medical Oncology
Yale Cancer Center
New Haven, Connecticut

Individual Learning Objectives and References/Evidence supporting the topics.

SESSION 1: Brain Metastases – One Size Does Not Fit All
Moderator: Rupesh Kotecha, M.D.

8:00-8:25 a.m.

Immunotherapy for Melanoma Brain Metastases
Sarah Weiss, M.D.

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

• Explain the rationale for using immunotherapy to treat melanoma brain metastases
• Identify recent data to support the use of immunotherapy to treat melanoma brain metastases

References supporting this topic


8:25-8:50 a.m.

Targeted Therapy for NSCLC Brain Metastases

Priscilla Brastianos, M.D.

Learning Objectives

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

• Describe the genetic alterations found in NSCLC brain metastases
• Demonstrate how brain metastases genetically evolve from their primary tumors
• Describe the role of precision medicine in NSCLC brain metastases
• Define which targeted therapies have CNS penetration.

References supporting this topic

► Sperduto et al. JAMA Onco 2016
► Brastianos et al. Cancer Discovery 2015

8:50-9:15 a.m.

Stereotactic Radiosurgery and Molecular Based Therapies

Rupesh Kotecha, M.D.

Learning Objectives

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

• Recognize the role of stereotactic radiosurgery in patients treated with molecular targeted therapies.
• Define the importance of timing and sequencing stereotactic radiosurgery around systemic therapy.

References supporting this topic

► PMID: 28113019, PMID: 30738402, PMID: 30726965, PMID: 28799876

9:15-9:40 a.m.

Hippocampal Avoidance WBRT: Is There a Need for WBRT and Is This Advance Important?
Paul D. Brown, M.D.

**Learning Objectives**

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

- Assess the continued importance of whole brain radiotherapy in the treatment of patients with brain metastases.
- Evaluate the role of hippocampal avoidance whole brain radiotherapy for patients with brain metastases.
- Examine the role of memantine in conjunction with whole brain radiotherapy for patients with brain metastases.

**References supporting this topic**


10:25-10:50 a.m.

**Stereotactic and Conventional Radiation Strategies**

Mark Bilsky, M.D.

**Learning Objectives**

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

- Demonstrate how to effectively treat pain and improve functional radiculopathy in patients with metastatic and primary tumors.
- Apply local tumor control and long-term palliation for both primary and metastatic tumors utilizing conventional radiotherapy techniques.

**References supporting this topic**


10:50-11:15 a.m.

**Improving Outcomes of Spine Surgery**

Vitaly Siomin, M.D.

**Learning Objectives**

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

- Describe the current evidence on the comparative safety and efficacy of lumbar fusion, decompression-alone; or non-operative care for degenerative indications.

**References supporting this topic**

11:15-11:40 a.m.

Interventional Radiology Advances

Brian Schiro, M.D.

Learning Objectives

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

• Review indications and outcomes of radiofrequency ablation of the spine.

• Recognize the synergistic effects of radiofrequency ablation and radiation therapy to treat bony metastases of the spine.

References supporting this topic


11:40 a.m.-12:05 p.m.

Spinal Tumor Imaging

Kevin Abrams, M.D.

Learning Objectives

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

• Describe typical and atypical imaging of spine tumors.

• Explain advanced imaging techniques for spinal tumor assessment.

• Identify tumor mimics in the spine.

References supporting this topic


1:30-1:55 p.m.

Chemotherapy for Glioblastoma: The Empire Strikes Back
Fabio M. Iwamoto, M.D.

**Learning Objectives**

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

* Examine the role of first-line therapy for glioblastoma patients.

**References supporting this topic**


1:55-2:20 p.m.

**Tumor Treating Fields: The Great Debate**

**Antagonist:** Jaishri Blakeley, M.D.

**Protagonist:** Nicholas Avgeropoulos, M.D.

**Learning Objectives**

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

* Describe the role of TTFields as a novel treatment modality for patients with newly diagnosed or recurrent glioblastoma multiforme.

**References supporting this topic**

► [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6356873/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6356873/)

2:20-2:45 p.m.

**Role of Immunotherapy in Gliomas**

Linda M. Liau, M.D., Ph.D., MBA

**Learning Objectives**

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

* Explain the current state of immunotherapy approaches for gliomas and identify future directions.

**References supporting this topic**

  [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5885078/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5885078/)

► J Neurooncol. Author manuscript; available in PMC 2016 Jul 1. Published in final edited form as:
  [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4797419/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4797419/)
3:25-3:50 p.m.

**Craniopharyngiomas: Revolutionary Advances**

Priscilla Brastianos, M.D.

**Learning Objectives**

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

- Define the genetic landscape of craniopharyngiomas which has led to the development of a national clinical trial.
- Demonstrate how targeted therapies may play a role in the management of craniopharyngiomas

**References supporting this topic**

- Brastianos et al. Nature Genetics 2014
- Brastianos et al. JNCI 2016

3:50-4:15 p.m.

**Neurofibromatosis: Treatment Advances**

Jaishri Blakeley, M.D.

**Learning Objectives**

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

- Recognize the meaningful treatment advances currently available for neurofibromatosis.

**References supporting this topic**


4:15-4:40 p.m.

**Cognitive Preservation Strategies in Radiation Therapy**

Rakesh Jalali, M.D.

**Learning Objectives**

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

- Examine the burden, trajectory and long term cognitive function in pediatric and adult brain tumors following radiation therapy.
- Analyze the impact of modern radiation therapy techniques and evolution of treatment paradigms in minimizing radiotherapy-induced cognitive impairment in brain tumor patients.

**References supporting this topic**


4:40-5:05 p.m.

Midline Gliomas: Changing the Landscape
Yazmin Odia, M.D.

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

• Recognize the molecular and natural history features of midline gliomas.
• Evaluate the effectiveness of novel agents clinically improving the landscape for patients with midline gliomas.

References supporting this topic

Applicable Credits: AMA Category 1  ■  Continuing Psychology Education  ■  Continuing Dental Education
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

Form Rev. 030316

CHARGES: Physicians BHSF EMP Other Fellows**

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Daily Rates

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<td>Saturday all day</td>
<td>$120</td>
<td>$55</td>
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</tbody>
</table>

*Group discounts available for three or more physicians who register together as a group by Friday, October 25. No add-ons. Call for details. **Registration must be accompanied by a letter from the Fellowship/Residency Director.

Note: The Miami Neuro Nursing Symposium, for nurses and allied health professionals, precedes the Neuro Symposium. CME credits will be available for this session as well. Details are provided below following those of the Miami Neuro symposium.


SYMPOSIUM DIRECTORS:

Miami Neuro Symposium
- Alberto Pinzon-Ardila, M.D., PH.D
- Kevin Abrams, M.D.
- Felipe De Los Rios La Rosa, M.D.
- Guilherme Dabus, M.D.
- Karel Fuentes, M.D.
- Bruno Gallo, M.D.
- Italo Linfante, M.D.

Miami Neuro Nursing
- Jayme Strauss, MSN, RN, MBA, SCRN
- Amy K. Starosciak, Ph.D.
- Kunal Patel, M.S., CNIM
Daniel D’Amour, RN, BA, BSN, CEN, SCRN

CREDIT HOUR(S) APPLIED FOR: Thursday, November 1  6.0 Cat. 1
Friday, November 2  6.0 Cat. 1
Saturday, November 3  6.0 Cat. 1
Entire Course  18 Cat 1

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.

Miami Neuro Overview ► This symposium will focus on recent advances in caring for neurology patients, stroke management, neuro-critical care, neuro-imaging, epilepsy, and movement disorders. The expert faculty will engage participants through complex cases, novel treatment strategies, and lively panel discussions.

Miami Neuro Nursing Overview ▶ Nurses are a crucial part of treatment and recovery of neuroscience patients. The Neuroscience Nursing Symposium offers a broad curriculum focusing on state-of-the-art evidence-based practices for nursing and other healthcare professionals who treat and care for neuroscience patients. The program will address the treatment and nursing care of the neuroscience patient from the emergency department through rehabilitation. The expert faculty will educate the audience about nursing issues related to neurological complications, hypothermia, stroke, epilepsy, rehabilitation and pharmacologic management of neuroscience patients. The goal of the program is to share the most innovative and evidenced-based clinical practices that have been implemented and are available to optimize patient outcomes throughout all areas of neuroscience.

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)
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 in the management of CNS tumors, neuro imaging modalities, cerebrovascular diseases and neurocritical 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)

► The ever-growing practical issues confronting neurological disorders today creates a gap in interdisciplinary care among the diverse body of physicians and clinicians that interface in the fields of neurological diseases. Unless immediate action is taken, the neurological burden is expected to become even more serious in the future.

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.)

DESIRE 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 and clinicians will ensure a meaningful partnership among neuro specialty groups in order to better characterize the clinical presentation, evaluation, diagnosis, and treatment and continued follow-up of neurology patients to achieve optimal patient outcomes and exemplary programmatic outcome.

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
- Consensus of experts
- Disease prevention (C12)
- Joint Commission initiatives (C12)
- Mortality/morbidity statistics
- National Patient Safety Goals
- National/regional data
- New diagnostic/therapeutic modality (C12)
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
Baptist Health South Florida

CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

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☐ Regulatory requirement  ☒ Other need identified (Explain): This symposium meets the 4-8 hours of stroke education requirement

► BHM received certification as a Comprehensive Stroke Center by the Joint Commission in 2014 and has achieved the highest AHA/ASA “Get With The Guidelines Quality” award for 2019, the Gold Plus - Honor Roll Elite Plus award. This symposium will meet the 4-8 hours of stroke education requirement for medical and clinical staff groups (ED, ICU, eICU, Neuroscience, Neurology, Neuroradiology, Neurosurgery, Interventional Neuroradiology, Vascular, Internal Medicine and Neuro Rehab). The symposium will showcase the multidisciplinary treatment approach, incorporate education on the specific complex patient care and how it reflects on positive outcomes.

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

► http://neuro-oncology.oxfordjournals.org/

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.

Wednesday, November 6, Miami Neuro Nursing Symposium - Seventh Annual

• Describe experiences shared by stroke survivors that identify strategies they found useful to cope with the diagnosis.

• Recognize the importance of a pre-hospital stroke evaluation to ensure that patients receive timely diagnosis and treatment.

• Describe the imaging modalities used to diagnose acute stroke.

• Recognize the utility and indications of imaging results in acute stroke.

• Determine the precise etiology of a stroke in order to minimize complications and prevent recurrence.

• Describe the use of antithrombotic treatments for patients in the first days after acute ischemic stroke onset.

• Recognize the importance of evaluating patients who present to the clinic with neurologic symptoms that may be consistent with stroke.

• Recognize the clinical features and diagnosis of convulsive status epilepticus in adults.

• Explain how causes, prognoses and treatments of status epilepticus differ in adults, and describe optimal evaluation and treatment requirements.

• Demonstrate how to prepare for sustained success in certified stroke centers.

• Recognize best practices for maintaining high-reliability stroke centers.

• Explain the evaluation and initial management of injuries to the cervical spinal column in adults, including the appropriate use of imaging studies.

• Recognize the clinical presentation of movement disorders: Parkinson’s disease, essential tremor and dystonia.

• Demonstrate the need for timely medical management of Parkinson’s disease and determine what medications to avoid.
Thursday, November 7, Miami Neuro Symposium - Ninth Annual (Day 1)

Learning Objectives

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

• Recognize triage patients who are possible candidates for IV TPA or endovascular treatment as stroke alerts.
• Describe proper patient selection of patients for IV TPA.
• Describe proper selection of patients for endovascular treatment.
• Explain common pitfalls for patient selection.
• Recognize and comply with Baptist Health’s stroke policy regarding acute stroke treatments.
• Examine the proper imaging workup in patients presenting with symptoms and signs of acute ischemic stroke.
• Recognize the advantages and disadvantages of CTA.
• Explain the pitfalls of CT perfusion.
• Analyze randomized trials, real-life registries and new devices in acute stroke thrombectomy.
• Recognize how antiplatelet therapy reduces the incidence of stroke in patients at high risk for atherosclerosis and in those with known symptomatic cerebrovascular disease.
• Identify several “rare” causes of stroke that most neurologists will encounter and describe the management of these conditions.
• Analyze current information on the efficacy and safety of procedures used for intracranial endovascular interventional treatment of cerebrovascular diseases and summarize key aspects of best practice.
• Assess recent data relevant to new technologies and emerging treatment strategies in cerebral arteriovenous malformations.
• Examine recent research advances in intracerebral hematoma and describe current management strategies.
• Illustrate a contemporary, evidence-based outline of the perioperative critical care management of patients with subarachnoid hemorrhage.
• Describe the evaluation and management of hematologic disorders associated with stroke.
• Recognize the evaluation and management of heparin-induced-thrombocytopenia.
• Identify common risk factors for PRES, RCVS and vasculitis.
• Recognize typical and atypical presentation of PRES, RCVS and vasculitis.

Friday, November 8, Miami Neuro Symposium (Day 2)

Learning Objectives
Upon completion of this session, participants should be better able to:

- Explain multiple modalities of treatments that are of increasing interest in epilepsy.
- Describe recent behavioral clinical trials in epilepsy, including cognitive behavioral therapy, mindfulness, progressive muscle relaxation and self-management.
- Explain why new therapies such as calcitonin gene-related peptide (CGRP) antagonists and neuromodulation devices are needed for the treatment of migraine.
- Describe CGRP antagonist treatments for patients with migraine.
- Examine neuromodulation treatments for patients with migraine.
- Review the American Headache Society’s position statement on integrating new migraine treatments into clinical practice.
- Describe various types of status epilepticus and explain appropriate treatment approaches.
- Distinguish primary from secondary headaches.
- Examine an algorithmic approach to classifying and diagnosing primary headache disorders.
- Analyze diagnostic criteria for chronic migraine and other types of primary chronic daily headache.
- Recognize risk factors for migraine chronification.
- Explain how to formulate a multidisciplinary treatment plan for patients with migraine.
- Examine the medical literature about the use of cannabis as a potential treatment for adults with essential tremor and appropriately disseminate information to patients regarding its use.
- Demonstrate the importance of continuous objective measures in the optimal selection of deep brain stimulation candidates with Parkinson’s disease.
- Explain the recent technical advances in deep brain stimulation.
- Examine the epidemiology, diagnosis and differential diagnosis of neuromuscular disorders.
- Evaluate the clinical features of ALS.
- Accurately diagnose and manage the early cognitive manifestations of dementias.
- Recognize clinical, diagnostic and pathological aspects of specific dementia syndromes and describe the treatment, risk factors and prevention.
- Describe the diagnosis and differential diagnosis of multiple sclerosis and examine treatment options for acute exacerbations.
- Examine the pharmacological basis of the anti-seizure effects of cannabis and particularly its non-psychoactive constituents.
- Critically examine the expanding range of evidence on the efficacy of these compounds in the management of different seizure types and epilepsy syndromes.
Impact Assessment Questions:

Thursday, November 7, Miami Neuro Symposium (Day 2)

- I triage patients who are possible candidates for IV TPA or endovascular treatment as stroke alerts.
- I properly select patients for endovascular treatment.
- I comply with Baptist Health’s stroke policy regarding acute stroke treatments.
- I properly manage imaging workup in patients presenting with symptoms and signs of acute ischemic stroke.
- I recognize the advantages and disadvantages of CTA.
- I am better able to identify “rare” causes of stroke and properly manage these conditions.
- I implement safety of procedures used for intracranial endovascular interventional treatment of cerebrovascular diseases.
- I properly manage hematologic disorders associated with stroke.
- I properly manage heparin-induced-thrombocytopenia.
- I identify common risk factors for PRES, RCVS and vasculitis.

Friday, November 8, Miami Neuro Symposium (Day 2)

- I suggest behavioral therapy, mindfulness, progressive muscle relaxation and self-management to my epilepsy patients.
- I distinguish primary from secondary headaches.
- I classify and diagnose primary headache disorders.
- I formulate multidisciplinary treatment plans for patients with migraine.
- I am aware to the importance of continuous objective measures in the optimal selection of deep brain stimulation candidates with Parkinson’s disease.
- I am better able to examine the epidemiology, diagnosis and differential diagnosis of neuromuscular disorders.
- I am better at evaluating the clinical features of ALS.
- I accurately diagnose and manage the early cognitive manifestations of dementias.
- I recognize clinical, diagnostic and pathological aspects of specific dementia syndromes and describe the treatment, risk factors and prevention.
- I am better able to diagnose and differentiate the diagnosis of multiple sclerosis.

Commitment to Change Test: ☑Yes ☐No
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.)  
--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**

► BHSF Stroke Committee, a multidisciplinary medical and clinical staff meet bimonthly and review all stroke related doctor’s order sets on an annual basis to update with the latest evidence based clinical-guidelines.

► CEA/CAS doctor’s order sets were revised in May 2018 under the leadership of neurointerventional radiologists and vascular physicians to include evidence-based practice and topics being addressed at this symposium.

► BHM and BHSF stroke dashboards are updated to monitor performance on a monthly/quarterly basis to showcase primary and comprehensive stroke patient outcomes.

► BHSF Epilepsy Operational Committee, a multidisciplinary medical and clinical staff meets quarterly to review epilepsy related doctor’s order sets on an annual basis to update with the latest evidence-based clinical guidelines.

► Deep Brain Stimulation Multidisciplinary Team meets monthly to review patient cases for possible deep brain stimulation procedure; data are collected on each patient to follow up on patient outcomes.
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. ______________________________________________________

► The Miami Neuro Symposium is a collaborative project between the Baptist Health Neuroscience Center and the Department of CME to improve patient care via implementation of evidenced-based approaches to care of the neurologically impaired patient.

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

DATE REVIEWED: July 25, 2019 REVIEWED BY: □ Accelerated Approval □ Executive Committee

☐ Live Committee

APPROVED: ☐ YES ☐ NO ■ Credits: AMA/PRA Category 18 Credits: 1

■ Continuing Psychology Education Credits Florida Only: #22 ☐ ■ Continuing Dental Education Credits: N/A

NOTE: The Miami Neuro Nurse Symposium, for nurses and allied health professionals, precedes the Miami Neuro Symposium. CME will be available for this session as well. All details are provided below following those of the Miami Brain and Miami Neuro Symposums

FACULTY

Miami Neuro – Symposium Directors

Kevin Abrams, M.D.
Medical Director, Neuroradiology and Magnetic Resonance Imaging
Baptist Hospital of Miami, Homestead Hospital and South Miami Hospital
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Alberto Pinzon-Ardila, M.D., Ph.D.
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Neurologist, Baptist Hospital of Miami and Doctors Hospital
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Miami Neuro Guest Faculty

Matthew Flaherty, M.D.
Assistant Professor of Neurology
University of Cincinnati
Cincinnati, Ohio

Brian M. Grosberg, M.D.
Director, Hartford HealthCare Ayer Neuroscience Institute Headache Center
Hartford HealthCare Medical Group
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Sheryl R. Haut, M.D.
Professor, Saul R. Korey Department of Neurology
Assistant Professor of Medicine, Department of Critical Care
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Kiwon Lee, M.D., FACP, FAHA, FCCM
Professor and Chief, Department of Neurology
Rutgers University Robert Wood Johnson Medical School
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Photo
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Photo
Charif Sidani, M.D.
Neuroradiologist
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SCHEDULE

Miami Neuro Symposium – Eighth Annual

Thursday, November 7 ■ 6.0 Cat. 1 Credits

7:30 a.m.   Continental Breakfast, Visit Exhibits and Posters
7:55 a.m.   Welcome and Introductions
Felipe De Los Rios La Rosa, M.D.

SESSION I: Cerebrovascular and Stroke
Moderator: Felipe De Los Rios La Rosa, M.D.

8:00 a.m.   Clinical Selection of Patients for IV TPA and Endovascular Treatment
Felipe De Los Rios La Rosa, M.D.

8:30 a.m.   Advanced Neuro Imaging and Stroke
Kevin Abrams, M.D.

9:00 a.m.   Randomized Trials, Real-Life Registries and New Devices in Acute Stroke Thrombectomy
Guilherme Dabus, M.D.

9:30 a.m.   New Concepts in Secondary Stroke Prevention
Felipe De Los Rios La Rosa, M.D.

10:00 a.m.  Break, Visit Exhibits and Posters

10:30 a.m.  How to Spot a Common Stroke Zebra: When and How to Look for One
Matthew Flaherty, M.D.

11:00 a.m.  Approach to Treatment of Unruptured Intracranial Aneurysms: Patient Selection and Treatment Options
Italo Linfante, M.D.

11:30 a.m.  Cerebral AVMs: Who Should Be Treated? Current and Future Treatment Options
Italo Linfante, M.D.

12:00 noon  **Challenging Case Presentations**
Moderator: Felipe De Los Rios La Rosa, M.D.
Panel: Kevin Abrams, M.D., Guilherme Dabus, M.D., Matthew Flaherty, M.D., Italo Linfante, M.D.

12:30 p.m.  *Lunch, Visit Exhibits and Posters*

**SESSION II: Critical Care**
Moderator: Karel Fuentes, M.D.

1:30 p.m.  **Management of Intracerebral Hematoma**
Matthew Flaherty, M.D.

2:00 p.m.  **Management of Subarachnoid Hemorrhage**
Kiwon Lee, M.D.

2:30 p.m.  *Break, Visit Exhibits and Posters*

3:00 p.m.  **Hematological Disorders and Stroke**
Camila Masias, M.D.

3:30 p.m.  **Imaging of PRES, RCVS, Vasculitis**
Charif Sidani, M.D.

4:00 p.m.  *Adjourn*

**Friday, November 8 ■ 6.0 Credits (Day 2)**

**SESSION III: Movement Disorders and Epilepsy**

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

7:55 a.m.  **Welcome and Introductions**
Bruno Gallo, M.D., Alberto Pinzon-Ardila, Ph.D., M.D.

8:00 a.m.  **Epilepsy Therapy Updates**
Sheryl Haut, M.D.

8:30 a.m.  **Update on Migraine Management**
Brian M. Grosberg, M.D.

9:00 a.m.  **Status Epilepticus Management**
Sheryl Haut, M.D.

9:30 a.m.  **The Rational Approach to Chronic Daily Headache**
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

Form Rev. 030316

Brian M. Grosberg, M.D.
10:00 a.m.  Break, Visit Exhibits and Posters
10:30 a.m.  Is There a Role for Cannabis in the Treatment of Essential Tremor?
            Fatta Nahab, M.D.
11:00 a.m.  MR-Guided Treatment/Essential Tremors/New Technology
            Bruno Gallo, M.D.
11:30 a.m.  Deep Brain Stimulation in Parkinson’s Disease
            Fatta Nahab, M.D.
12:00 noon Lunch, Visit Exhibits and Posters

SESSION IV: Hot Topics in Neurology
1:00 p.m.   Neuromuscular Disorders and ALS
            Jorge Pardo, M.D.
1:30 p.m.   Dementia
            Brad Herskowitz, M.D.
2:00 p.m.   Break, Visit Exhibits and Posters
2:30 p.m.   Multiple Sclerosis
            Carlos Ramirez-Calderon, M.D.
3:00 p.m.   Is There a Role in Cannabis in the Treatment of Epilepsy?
            Alberto Pinzon-Ardila, Ph.D., M.D.
3:30 p.m.   Panel Discussion With Question-and-Answer Session
            Moderators: Alberto Pinzon-Ardila, M.D., Bruno Gallo, M.D.
            Panel: Sheryl Haut, M.D., Brian M. Grosberg, M.D., Fatta Nahab, M.D., Jorge Pardo, M.D., Brad Herskowitz, M.D., Carlos Ramirez-Calderon, M.D.
4:00 p.m.   Adjourn

Learning Objectives and References Supporting the Topic

Miami Neuro Symposium - Ninth Annual (Day 1)
Thursday, November 7,
8:00  8:30  0:30
Clinical Selection of Patients for IV TPA and Endovascular Treatment
Felipe De Los Rios La Rosa, M.D.

Learning Objectives

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

• Recognize triage patients who are possible candidates for IV TPA or endovascular treatment as stroke alerts.
• Describe proper patient selection of patients for IV TPA.
• Describe proper selection of patients for endovascular treatment.
• Explain common pitfalls for patient selection.
• Recognize and comply with Baptist Health South Florida stroke policy regarding acute stroke treatments.

References supporting this topic

► Ma H, et al. thrombolysis guided by perfusion imaging up to 9 hours after onset of stroke. The new England journal of medicine, 2019

8:30 9:00 0:30

Advanced Neuro Imaging and Stroke

Kevin Abrams, M.D.

Learning Objectives

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

• Examine the proper imaging workup in patients presenting with symptoms and signs of acute ischemic stroke.
• Recognize the advantages and disadvantages of CTA.
• Explain the pitfalls of CT perfusion.

References supporting this topic

► https://doi.org/10.1016/j.jacc.2016.11.045

9:00 9:30 0:30

Randomized Trials, Real-Life Registries and New Devices in Acute Stroke Thrombectomy

Guilherme Dabus, M.D.

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

• Analyze randomized trials, real-life registries and new devices in acute stroke thrombectomy.

References supporting this topic
Published online 2017 Oct 11. doi: 10.1159/000480353

9:30  10:00  0:30

New Concepts in Secondary Stroke Prevention
Felipe De Los Rios La Rosa, M.D.

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

• Recognize how antiplatelet therapy reduces the incidence of stroke in patients at high risk for atherosclerosis and in those with known symptomatic cerebrovascular disease.

References supporting this topic

10:30  11:00  0:30

How to Spot a Common Stroke Zebra: When and How to Look For Them
Matthew Flaherty, M.D.

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

• Identify several “rare” causes of stroke that most neurologists will encounter and describe the management of these conditions.

References supporting this topic
► JAMA Neurol. 2017 Sep; 74(9): 1048–1055.

11:00  11:30  0:30

Approach to Treatment of Unruptured Intracranial Aneurysms: Patient Selection and Treatment Options
Italo Linfante, M.D.
Learning Objectives

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

• Analyze current information on the efficacy and safety of procedures used for intracranial endovascular interventional treatment of cerebrovascular diseases and summarize key aspects of best practice.

References supporting this topic

► Originally published 22 May 2018 https://doi.org/10.1161/CIR.0000000000000567 Circulation. 2018;137:e661–e689

11:30  12:00  0:30

Cerebral AVMs: Who Should be Treated: Current and Future Treatment Options

Italo Linfante, M.D.

Learning Objectives

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

• Assess recent data relevant to new technologies and emerging treatment strategies in cerebral arteriovenous malformations.

References supporting this topic

► https://www.ahajournals.org/doi/pdf/10.1161/01.STR.0000259824.10732.bb?download=true

1:00  1:30  0:30

Management of Intracerebral Hematoma

Matthew Flaherty, M.D.

Learning Objectives

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

• Examine recent research advances in intracerebral hematoma and describe current management strategies.

References supporting this topic


2:00  2:30  0:30

Management of Subarachnoid Hemorrhage

Kiwon Lee, M.D.

Learning Objectives

Upon completion of my presentation, participants should be better able to:
• Illustrate a contemporary, evidence-based outline of the perioperative critical care management of patients with subarachnoid hemorrhage.

References supporting this topic
Published online 2014 Aug 26. doi: 10.4097/kjae.2014.67.2.77

3:00 3:30 0:30

Hematological Disorders and Stroke
Camila Masias, M.D.

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Describe the evaluation and management of hematologic disorders associated with stroke.
• Recognize the evaluation and management of heparin-induced-thrombocytopenia.

References supporting this topic
► G Arepally Heparin-Induced-Thrombocytopenia. Blood 2017. 129:2864-2872

3:30 4:00 0:30

Imaging of PRES, RCVS, Vasculitis
Charif Sidani, M.D.

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Identify common risk factors for PRES, RCVS and vasculitis.
• Recognize typical and atypical presentation of PRES, RCVS, vasculitis.

References supporting this topic
► Distinct Imaging Patterns and Lesion Distribution in Posterior Reversible Encephalopathy Syndrome AJNR 20707 http://www.ajnr.org/content/28/7/1320
► Reversible Cerebral Vasoconstriction Syndrome, Part 1: Epidemiology, Pathogenesis, and Clinical Course AJNR 2015 http://www.ajnr.org/content/36/8/1392

Friday, November 8, Miami Neuro Symposium (Day 2)
8:00  8:30  0:30

**Epilepsy Therapy Updates**

*Sheryl Haut, M.D.*

**Learning Objectives**

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

- Explain multiple modalities of treatments that are of increasing interest in epilepsy.
- Describe recent behavioral clinical trials in epilepsy, including cognitive behavioral therapy, mindfulness, progressive muscle relaxation and self-management.

**References supporting this topic**

- Current Opinion in Neurology 32(2):1 · April 2019 with 20 Reads

DOI: 10.1097/WCO.0000000000000661

8:30  9:00  0:30

**Update on Migraine Management**

*Brian M. Grosberg, M.D.*

**Learning Objectives**

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

- Explain why new therapies such as calcitonin gene-related peptide (CGRP) antagonists and neuromodulation devices are needed for the treatment of migraine
- Describe CGRP antagonist treatments for patients with migraine.
- Examine neuromodulation treatments for patients with migraine.
- Review the American Headache Society's position statement on integrating new migraine treatments into clinical practice

**References supporting this topic**


Published online 2017 Mar 20. doi: 10.1007/s00415-017-8434-y

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5587613/

9:00  9:30  0:30

**Status Epilepticus Management**

*Sheryl Haut, M.D.*
Learning Objectives

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

• Describe various types of status epilepticus and explain appropriate treatment approaches.

References supporting this topic

► http://dx.doi.org/10.1136/jnnp.70.suppl_2.ii22

9:30  10:00  0:30

The Rational Approach to Chronic Daily Headache

Brian M. Grosberg, M.D.

Learning Objectives

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

• Distinguish primary from secondary headaches.

• Examine an algorithmic approach to classifying and diagnosing primary headache disorders.

• Analyze diagnostic criteria for chronic migraine and other types of primary chronic daily headache.

• Recognize risk factors for migraine chronification.

• Explain how to formulate a multidisciplinary treatment plan for patients with migraine.

References supporting this topic

► https://www.uptodate.com/contents/overview-of-chronic-daily-headache?search=The%20Rational%20Approach%20to%20Chronic%20Daily%20Headache&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

10:30  11:00  0:30

The Role of Cannabis in Essential Tremor

Fatta Nahab, M.D.

• Examine the medical literature about the use of cannabis as a potential treatment for adults with essential tremor and appropriately disseminate information to patients regarding its use.

References supporting this topic

► https://clinicaltrials.gov/ct2/show/NCT03805750

► https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3966544/ PRESS RELEASE (I'll omit this):
MR Guided Treatment/Essential Tremors/New Technology
Bruno Gallo, M.D.

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Analyze current, clinical, state-of-the-art functional neurosurgery in the treatment of Parkinson's disease, tremor, and dystonia.

References supporting this topic
► Movement Disorders 32(1):36-52 · January 2017 with 65 Reads
DOI: 10.1002/mds.26890

11:30  12:00  0:30

Advances in Deep Brain Stimulation for Parkinson's Disease
Fatta Nahab, M.D.

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Demonstrate the importance of continuous objective measures in the optimal selection of deep brain stimulation candidates with Parkinson’s disease.
• Explain the recent technical advances in deep brain stimulation.

References supporting this topic
► https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6440024/
► https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5349504/

1:00  1:30  0:30

Neuromuscular Disorders and ALS
Jorge Pardo, M.D.

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Examine the epidemiology, diagnosis and differential diagnosis of neuromuscular disorders.
• Evaluate the clinical features of ALS.

References supporting this topic
1:30  2:00  0:30

Dementia
Brad Herskowitz, MD

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Accurately diagnose and manage the early cognitive manifestations of dementias.
• Recognize clinical, diagnostic and pathological aspects of specific dementia syndromes and describe the treatment, risk factors and prevention.

References supporting this topic
► https://www.uptodate.com/contents/evaluation-of-cognitive-impairment-and-dementia?search=Dementia&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

2:30  3:00  0:30

Multiple Sclerosis
Carlos Ramirez-Calderon, M.D.

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Describe the diagnosis and differential diagnosis of multiple sclerosis and examine treatment options for acute exacerbations.

References supporting this topic

3:00  3:30  0:30

Cannabinoids Update
Alberto Pinzon-Ardila, M.D.

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Recognize anti-seizure effects of cannabis and its use in treatment of Lennox Gastaut and Dravet syndromes.
• Critically examine the expanding range of evidence on the efficacy of these compounds in the management of different seizure types and epilepsy syndromes.
• Examine the medical literature about the use of cannabis in other neurological conditions and appropriately disseminate information to patients regarding its use.

References supporting this topic


► [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5767492/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5767492/)

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**Neuro Nursing Symposium – Seventh Annual**

**Improving the Quality of Neuroscience Patient Care**

**Wednesday, November 6, 2019**

**Hilton Miami Dadeland, Florida**

**6.0 Cat. 1**

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**Symposium Directors**

**Jayme Strauss, MSN, RN, MBA, SCRN**

Director of Neuroscience Clinical and Business Operations at Baptist Hospital of Miami

Miami, Florida

---

**Amy K. Starosciak, Ph.D.**

Supervisor of Clinical Research at Baptist Health Neuroscience Center

Clinical Assistant Professor of Neuroscience

Florida International University Herbert Wertheim College of Medicine
CONTINUING MEDICAL EDUCATION ACTIVITY APPLICATION

Kunal Patel M.S., CNIM
Product Line Manager for Baptist Health Neuroscience Center
Miami, Florida

Daniel D’Amour, RN, BA, BSN, CEN, SCRN
Baptist Health System-wide Stroke Program Manager
Miami, Florida

Miami Neuro Nursing Guest Faculty

Aimee E. Green-Blumstein, ARNP
Acute Care Nurse Practitioner
South Miami Hospital
Miami, Florida
Joan Miravite, DNP, RN, FNP-BC
Doctor of Nursing Practice
Department of Neurology
Center for Movement Disorders
Parkinson Foundation Center of Excellence
Mount Sinai Beth Israel
New York, New York

Jessilyn Pozo, R.N.
Neuroscience Nurse
Baptist Hospital of Miami
Miami, Florida

Stephanie Rubenstein, R.N., SCRN
Stroke Coordinator
Marcus Neuroscience Institute
Boca Raton Regional Hospital
Boca Raton, Florida
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

Karen B. Seagraves, PhD, MPH, RN, APRN, NEA-BC, FAHA
Executive Director of Neuroscience Center
Grady Health System
Reviewer for the Joint Commission
Atlanta, Georgia

Raul A. Vasquez-Castellanos M.D.
Neurologist, Baptist Health South Florida
Department of Neuroscience
Miami, Florida

Photo
Andrew R. Waisbrot, B.S.N., R.N.
Nurse, Baptist Hospital of Miami
Miami, Florida

Schedule

Miami Neuro Nursing Symposium – Seventh Annual

**Wednesday, November 6** (6.0 Cat. 1)

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

7:55 a.m.  Welcome and Introductions
            Jayme Strauss, MSN, R.N.
8:00 a.m.  Stroke Survivor Stories  
Andrew Waisbrot, BSN, R.N.

8:30 a.m.  Pre-Hospital Stroke Evaluation  
Daniel D’Amour, R.N., BA, BSN, CEN, SCRN

9:00 a.m.  Alphabet Soup: Decoding Stroke Imaging  
Karen Seagraves, Ph.D., MPH

9:30 a.m.  Hemorrhagic vs. Ischemic Stroke Assessment and Management  
Jessilyn Pozo, R.N.

10:00 a.m.  Visit Exhibits and Posters

10:30 a.m.  NIHSS and Pitfalls  
Stephanie Rubinstein, R.N., SCRN

11:00 a.m.  Stroke Assessment: To Infinity and Beyond  
Jayme Strauss, R.N., MSN, MBA, SCRN

11:30 a.m.  Decoding Status Epilepticus Management  
Aimee E. Green-Blumstein, ARNP

12:00 Noon  Lunch, Visit Exhibits and Posters

1:00 p.m.  Stroke Certification: Inception, Evolution and Actualization  
Karen Seagraves, Ph.D. MPH

1:30 p.m.  Assessing the Complex Spine Patient  
Raul A. Vasquez-Castellanos, M.D.

2:00 p.m.  Break, Visit Exhibits and Posters

2:30 p.m.  Inpatient Management of Parkinson's Disease Post-DBS  
Joan Miravite, DNP, R.N., FNP-BC

3:00 p.m.

3:30 p.m.

4:00 p.m.  Adjourn

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Learning Objectives and References Supporting the Talks

Miami Neuro Nursing Learning Objectives
Wednesday, November 6, Miami Neuro Nursing Symposium - Seventh Annual

8:00-8:30 a.m.

Stroke Survivor Stories
Andrew Waisbrot, BSN, RN

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

• Describe experiences shared by stroke survivors that identify strategies they found useful to cope with the diagnosis.

References supporting this topic
► https://www.stroke.org/category/faces-of-stroke/

8:30 9:00 0:30

Pre-Hospital Stroke Evaluation
Daniel D’Amour, RN, BA, BSN, CEN, SCRN

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

• Recognize the importance of a pre-hospital stroke evaluation to ensure that patients receive timely diagnosis and treatment.

References supporting this topic

9:00 9:30 0:30

Alphabet Soup: Decoding Stroke Imaging
Karen Seagraves, MSN, MPH

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

• Describe the imaging modalities used to diagnose acute stroke.

• Recognize the utility and indications of imaging results in acute stroke.

References supporting this topic
► https://www.uptodate.com/contents/initial-assessment-and-management-of-acute-stroke?search=Describe%20the%20imaging%20modalities%20used%20to%20diagnose%20acute%20stroke.&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2
9:30    10:00   0:30
Hemorrhagic vs. Ischemic Stroke Assessment and Management
Jessilyn Pozo, RN

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Determine the precise etiology of a stroke in order to minimize complications and prevent recurrence.

References supporting this topic

10:30   11:00   0:30
NIHSS and Pitfalls
Stephanie Rubinstein, R.N., SCRN

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Describe the use of antithrombotic treatments for patients in the first days after acute ischemic stroke onset.

References supporting this topic

11:00   11:30   0:30
Stroke Assessment: To Infinity and Beyond
Jayme Strauss, RN, MSN, MBA, SCRN

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Recognize the importance of evaluating patients who present with neurologic symptoms that may be consistent with stroke.

References supporting this topic
► https://www.uptodate.com/contents/overview-of-the-evaluation-of-stroke?search=Stroke%20Assessment:%20To%20Infinity%20and%20Beyond&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1
Decoding Status Epilepticus Management
Aimee E. Green-Blumstein, ARNP

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Recognize the clinical features and diagnosis of convulsive status epilepticus in adults.
• Explain how causes, prognoses and treatments differ and optimal evaluation and treatment require an understanding of both the type of status epilepticus and the underlying cause.

References supporting this topic

Stroke Certification: Inception, Evolution and Actualization
Karen Seagraves, MSN, MPH

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Demonstrate how to prepare for sustained success in certified stroke centers.
• Recognize best practices for maintaining high-reliability stroke centers

References supporting this topic

Assessing the Complex Spine Patient
Raul A Vasquez-Castellanos, M.D.

Learning Objectives
Upon completion of my presentation, participants should be better able to:
• Explain the evaluation and initial management of injuries to the cervical spinal column in adults, including the appropriate use of imaging studies.

References supporting this topic
Inpatient Management of Parkinson’s Disease Post Deep Brain Stimulation

Joan Miravite, DNP, RN, FNP-BC

Learning Objectives

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

• Recognize the clinical presentation of movement disorders: Parkinson’s disease, essential tremor and dystonia.
• Demonstrate the need for timely medical management of Parkinson’s disease and determine what medications to avoid.
• Demonstrate proper guidance on how to manage the family and patient regarding post-operative expectations.

References supporting this topic


TOPIC

Learning Objectives

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

References supporting this topic

►

TOPIC

Learning Objectives

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

References supporting this topic

►
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

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

CME ACTIVITY TITLE: Inaugural Miami Cancer Institute Summit of the Americas on Immunotherapies for Hematologic Malignancies

DATE: January 24 – 25, 2020

TIME: Friday, January 24: 8:45 a.m. – 4:30 p.m.
         Saturday, January 25: 8:30 a.m. – 1:00 p.m.

CREDIT HOUR(S) APPLIED FOR: 10 cat. 1
(Friday – 6.0 Cat. 1, Saturday – 4.0 Cat 1)

LOCATION: The Ritz-Carlton, Coconut Grove, Miami, Florida

TARGET AUDIENCE: This educational program is directed toward hematologists, oncologists, pathologists, radiation oncologists, palliative care staff, oncology, hematology nurses, pharmacists and other allied health care team members interested in the treatment of patients with hematologic malignancies.

SYMPOSIUM DIRECTOR: Guenther Koehne, M.D., Ph.D.  CME MANAGER: Eleanor Abreu

SYMPOSIUM CO-DIRECTORS: Robert Sackstein, M.D., Ph.D. and Marcel van den Brink, M.D., Ph.D.

EXPECTED NUMBER OF ATTENDEES: 100

CHARGES: Physicians  BHSF EMP  Other  Fellows
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

Form Rev. 030316

Early Registration

| Entire Course | $325 | $55 | $165 | $95 |

Registration After November 1

|        | $450 | $75 | $215 | $125 |

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.

Given the increasing frequency of hematologic malignancies, complexities of treatments with novel agents and particularly with immunotherapeutic approaches, there is a need to provide an opportunity for oncologists, hematologists, oncology nurses and pharmacists to engage in thoughtful discussions with experts in these fields. In addition, there is emerging data about the biology of these malignancies impacting optimal management of patients with these disorders. Clinical decision making and management therefore has become more complex.

This one-and-a-half-day symposium has been designed to provide an overview and opportunity to learn about the most recent advances in the treatment of leukemia, lymphoma, multiple myeloma and stem cell transplantation by novel immunotherapies and treatment combinations. Updates on evolving immunologically and molecular based system therapies will be profiled and discussed.

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)

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)

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

- Summarize the evolving therapeutic strategies in the treatment of hematologic malignancies.
- Provide an update of new molecular and immunological treatments being developed for these diseases.
- Discuss the rationale for new targeted diagnostic and therapeutic strategies for lymphoma, myeloma and leukemia.
- Review the role and timing of hematopoietic cell transplantation and potential combinations of immunotherapeutic treatment 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 2, include list at end of application.)

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

Adam D. Cohen, M.D.
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

Assistant Professor, Medicine
Abramson Cancer Center
University of Pennsylvania
Philadelphia, Pennsylvania

Adam D. Cohen, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Guenther Koehne M.D., Ph.D.
Deputy Director of Miami Cancer Institute
Chief of Blood & Marrow Transplant and Hematologic Oncology
Miami Cancer Institute
Miami, Florida

Guenther Koehne, M.D., Ph.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Ola Landgren, M.D., Ph.D.
Professor of Medicine
Chief, Myeloma Service
Department of Medicine
Memorial Sloan Kettering Cancer Center
New York, New York

Ola Landgren, M.D., Ph.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Richard O’Reilly, M.D.
Claire L. Tow in Pediatric Oncology Research
Attending Physician
Continuing Medical Education
Activity Application

Richard O’Reilly, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Susan E. Prockop, M.D.
Pediatric Oncology; Allogeneic and Autologous Bone Marrow and Peripheral Blood Stem Cell Transplantation
Congenital and Acquired Diseases of Hematopoiesis and Immunity
Memorial Sloan Kettering
New York, New York

Susan E. Prockop, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Katy Rezvani, M.D.
Professor of Medicine
Chief of Section of Cellular Therapy
MD Anderson
Houston, Texas

Katy Rezvani, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Paul G. Richardson, M.D.
Clinical Program Leader
Director of Clinical Research
Jerome Lipper Multiple Myeloma Center
Dana-Farber Cancer Institute
Boston, Massachusetts

Paul G. Richardson, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Robert Sackstein, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Michel W. Saldelain, M.D., Ph.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Elizabeth J. Shpall, M.D.
Cancer Center Support Grant Programs
Stem Cell Transplantation
Brain Cancer
MD Anderson Cancer Center
Houston, Texas
Elizabeth J. Shpall, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Robert Soiffer, M.D.
Professor of Medicine
Harvard Medical School
Chief - Division of Hematologic Malignancies
Brigham and Women’s Hospital
Boston, Massachusetts

Robert Soiffer, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Wendy Stock, M.D.
Anjuli Seth Nayak Professor of Medicine,
Section of Hematology/Oncology
University of Chicago

Wendy Stock, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Marty Tallman, M.D.
Chief, Leukemia Service
Memorial Sloan Kettering
Professor of Medicine
Weil Cornell Medical College
New York, New York

Marty Tallman, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Marcel R.M. van den Brink, M.D., Ph.D.
Head, Division of Hematologic Malignancies
Memorial Sloan Kettering Cancer Center
New York, New York

Marcel R.M. vanden Brink, M.D., Ph.D. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Anas Younes, M.D.
Chief Lymphoma Service
Memorial Sloan Kettering
New York, New York

Anas Younes, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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: ________________________________________________________________
Friday, January 24, 2020

Marty Tallman, M.D.

**Landscape of Acute Myeloid Leukemia in 2020**

- Summarize recently approved agents for the treatment of acute myeloid leukemia (AML).
- Explain the mechanism of action of the newly approved agents in AML.
- Recognize how to incorporate the newly approved agents into current therapeutic strategies.

**REFERENCE:**

Acute myeloid leukemia (AML) is a heterogeneous disease. Until recently, treatment for patients with AML was limited to induction chemotherapy with cytarabine and anthracycline or hypomethylating agents, and, in some instances, allogeneic hematopoietic stem cell transplant. With the recent approval of new therapies—i.e., CPX-351, enasidenib, ivosidenib, gemtuzumab ozogamicin, and midostaurin—a new era in AML treatment has emerged. Comprehensive diagnostic testing, such as cytogenetic and molecular testing, is necessary.
for establishing patient eligibility for these new agents and should be performed in a timely manner. However, choosing a therapy for patients who are eligible for multiple treatments may be a complex process, particularly for patients with newly diagnosed AML. This review discusses data, including associated safety profiles that supported these recent approvals, and provides insights to help clinicians navigate new therapy options for this devastating disease. Given the heterogeneity of AML, the treatment landscape will likely continue to grow and evolve as additional agents (and their combinations) are approved for the treatment of subpopulations of patients with AML. Physicians will need to remain abreast of the ever-changing treatment landscape.


http://ovidsp.dc1.ovid.com/sp-3.33.0b/ovidweb.cgi?&S=LJEKFPDDGLACFCLEKPDKIFKIBMNFAA00&Complete+Reference=S.sh.49%7c3%7c1&Counter5=SS_view_found_complete%7c30223250%7cmedf%7cmedline%7cmedl&Counter5Data=30223250%7cmedf%7cmedline%7cmedl

Robert Soiffer, M.D.

Allogeneic Transplants for AML in 2020

- Assess infections associated with high mortality in immunocompromised patients.
- Measure the duration of neutropenia during intensive induction chemotherapy and hematopoietic stem cell transplantation.

REFERENCE:

Disseminated *Fusarium* infection is associated with high mortality in immunocompromised patients. Patients with acute myeloid leukemia (AML) often have an extended duration of neutropenia during intensive induction chemotherapy, consolidation chemotherapy, and hematopoietic stem cell transplantation (SCT). There is no consensus regarding management of invasive disseminated *Fusarium* infections in the setting of prolonged neutropenia (Tortorano et al., 2014) [1]. We report a case of disseminated *Fusarium* in a patient with relapsed AML who underwent successful chemotherapy and haplo-identical allogeneic SCT with administration of granulocyte colony stimulating factor (G-CSF) and granulocyte infusions.


Published online 2017 Jul 18. doi: 10.1016/j.lrr.2017.07.001

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5536877/

Hagop Kantarjian, M.D.

Landscape of Acute Lymphoid Leukemia (ALL)

- Assess and define the prevalence and genomic landscape of Ph-like ALL in adults and assess response to conventional chemotherapy.
- Evaluate the clinical utility of agents in treatment of Ph-like ALL.

REFERENCE:
Philadelphia chromosome (Ph) –like acute lymphoblastic leukemia (ALL) is a high-risk subtype of childhood ALL characterized by kinase-activating alterations that are amenable to treatment with tyrosine kinase inhibitors. We sought to define the prevalence and genomic landscape of Ph-like ALL in adults and assess response to conventional chemotherapy.

Published online 2016 Nov 21. doi: [10.1200/JCO.2016.69.0073](https://doi.org/10.1200/JCO.2016.69.0073)

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5455698/

**Wendy Stock, M.D.**

**Minimal Residual Disease in ALL**

- Implement the use of minimal residual testing in acute myeloid leukemia to assess treatment responses.
- List the various techniques used in molecular approaches to MRD.

**REFERENCE:**

Minimal residual disease (MRD) testing in acute myeloid leukemia is increasingly being used to assess treatment response and stratify the risk of relapse for individual patients. Molecular methods for MRD testing began with PCR-based assays for individual recurrent mutations. To date, there is robust evidence for testing NPM1, CBFB-MYH11, and RUNX1/RUNXT1 mutations using this approach, though the best timing and threshold level for each mutation varies. More recent approaches have been with PCR-based multigene panels, occasionally combined with flow cytometric techniques, and next-generation sequencing techniques. This review outlines the various techniques used in molecular approaches to MRD, the evidence behind individual mutation testing, and the novel approaches for evaluating multigene MRD so that clinicians can understand and incorporate these evaluations into their practice.

Molecular Minimal Residual Disease Testing in Acute Myeloid Leukemia: A Review for the Practicing Clinician
DOI: [https://doi.org/10.1016/j.clml.2018.06.017](https://doi.org/10.1016/j.clml.2018.06.017)


**Robert Soiffer, M.D.**

**Allogeneic Transplants for ALL in 2020**

- Describe the status of existing personnel and center infrastructure needed to support hematopoietic cell transplantation.
- Develop and implement earlier exposure to HCT care, survivorship issues and the decision making process.

**REFERENCE:**
The National Marrow Donor Program, in partnership with the American Society for Blood and Marrow Transplantation, sponsored and organized a series of symposia to identify complex issues affecting the delivery of hematopoietic cell transplantation (HCT) and to collaboratively develop options for solutions. “Hematopoietic Cell Transplantation in 2020: A System Capacity Initiative” used a deliberative process model to engage professional organizations, experts, transplant centers, and stakeholders in a national collaborative effort. Year 2 efforts emphasized data analysis and identification of innovative ideas to increase HCT system efficiency, address future capacity requirements, and ensure adequate reimbursement for HCT programs to meet the projected need for HCT. This report highlights the deliberations and recommendations of Year 2 and the associated symposium held in September 2011.

Published online 2012 Oct 15. doi: 10.1016/j.bbmt.2012.10.005
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3617925/

Anas Younes, M.D.

Landscape of Non-Hodgkin Lymphoma in 2020

- Implement genomic technologies including microarrays and next generation sequencing.
- Describe broad genomic findings that characterize lymphoma types.
- Discuss new therapeutic opportunities that arise.

REFERENCE:

In this review, we examine the genomic landscapes of lymphomas that arise from B, T, and natural killer cells. Lymphomas represent a striking spectrum of clinical behaviors. Although some lymphomas are curable with standard therapy, the majority of the affected patients succumb to their disease. Here, the genetic underpinnings of these heterogeneous entities are reviewed. We consider B-cell lymphomas, including Burkitt lymphoma, diffuse large B-cell lymphoma, Hodgkin lymphoma, and primary mediastinal B-cell lymphoma. We also examine T-cell lymphomas, including anaplastic large-cell lymphoma, angioimmunoblastic T-cell lymphoma, cutaneous T-cell lymphoma, adult T-cell leukemia/lymphoma, and other peripheral T-cell lymphomas. Together, these malignancies make up most lymphomas diagnosed around the world. Genomic technologies, including microarrays and next-generation sequencing, have enabled a better understanding of the molecular underpinnings of these cancers. We describe the broad genomics findings that characterize these lymphoma types and discuss new therapeutic opportunities that arise from these findings.


Anas Younes, M.D.

Landscape of Hodgkins Disease in 2020

- Summarize current treatment regimens upfront and in a relapse setting.
- Identify the significance of radiation therapy when treating Hodgkin’s Disease.
- Examine the role of checkpoint inhibitors and their combinations in Hodgkin’s Disease.
REFERENCE:

Hodgkin lymphoma is considered a prime example of treatment success, with cure rates exceeding 80% using modern combined modality therapies. However, especially in adolescents and young adults, treatment-related toxicity and long-term morbidity still represent persistent challenges. Moreover, outcomes in patients with relapsed or refractory disease remain unfavorable in the era of high-dose chemotherapy and stem-cell transplantation. Hence, there is a high demand for novel and innovative alternative treatment approaches. In recent years, many new therapeutic agents have emerged from preclinical and clinical studies that target molecular hallmarks of Hodgkin lymphoma.


Paul Richardson, M.D.

Landscape of Multiple Myeloma in 2020

- Implement an appropriate treatment regimen in upon onset and during a relapse.
- Apply novel targeted therapeutic approached and combination for multiple myeloma.
- Examine the role of auto SCT in MM in the era of novel combinations.

REFERENCE:

Significant advancements have been made in the molecular mechanisms of myelomagenesis, diagnostic methods, prognostication, and the treatment options in multiple myeloma (MM) over the last decade. Despite these, MM remains a heterogeneous disease with differing outcomes. As myeloma treatment landscape continues to expand, personalized treatment that provides maximum benefit to a specific patient becomes more important. In the last few years, serum monoclonal proteins including the serum-free light chain assays, imaging, and cytogenetics have been used to predict the outcomes of MM patients receiving different types of therapies.


Ola Landgren, M.D., Ph.D.

Minimal Residual Disease (MRD) in Multiple Myeloma
• Describe current clinical methods for MRD tracking in multiple myeloma.
• Discuss clinical trials data including MRD status and clinical outcomes.
• Assess future technologies for MRD tracking and future clinical directions.

REFERENCE:
The past decade, several highly efficacious drugs have been approved for the treatment of multiple myeloma. Many of these newer drugs are less toxic than older chemotherapy drugs. Using modern combination therapy in newly diagnosed multiple myeloma patients, high proportions of newly diagnosed multiple myeloma patients obtain minimal residual disease (MRD) negativity and MRD testing has rapidly become an integral part of clinical trials focusing on patients in this setting. Only recently, MRD negativity was reported in clinical trials focusing on older newly diagnosed multiple myeloma patients (ie, nontransplant candidates), as well as studies focusing on patients with relapsed or refractory multiple myeloma. In the past, deeper responses were rarely seen in these patient categories due to inferior therapies and lack of MRD assays. The reason for the rapidly increased interest in MRD testing in all types of clinical trials is the fact that MRD negativity is closely correlated with longer progression-free survival which has been documented in recent meta-analyses. Consequently, MRD negativity has the potential to soon become a regulatory surrogate end-point for drug approval. This review dissects and discusses current data on MRD in multiple myeloma, it outlines new hypotheses, which can be tested in future clinical studies, and it discusses opportunities and future avenues for translational research. The goal of this article is to stimulate critical analysis of our current treatment landscape and development of future translational research involving MRD testing.


Adam Cohen, M.D.

Targeted Therapies in Multiple Myeloma

• Summarize the mechanistic differences between different immunotherapies for myeloma, such as antibody-drug conjugates, bispecific antibodies, and CAR T cells.
• Describe the clinical efficacy to date for different BCMA-targeted immunotherapies in relapsed/refractory myeloma.
• Assess the potential toxicities of the different immunotherapeutic modalities in myeloma.

REFERENCE:
B-cell maturation antigen (BCMA) is a cell-surface receptor of the tumour necrosis superfamily required for plasma cell survival. BMCA is universally detected on patient-derived myeloma cells and has emerged as a selective antigen to be targeted by novel treatments in multiple myeloma. We assessed the safety, tolerability, and preliminary clinical activity of GSK2857916, a novel anti-BCMA antibody conjugated to microtubule-disrupting agent monomethyl auristatin F, in patients with relapsed and refractory multiple myeloma.

https://www.ncbi.nlm.nih.gov/pubmed/30442502
Guenther Koehne, M.D., Ph.D.

**Wilm’s Tumor Antigen 1 in Multiple Myeloma**

- Identify WT1 as a target on malignant plasma cells.
- Assess targeting WT1 in myeloma through a peptide vaccine approach post auto SCT.
- Integrate potential targeting of WT1 post allo SCT by adoptive immunotherapy.

**REFERENCE:**

The question of whether human tumors express antigens that can be recognized by the immune system has been answered with a resounding YES. Most were identified through spontaneous antitumor humoral and cellular immune responses found in cancer patients and include peptides, glycopeptides, phosphopeptides, viral peptides, and peptides resulting from common mutations in oncogenes and tumor-suppressor genes, or common gene fusion events. Many have been extensively tested as candidates for anticancer vaccines. More recently, attention has been focused on the potentially large number of unique tumor antigens, mutated neoantigens, that are the predicted products of the numerous mutations revealed by exome sequencing of primary tumors.


[http://ovidspdc2.ovid.com/sp-3.33.0b/ovidweb.cgi?&S=KBGLFPKLOFEBPLFIJPCKMHBXGAI00&Complete+Reference=S.sh.91%7c19%7c1&Counter5=SS_view_found_complete%7c28465452%7cmedf%7cmedline%7cmed13&Counter5Data=28465452%7cmedf%7cmedline%7cmed13](http://ovidspdc2.ovid.com/sp-3.33.0b/ovidweb.cgi?&S=KBGLFPKLOFEBPLFIJPCKMHBXGAI00&Complete+Reference=S.sh.91%7c19%7c1&Counter5=SS_view_found_complete%7c28465452%7cmedf%7cmedline%7cmed13&Counter5Data=28465452%7cmedf%7cmedline%7cmed13)

**Saturday, January 25, 2020**

Robert Sackstein, M.D.

**Optimizing Adoptive Cell Immunotherapeutics via GPS**

- Identify the molecular basis of cell migration.
- Illustrate how site-specific migration cells can be achieved for adoptive immunotherapy applications.
- Explain how to execute improved site-specific cell trafficking, yielding higher efficacy, safer outcomes and lower costs for adoptive immunotherapy applications.

**REFERENCE:**

Cancer immunotherapy, a treatment that selectively augments a patient's anti-tumor immune response, is a breakthrough advancement in personalized medicine. A subset of cancer patients undergoing immunotherapy have displayed robust and long-lasting therapeutic responses. Currently, the spotlight is on the use of blocking antibodies against the T-cell checkpoint molecules, cytotoxic T-lymphocyte-associated antigen 4 (CTLA-4) and programed cell death-1 (PD-1)/programed death-ligand 1 (PD-L1), which have been effectively used to combat many cancers types.

http://ovidsp.dc2.ovid.com/sp-3.33.0b/ovidweb.cgi?&S=KBGLFPKLOFEBPLFJPCKMHBHEGAIAA00&Complete+Reference=S.sh.98%7c19%7c1&Counter5=SS_view_found_complete%7c30277835%7cmedf%7cmedline%7cmedl&Counter5Data=30277835%7cmedf%7cmedline%7cmedl

Michel Sadelain, M.D., Ph.D.

Landscape of CAR T cells

- Illustrate both the potential and the challenges of CAR-T cell therapy.
- Identify the biological challenges of newly developed technology to understand the disease biology.

REFERENCE:

Chimeric antigen receptor (CAR) T-cell therapy has dramatically shifted the landscape of treatment for lymphoid malignancies, especially diffuse large B-cell lymphoma (DLBCL) and acute lymphoblastic leukemia (ALL). However, there continue to be significant limitations of this therapy, such as incomplete or nonsustained responses and severe toxicities in a subset of patients. Furthermore, expanding the role of CAR T-cell therapy to new disease types is an important next step. In this review, we will highlight landmark trials for anti-CD19 CAR T cells and first-in-human trials of novel CARs, as well as discuss promising innovative CAR designs that are still undergoing preclinical development. Lastly, we will discuss toxicity and mechanisms of CAR T-cell resistance and failure, as well as potential future treatment approaches to these common issues.


http://ovidsp.dc2.ovid.com/sp-3.33.0b/ovidweb.cgi?&S=KBGLFPKLOFEBPLFJPCKMHBHEGAIAA00&Complete+Reference=S.sh.105%7c3%7c1&Counter5=SS_view_found_complete%7c31187533%7cmedf%7cmedline%7cmedl&Counter5Data=31187533%7cmedf%7cmedline%7cmedl

Katy Rezvani, M.D.

Do CARS Always have to be T Cells?

- Discuss neurokinin (NK) cells as alternative effectors for CAR engineering.
- Assess strategies that enhance NK cell in vivo proliferation and persistence.

REFERENCE:

Recent advances in the field of cellular therapy have focused on autologous T cells engineered to express a chimeric antigen receptor (CAR) against tumor antigens. Remarkable responses have been observed in patients receiving autologous CD19-redirected T cells for the treatment of B-lymphoid malignancies. However, the generation of autologous products for each patient is logistically challenging and expensive. Extensive research efforts are ongoing to generate an off-the-shelf cellular product for the treatment of cancer patients. Natural killer (NK) cells are attractive contenders since they have potent anti-tumor activity, and their safety in the allogeneic setting expands the cell sources for NK cell therapy beyond an autologous one. In this review, we discuss advantages and limitations of NK cellular therapy, and novel genetic engineering strategies that may be applied to overcome some of the limitations. Next-generation engineered NK cells are
showing great promise in the preclinical setting and it is likely that in the next few years CAR-engineered NK cells will be incorporated into the current armamentarium of cell-based cancer therapeutics.


Richard O'Reilly, M.D.

**Landscape of Allogenic Transplants**

- Implement current allogeneic transplant approaches.
- Assess strategies with the different conditioning regimen.
- Compare the pros and cons of allogeneic transplant strategies.

**REFERENCE:**

Alemtuzumab (ALM) is used for T cell depletion in the context of allogeneic hematopoietic stem cell transplantation (alloSCT) to prevent acute graft-versus-host disease and graft rejection. Following ALM-based T cell-depleted alloSCT, relatively rapid recovery of circulating T cells has been described, including T cells that lack membrane expression of the GPI-anchored ALM target Ag CD52. We show, in a cohort of 89 human recipients of an ALM-based T cell-depleted alloSCT graft, that early lymphocyte reconstitution always coincided with the presence of large populations of T cells lacking CD52 membrane expression. In contrast, loss of CD52 expression was not overt within B cells or NK cells. We show that loss of CD52 expression from the T cell membrane resulted from loss of GPI anchor expression caused by a highly polyclonal mutational landscape in the PIGA gene.

Journal of Immunology. 200(6):2199-2208, 2018 03 15.

http://ovidsp dc2. ovid. com/ sp-3.33.0b/ ovidweb. cgif? S=KBGLF PKLOF BPLFJUPCKMHBHEGAIA00& Complete+Reference=S.sh.112% 7c3% 7c1& Counter5=SS_vie w_found_complete% 7c29427418% 7cmedf% 7cmedline% 7cmed& Counter5Data=29427418% 7cmedf% 7cmedline% 7cmed

Marcel van den Brink, M.D., Ph.D.

**Microbiome in Stem Cell Transplants – Does it Matter?**

- Describe how patients undergoing allogenic hematopoietic cell transplantation (allo-HCT) incur changes in their intestinal microbiota.
- Demonstrate that these changes in the intestinal microbiota are associated with clinically relevant outcomes relevant outcomes in patients undergoing allo-HCT including overall survival and lethal graft-versus-host-disease.

**REFERENCE:**

Gut microbiota, the collective community of microorganisms inhabiting the intestine, have been shown to provide many beneficial functions for the host. Recent advances in next-generation sequencing and advanced molecular biology approaches have allowed researchers to identify gut microbiota signatures associated with disease processes and, in some cases, establish causality and elucidate underlying mechanisms.

http://ovidsp.dc1.ovid.com/sp-3.33.0b/ovidweb.cgi?&S=JBCAFPNBHJACFCIAKPDKDGINBFPGA00&Complete+Reference=S.sh.24%7c4%7c1&Counter5=SS_view_found_complete%7c28720679%7cmedf%7cmedline%7cmed13&Counter5Data=28720679%7cmedf%7cmedline%7cmed13

Guenther Koehne, M.D., Ph.D.

Adoptive Immunotherapy with donor-derived T-Cells

- Identify the principles of generating donor-derived antigen-specific T lymphocytes.
- Discuss and explain the clinical effectiveness of donor-derived antigen-specific T cells for the treatment of viral complications post allo SCT.

REFERENCE:

Regulatory T cell (Treg) therapy has been exploited in autoimmune disease, solid organ transplantation and in efforts to prevent or treat graft-versus-host disease (GVHD). However, our knowledge on the in-vivo persistence of transfused Treg is limited. Whether Treg transfusion leads to notable changes in the overall Treg repertoire or whether longevity of Treg in the periphery is restricted to certain clones is unknown. Here we use T cell receptor alpha chain sequencing (TCR-alpha-NGS) to monitor changes in the repertoire of Treg upon polyclonal expansion and after subsequent adoptive transfer.


http://ovidsp.dc2.ovid.com/sp-3.33.0b/ovidweb.cgi?&S=KBGLFKLQFEBPLJFUPCKMHBEGAA00&Complete+Reference=S.sh.119%7c9%7c1&Counter5=SS_view_found_complete%7c27774628%7cmedf%7cmedline%7cmed13&Counter5Data=27774628%7cmedf%7cmedline%7cmed13

Susan Prockop, M.D.

Adoptive Immunotherapy with 3rd. party-derived T-Cells

- Execute the new regimen for T-cell immunotherapy developed to prevent or manage relapse of leukemia following HCT.
- Assess and implement CD8+ and CD4+ T cells engineered with a minor histocompatibility antigen-targeting TCR, CD8 coreceptor and safety switch.

REFERENCE:

Adoptive T-Cell Therapy with 3rd Party CMV-pp65-Specific CTLs for CMV Viremia and Disease Arising after Allogeneic Hematopoietic Stem Cell Transplant
Blood 2017 130:747;
http://www.bloodjournal.org/content/130/Suppl_1/747

Inaugural MCI Summit of the Americas on Immunotherapies for Hematologic Malignancies
Agenda

Schedules are subject to change.

Friday, January 24, 2020

7:30 a.m.  
Registration and Continental Breakfast

8:30 a.m.  
Welcome and Introductions  
Guenther Koehne, M.D., Ph.D.

8:45 a.m. – 10:15 a.m.

Acute Myeloid Leukemia

Landscape of AML in 2020  
Marty Tallman, M.D.  
Memorial Sloan Kettering Cancer Center

Allogeneic Transplants for AML in 2020  
Robert Soiffer, M.D.  
Dana Farber Cancer Institute

10:15 a.m.  
Break and Exhibits

10:45 p.m. – 12:15 p.m.
Acute Lymphoid Leukemia

Landscape of ALL in 2020
Hagop Kantarjian, M.D.
MD Anderson Cancer Center

MRD in ALL
Wendy Stock, M.D.
University of Chicago

Allogeneic Transplants for ALL in 2020
Robert Soiffer, M.D.
Dana Farber Cancer Institute

12:15 p.m. – 12:45 a.m.

Non-Hodgkin Lymphoma + Hodgkin Disease

Landscape of NHL in 2020
Anas Younes, M.D.
Memorial Sloan Kettering Cancer Center

12:45 p.m. – 1:45 p.m.  Lunch and Exhibits

1:45 p.m. – 2:15 p.m.

Landscape of Hodgkin’s Disease in 2020
Anas Younes, M.D.
Memorial Sloan Kettering Cancer Center
2:15 p.m.- 3:15 p.m.

Multiple Myeloma

**Landscape of Multiple Myeloma in 2020**
Paul Richardson, M.D.
Dana Farber Cancer Center

**MRD in Multiple Myeloma**
Ola Landgren, M.D., PhD
Memorial Sloan Kettering Cancer Center

3:15 p.m. – 3:30 p.m.      *Break and Exhibits*

3:30 p.m. – 4:30 p.m.

**Targeted Therapies in Multiple Myeloma**
Adam Cohen, M.D.
University of Pennsylvania

**Wilms' Tumor Antigen 1 in Multiple Myeloma**
Guenther Koehne, M.D., Ph.D.
Miami Cancer Institute

4:30 p.m.       *Adjourn*
Saturday, January 25, 2020

7:30 a.m. 
Registration and Continental Breakfast

8:15 a.m. 
Welcome and Introductions
Gunether Koehne, M.D., Ph.D.

8:30 a.m. 9:15 a.m.

Keynote Address
Optimizing Adoptive Cell Immunotherapeutics via GPS
Robert Sackstein, M.D., Ph.D.
Florida International University

9:15 a.m. – 10:30 a.m.

CAR Cell Therapies

Landscape of CAR T-cells in 2020
Michel Sadelain, M.D., PhD
Memorial Sloan Kettering Cancer Center

Do CARs always have to be T Cells?
Katy Rezvani, M.D.
MD Anderson Cancer Center

10:30 a.m. - 11:00 a.m. 
Break and Exhibits
11:00 a.m. – 1:00 p.m.

Allogeneic Transplants & Adoptive Immunotherapies

Landscape of Allogeneic Transplants in 2020
Richard O’Reilly, M.D.
Memorial Sloan Kettering Cancer Center

Microbiome in Stem Cell Transplants. Does it matter?
Marcel van den Brink, M.D., PhD
Memorial Sloan Kettering Cancer Center

Adoptive Immunotherapy with donor-derived T-Cells
Guenther Koehne, M.D., Ph.D.
Miami Cancer Institute

Adoptive Immunotherapy with 3rd party-derived T-Cells
Susan Prockop, M.D.
Memorial Sloan Kettering Cancer Center

1:00 p.m. Adjourn

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Anas Younes, M.D.
CME ACTIVITY TITLE: Evidence-based Clinical Care Conference Series: Sepsis Clinical Pathway

DATE: TBD

TIME: TBD

LOCATION: TBD

CREDIT HOUR(S) APPLIED FOR: TBD

TARGET AUDIENCE: Critical Care Physicians, Emergency Department Physicians, Hospitalists, Internal Medicine Physicians, Infectious Disease Physicians, General Surgeons, Oncologists and Obstetricians, Nurses, Nurse Practitioners and Physician Assistants.

CONFERENCE DIRECTOR: Eduardo Martinez-DuBouchet, M.D.

CME MANAGER: Marie Vital Acle

CONFERENCE COORDINATOR: Tatiana Posada

EXPECTED NUMBER OF ATTENDEES: 200 annually

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)

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

Sepsis/Severe Sepsis/Septic Shock is a significant healthcare concern for the U.S. population because of its high prevalence, morbidity, mortality and medical costs. Mortality from sepsis increases 8% for every hour that antibiotic treatment is delayed. Sepsis is a leading cause of death in U.S. hospitals. This course provides a review of the Sepsis Clinical Pathway at Baptist Health South Florida.

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 may not be aware of evidence-based standardization efforts throughout Baptist Health that are impacting algorithms of care. This course reviews the sepsis clinical pathway at Baptist Health.

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 power plans for sepsis consistently as evidenced by clinical pathway utilization.

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
☑ Consensus of experts
☐ Disease prevention (C12)
☐ Joint Commission initiatives (C12)
☑ Mortality/morbidity statistics
☐ National Patient Safety Goals
☐ National/regional data
☐ New diagnostic/therapeutic modality (C12)
☑ New or updated policy/protocol
☑ Patient care data
☐ Peer review data
☑ Process improvement initiatives (C16 & 21)
☐ Regulatory requirement
☐ Other need identified (Explain): ______________
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

Research/literature review

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

The system-wide evidence-based clinical care committee is comprised of multidisciplinary stakeholders who have assessed diagnosis related groups (DRGs) to determine new current standard of care and develop treatment algorithms. It is the recommendation of theses committees, based on extensive evidenced-based research, to modify delivery of care to improve efficiency and ensure all patients receive the same quality care throughout Baptist Health removing variances. These standardization efforts are supported by implementation of Cerner EMS system and monitored by utilization metrics.

The evidence used to create the algorithms of care for sepsis are as follows:


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:

- Explain the evidence-based data supporting standardization efforts to ensure consistent delivery of care in sepsis patients.
- Identify and triage sepsis patients according to clinical pathways and consistently implement appropriate, timely treatment protocols.
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. EBCC Metrics Data to be provided to CME Department upon request.

- Other____________________

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

CONTENT CONTRIBUTORS

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eICU Associate Medical Director
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Baptist Clinical Enterprise, Baptist Health South Florida

Lellany Ruiz
Project Manager, Evidence-Based Clinical Care
Baptist Clinical Enterprise, Baptist Health South Florida
Lisa-Mae Williams, R.N.
Director of Operations, eICU
Baptist Health South Florida

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

**Content contributors have** indicated that neither they nor their spouses/partners have relevant financial relationships with commercial interest companies, and they will not include off-label or unapproved product usage in their presentations or discussions.

All other team members and those involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

**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.)  EBCC Committee (Hip Fracture) design team members.

**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: Algorithms of care are

**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 course is planned in collaboration with the evidence-based clinical care committee in support of system-wide standardization efforts.*

**COMMERCIAL SUPPORT:**  □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.
(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider:

Course video:

Course handout:

Quiz Questions

COURSE HANDOUT PAGE NOTES: Please insert the following text on course handout page:

NOTE: Physicians should bookmark this course to access all protocols, policies and procedures at your convenience via your CME Portal account. All algorithms will be available on CERNER.

DATE REVIEWED: __________ 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: Rehabilitation of the Person With Breast Cancer

COURSE APPROVAL: August 2019                     COURSE EXPIRATION: August 2022

CREDIT HOUR(S) APPLIED FOR:

TARGET AUDIENCE: Breast Surgeons, General Surgeons, Reconstructive Surgeons, Obstetricians and Gynecologists, Oncologists, Medical Oncologists, Physiatrists, Radiation Oncologists, General Practitioners and all other interested healthcare professionals.

SYMPOSIUM DIRECTORS: Gladys L. Giron, M.D., FACS, Starr K. Mautner, M.D., Nicholas C. Lambrou, M.D., and John P. Diaz, M.D., FACOG

CME MANAGER: Eleanor Abreu (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 200  CHARGE: 0

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 & 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 that keyword searches will pull from this description.

Adrian Cristian, M.D., MHCM, Chief, Cancer Rehabilitation, Miami Cancer Institute with address the significant impact of loss of function as a result of breast cancer and its treatments-especially shoulder dysfunction, lymphedema, chemotherapy induced neuropathy (CIN).
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)

► Not all medical oncologists, radiation oncologists, breast cancer surgeons, plastic surgeons and APP’s know about the significant impact of loss of function as a result of breast cancer and its treatments—especially shoulder dysfunction, lymphedema, chemotherapy induced neuropathy (CIN). Those that do know are often referring the patients later than necessary, when it is more difficult to treat the breast cancer related impairment.

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)

► Optimally, all patients with breast cancer should be screened for cancer related impairments such as shoulder dysfunction, lymphedema and chemotherapy induced neuropathy and refer early to cancer rehabilitation services, especially after breast cancer surgery and/or radiation 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 and explain below.)

☑ Best practice parameters
☐ Disease prevention (C12)
☐ Mortality/morbidity statistics
☐ National/regional data
☐ Consensus of experts
☐ Joint Commission initiatives (C12)
☐ National Patient Safety Goals
☐ New diagnostic/therapeutic modality (C12)
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:


Bibliography and Additional Resources:

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:

- Describe breast cancer related impairments and their impact on the quality of life for the patient.
- Explain available treatments of cancer related impairments.
- Identify strategies to minimize barriers to early referral for cancer related impairments.

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.)

Adrian Cristian, M.D., MHCM
Chief, Cancer Rehabilitation
Miami Cancer Institute
Professor, Rehabilitation Medicine
Division of Rehabilitation Medicine
Department of Neuroscience
Herbert Wertheim College of Medicine
Florida International University
Miami, Florida

Adrian Cristian, M.D., MHCM, indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

Symposium Directors

Gladys L. Giron, M.D., has indicated that her spouse is a member of the speakers bureau and a consultant with Stryker.

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Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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.
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

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. This course is a result of the Women’s Cancer Symposium a Miami Cancer Institute initiative.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM172

Course video:

Course handout:

Quiz

1. Which of the following is not a common breast cancer-related impairment?
a. Shoulder dysfunction
b. Lymphedema of the arm
c. Chemotherapy-induced peripheral neuropathy
d. Lymphedema of the leg

2. Which of the following is a risk factor for the development of lymphedema in a person with breast cancer?
   a. History of axillary lymph node dissection
   b. History of mastectomy or lumpectomy
   c. History of radiation therapy as part of the breast cancer treatment
   d. a and b

3. Which of the following is an important treatment for balance impairment in breast cancer with chemotherapy-induced peripheral neuropathy?
   a. Physical therapy
   b. Occupational therapy
   c. Neuropsychology
   d. Social work

4. Which of the following is not associated with chemotherapy-induced peripheral neuropathy?
   a. Balance problems
   b. Fall risk
   c. Hand weakness and difficulty buttoning and unbuttoning shirts
   d. Swallowing dysfunction
CME ACTIVITY TITLE: Rehabilitation of the Person With Gynecologic Cancer

COURSE APPROVAL: August 2019                   COURSE EXPIRATION: August 2022

CREDIT HOUR(S) APPLIED FOR:

TARGET AUDIENCE: Breast Surgeons, General Surgeons, Reconstructive Surgeons, Obstetricians and Gynecologists, Oncologists, Medical Oncologists, Psychiatrists, Radiation Oncologists, General Practitioners and all other interested healthcare professionals.

SYMPOSIUM DIRECTORS: Gladys L. Giron, M.D., FACS, Starr K. Mautner, M.D., Nicholas C. Lambrou, M.D., and John P. Diaz, M.D., FACOG

CME MANAGER: Eleanor Abreu (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 200                    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)
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- 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.

Adrian Cristian, M.D., MHCM, Chief, Cancer Rehabilitation, Miami Cancer Institute with address the significant impact of loss of function as a result of gynecologic cancer and its treatments—especially lower extremity lymphedema, chemotherapy induced neuropathy (CIN) and debility.

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)

► Not all medical oncologists, radiation oncologists, gynecologic oncology surgeons and APP’s know about the significant impact of loss of function as a result of gynecologic cancer and its treatments—especially lower extremity lymphedema, chemotherapy induced neuropathy (CIN) and debility. Those that do know are often referring the patients later than necessary, when it is more difficult to treat the breast cancer related impairment.

**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)*

► Optimally, all patients with gynecologic cancer should be screened for cancer related impairments such as lower extremity lymphedema, chemotherapy induced neuropathy (CIN), balance impairment and debility and refer early to cancer rehabilitation services, especially after gynecologic cancer surgery and/or radiation 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 and explain below.)**

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

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


Bibliography and Additional Resources:

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:

- Describe gynecologic cancer related impairments and their impact on the quality of life for the patient
- Describe the treatments of gynecologic cancer related impairments
- Identify strategies to minimize barriers to early referral for cancer related impairments.

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.

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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.) ____________________________________________
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

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. This course is a result of the Women’s Cancer Symposium a Miami Cancer Institute initiative.

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM171

Course video:

Course handout:

Quiz Questions

1. Which of the following are common gynecologic cancer-related impairments?
   a. Shoulder dysfunction
   b. Lymphedema of the lower extremity
   c. Chemotherapy-induced peripheral neuropathy
   d. b and c

2. Which of the following is a risk factor for the development of lymphedema in a woman with gynecologic cancer?
a. History of lymph node dissection
b. History of mastectomy or lumpectomy
c. History of radiation therapy as part of the treatment for gynecologic cancer.
d. a and c

3. Which of the following is an important treatment for balance impairment in breast cancer with chemotherapy-induced peripheral neuropathy?
   a. Physical therapy
   b. Occupational therapy
   c. Neuropsychology
   d. Social work

4. Which of the following is not associated with chemotherapy-induced peripheral neuropathy?
   a. Balance problems
   b. Fall risk
   c. Hand weakness and difficulty buttoning and unbuttoning shirts
   d. Lymphedema

DATE REVIEWED: ________________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee
☐ Live Committee

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

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

CME ACTIVITY TITLE: Managing the Cancer Patient: Adverse Effects of Pharmacologic Interventions

COURSE APPROVAL: September 2019 COURSE EXPIRATION: September

CREDIT HOUR(S) APPLIED FOR:
**TARGET AUDIENCE:** Hospitalists, Emergency Medicine Physicians, Pulmonologists, Internists, Residents, Nurse Practitioners, Physician Assistants, Pharmacists, Pharmacy Technicians, and any other interested healthcare professionals. 
Nurse practitioners – only if 1 cat 1 (or more)

**CONFERENCE DIRECTOR:** Andres Soto, M.D.  
**CME MANAGER:** Eleanor Abreu (Live)/Marie Vital Acle (Online)

**EXPECTED NUMBER OF ATTENDEES:** 0  
**CHARGE:** 0

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

<table>
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<th>ARS</th>
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</thead>
<tbody>
<tr>
<td>Case Studies</td>
<td>Manuscript review activity</td>
</tr>
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<td>Didactic Lecture</td>
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<td>Journal-based CME activity</td>
<td>Test item writing activity</td>
</tr>
<tr>
<td>Learning from Teaching</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

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

Oncology patients often present to the emergency department acutely ill with complications of their cancer treatment. A panel will discuss the pathophysiology of common oncologic emergencies and provide strategies to manage immune related adverse events (IRAE).

**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)

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Noncompliance</th>
<th>Lifestyle</th>
<th>Resistance to change</th>
<th>Cost of care/Lack of insurance</th>
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</thead>
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<td>Physician:</td>
<td>Noncompliance</td>
<td>Resistance to change</td>
<td>Communication skills</td>
<td>Reimbursement issues</td>
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<td>Resources:</td>
<td>Institutional Capabilities</td>
<td>Physician Practice Limitations</td>
<td>Community Service Limitations</td>
<td></td>
</tr>
<tr>
<td>State of Science:</td>
<td>Limited or no treatment modalities</td>
<td>Limited or no diagnostic modalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>Please describe</td>
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</tr>
</tbody>
</table>
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 number of oncology agents on the market are increasing, especially oral formulations. What was once primarily dedicated to the oncologist may now present to the general practitioner or emergency department. Currently, these practitioners’ may not be aware of the proper prescribing, adverse effects, and monitoring of these agents. Treatment of emergencies and handling of these agents outside of the pharmacy are critical elements of these types of agents.

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)

► Practitioners are aware of potential immune related adverse events for available oncology agents and are able to implement the appropriate treatment plan.

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
- Consensus of experts
- Disease prevention (C12)
- Joint Commission initiatives (C12)
- Mortality/morbidity statistics
- National Patient Safety Goals
- National/regional data
- New diagnostic/therapeutic modality (C12)
- New or updated policy/protocol
- Patient care data
Non-oncologists are considerably over pessimistic regarding their perception of the cancer patients’ prognosis. A pessimistic perception of prognosis might cause under treatment and therefore affect both patients’ quality of life and their actual survival. Education regarding cancer therapy and its benefits should be emphasized for non-oncologists involved in cancer patient care.


Over the last decade anticancer treatment has experienced encouraging changes. One of the latest developments is immunotherapy, which is increasingly becoming a mainstay for the treatment of these malignancies. Unlike conventional chemotherapy, immunotherapy enhances anti-tumor immune response by blocking inhibitory immune checkpoints, and allowing our own immune system to fight against the tumor cells, arising as a new and innovative mechanism of action. Therefore, although well tolerated, these drugs have a unique side effect profile and are known to cause immune-related adverse events (irAEs). Adverse effects of immunotherapy are most commonly observed in the skin, gastrointestinal tract, liver, lung and endocrine systems. Less common toxicities may include neurological, haematological, cardiac, ocular or rheumatologic involvement. As far as we know, cancer patients are frequently seen in the Emergency Department due to treatment related toxicities, thus there is an increasing necessity to learn about this particular side effect profile given that they entail a different and unique management than that of classic chemotherapy drugs.


**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:

- Describe the pathophysiology of common oncologic emergencies.
- Identify signs, symptoms, and complications which result from ineffective chemotherapy.
- Implement pharmacological interventions for cancer patients presenting with disease related symptoms.
- Explain mechanism of action for targeted IV immunotherapy.
- Implement appropriate treatment modalities utilized in patients with immune related adverse events (IRAE).
 Execute the requirements of the United States Pharmacopeia on receiving, storing, and transporting hazardous drugs.

**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.)

**PANELISTS**

Alyssa Donadio, Pharm.D.,
BCPS – Clinical Pharmacy Specialist

Maria de la Matute, APRN, MSN, OCN, BMT-CN

Christine Ibarra, Pharm.D.
BCPS – Clinical Pharmacy Specialist
Faculty disclosure statement (as it should appear on course shell):

Alyssa Donadio, Pharm.D., Mariadela Matute, APRN, MSN, OCN, BMT-CN, Christine Ibarra, Pharm.D., Lilit Smith, Pharm.D., MBA, have indicated that neither they nor their spouses/partners have relevant financial relationships with commercial interest companies, and they will not include off-label or unapproved product usage in their presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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. ______________________________________________________
This event is in collaboration with the Graduate Medical Education Program.

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

**ETHOS CONTENT**

**YOU MAY ALSO BE INTERESTED IN:** List names of up to two courses with similar target audiences. Please list complete course title.

**External:**

**Provider:** 2019IEM169

**Course video:**

**Course handout:**

**Quiz Questions**

1. Which of the following is not a recognized immune-related adverse event?
   a. Rash
   b. Diarrhea
   c. Nephritis
   d. **Changes in mood**

2. Case Question: MF is a 50 y/o male admitted with presumed multiple myeloma. His presenting labs include serum creatinine 2.1 mg/dL, calcium 11.1 mg/dL, and albumin 2.4 g/dL. Aggressive hydration with a bolus of 1000 mL over 1 hour was initiated.

   Which of the following interventions would be most appropriate for MF at this time?
   a. Calcitonin 200 units intranasal q12h x 4 doses
   b. Zoledronic acid 3 mg IV x 1
   c. **Pamidronate 90 mg IV x 1**
   d. Denosumab 120 mg IV x 1
3. If MF’s calcium does not return to normal after the initial treatment, when can retreatment with a bisphosphonate be considered?
   a. 24 hours
   b. 48 hours
   c. 7 days
   d. 14 days

4. Hazardous handling of medications are used in which of the following areas?
   a. Miami Cancer Institute
   b. Inpatient areas at Baptist Hospital
   c. South Miami Emergency Department
   d. All of the above

DATE REVIEWED: __________  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: Conversations in Ethics – Ethical Challenges with Informed Consent

DATE: Friday, September 27, 2019  TIME: 12 noon – 1 p.m.  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: HH Auditorium
VIDEO CONFERENCED: BHM 5 MCVI Side-A; SMH CI-F; MH Exec. Conf. Rm

LIVE WEBCAST

TARGET AUDIENCE: Physicians, Psychologists, Physician Assistants, Nurse Practitioners, Nurses, Social Workers, Respiratory Therapists, Clinical Chaplains, Pharmacists, Medical Students, Registered Dietitians and other interest healthcare professionals.

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH
CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN, Director, Bioethics Program
CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 50-60 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)

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

Informed consent is a process that begins when a patient consents to treatment on admission. Historically, informed consent had been influenced by an interpretation of informed decision making as a legal obligation in which the emphasis is full disclosure, rather than an ethical obligation toward mutual decision making by fostering understanding. Recently, the imperative has emerged to reassess and reevaluate how treatment decisions are made between physicians and patients to help improve patient and family outcomes. The healthcare team, patient, and family are sometimes faced with challenges in this process. Join us as we discuss what informed consent means, the process, challenges we face, and give some examples of previous cases and the outcomes while maintaining confidentiality.
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)

► In an era of health system reform, the imperative has emerged to reassess and reevaluate how treatment decisions are made between physician and patient. Numerous studies have demonstrated that current informed consent practices do not adequately serve either patients or physicians, and the increasing focus on patient-centered health care in the medical community has prompted a movement for tangible change. In the past few decades, ethicists and physicians have advocated for shared decision making to form the basis for arriving at treatment decisions with patients. Proponents argue that physicians who adopt this process can maximize the value of physician-patient interactions, foster better patient and physician satisfaction, improve health outcomes, lower malpractice claims, and, above all, realize the highest ideals in the practice of medicine.


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)

► Healthcare professionals apply appropriate steps to obtain optimum informed consent.

► A discussion on the effectiveness of informed consent as representing a patient’s knowledge, understanding, and appreciation of the material risks and benefits of all treatment options should begin with patient health literacy. Health literacy refers to a patient who is sufficiently educated and informed of the most relevant risks and benefits of a proposed course of treatment in order to make a thoughtful decision about consent.38 One might describe health literacy as being concerned with the “informed” part of informed consent, requiring the abilities to read, comprehend, and analyze information; understand instructions, symbols, charts, and diagrams; appropriately weigh risks and benefits; and, ultimately, to make informed, reasoned decisions; and take action.


Indicate what this activity is designed to change.

- Designed to change competence
- Designed to change performance
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): Bioethics Committee Requested

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* 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:

- Identify what constitutes as informed consent.
- Describe the process for informed consent.
- Identify vulnerable populations and the safeguards in place to protect such individuals.
- Describe the exceptions to the requirements for obtaining informed consent.
- Apply appropriate steps to improve understanding of informed consent.

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
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

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.)

Christina Edozie, MSN, RN, CCRN
Bioethics & Patient Rights Coordinator
Homestead & West Kendall Baptist Hospitals

Shamma Legrand, MSN
Clinical Risk Manager
Homestead Hospital

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

Due to the non-clinical nature of the content discussed, the speakers have no relevant financial relationships to disclose.

*This CME activity will not cover content that would involve products or services of commercial interests. Therefore, no opportunity exists for a conflict of interest based on the financial relationships of faculty and those persons in control of content. Since these relationships are not relevant, no disclosure information was collected.*

**Non-clinical content:** All activities that are considered non-clinical must be vetted by the Department Director. If there is no opportunity to affect the content of CME concerning the products or services of a commercial interest, then there can be no relevant financial relationships or conflicts of interest. Both the following statements must apply. Reference SOP “Disclosures for Activities with Non-Clinical Content” for further instructions and necessary steps to ensure compliance.

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

**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. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.

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

(Ethos Content) You may also be interested in: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: _________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee
☐ Live Committee

APPROVED: ☐ YES ☐ NO □ Credits: AMA/PRA Category 1 Credits: #_1

Continuing Psychology Education Credits: #_1 ☐ N/A □ Continuing Dental Education Credits: #_ □ N/A

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

CME ACTIVITY TITLE: Conversations in Ethics – Providing Gender and Orientation Affirming Patient Care: Clinical Care Updates and Ethical Considerations
Research reveals health disparities when comparing heterosexual with gay, lesbian and bisexual youth and adults, as well as transgender and non-transgender populations. Gay and bisexual patients are at greater risk for cardiovascular disease, sexually transmitted diseases, obesity, and substance use. Even more dramatic health disparities, including higher incidence
of suicidal ideation and feeling rejected by healthcare providers, is found among patients who identify as intersex, transgender, or gender non-binary. What can each medical professional do to help reduce these disparities, and provide more affirming patient care, interpersonally and in the larger health system environment? How can medical professionals navigate ethical dilemmas that can arise when serving these patients? Join us as Dr. Lauren Abern, OB/GYN from Planned Parenthood of South, East, and North Florida, and Joseph Zolobczuk, MS Ed. from YES Institute, open a conversation about these topics. The presentation will include a panel of patients and their families who will share their personal experiences within healthcare settings, and engage in dialogue focused on improving care delivery and health outcomes.

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.

One of the Healthy People 2020 objectives from the Office of Disease Prevention and Health Promotion is to improve the health, safety, and well-being of individuals in the lesbian, gay, bisexual, and transgender (LGBT) population.1 This population faces health disparities with barriers to healthcare and other issues that include (but are not limited to) discrimination, social stigma, and violations of their rights. In addition, according to the National Alliance on Mental Illness, the LGBT population experiences a higher incidence of a variety of mental and physical disorders that require special attention.2 These healthcare concerns include depression, substance abuse, and sexually transmitted infections.

In order to overcome some of the identified obstacles as well as to begin to address obstacles that have not yet been identified—such as barriers to accessing healthcare services—it is necessary to create a healthcare environment that is non-judgmental and welcoming to healthcare consumers with diverse backgrounds. Healthcare professionals must develop cultural competence and sensitivity, not only for the purpose of communicating with diverse patient populations, but also to enhance their capabilities in creating policies and determining the provision of best services.

This Practice Brief provides guidance for enhanced health information management (HIM) practices not only specifically for the LGBT population but also for any of the many varieties of sexual orientation or gender identity groups.

http://bok.ahima.org/doc?oid=302067#.XUHMYrxFKiUm

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)

► As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

https://pediatrics.aappublications.org/content/142/4/e20182162.short

► One of the Healthy People 2020 objectives from the Office of Disease Prevention and Health Promotion is to improve the health, safety, and well-being of individuals in the lesbian, gay, bisexual, and transgender (LGBT) population.1 This population faces health disparities with barriers to healthcare and other issues that include (but are not limited to) discrimination, social stigma, and violations of their rights. In addition, according to the National Alliance on Mental Illness, the LGBT population experiences a higher incidence of a variety of mental and physical disorders that require special attention.2 These healthcare concerns include depression, substance abuse, and sexually transmitted infections.

In order to overcome some of the identified obstacles as well as to begin to address obstacles that have not yet been identified—such as barriers to accessing healthcare services—it is necessary to create a healthcare environment that is non-judgmental and welcoming to healthcare consumers with diverse backgrounds. Healthcare professionals must develop cultural competence and sensitivity, not only for the purpose of communicating with diverse patient populations, but also to enhance their capabilities in creating policies and determining the provision of best services.

http://bok.ahima.org/doc?oid=302067#.XUHMYrxKiUm

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 and healthcare professionals are able to identify the primary medical and mental health needs and provide optimum patient-centered care for this population of patients.
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): Bioethics Committee Requested

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* 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:

- Engage in authentic dialogue on the topic of gender and sexual orientation in medical care.
- Examine unconscious bias and assumptions in the medical care for gay, bisexual, and transgender patient populations.
- Identify the primary medical and mental health concerns for individuals and their families who are dealing with gender transitioning and sexual orientation social stigma.
- Appropriately address common ethical dilemmas that arise when serving this patient population.
- Access primary community-based, mental health, and medical resources and referrals available to youth, adults, and families in the target populations.

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.)

Lauren Abern, M.D.
Obstetrician-Gynecologist
Planned Parenthood of South, East, and North Florida
Miami, Florida
Faculty disclosure statement (as it should appear on course shell):

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- CME Activity content is non-clinical.

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. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

► ETHICAL AND MEDICAL CHALLENGES: ACCESS TO FERTILITY SERVICES BY TRANSGENDER PERSONS

DATE REVIEWED: ___________ 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


DATE: Wednesday, August 21, 2019  TIME: 5pm – 6pm  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: Baptist Hospital of Miami, Auditorium

WEBCAST: Recorded only – no live participants
TARGET AUDIENCE: Physicians, Physician Assistants, Nurse Practitioners, Nurses, Pharmacists, Nursing Students, Medical Students, and other interest healthcare professionals.

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH

CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN

CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 30 - 50

CHARGE: 0

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

- [ ] ARS
- [x] Case Studies
- [x] 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
- [x] Live activity
- [ ] Manuscript review activity
- [ ] Panel
- [ ] PI CME activity
- [x] 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.

Pain is the symptom most feared by many patients with a terminal condition. According to the World Health Organization, pain management at the end of life is the right of the patient and the duty of the clinician. However, studies have shown that many patients and families suffer from untreated pain at the end of life. The inability to effectively treat pain often results from lack of clinician training in pain and symptom management as well as fear of violating ethical, legal, and professional standards in the administration of pain management at the end of life. This workshop is coordinated to increase clinicians’ knowledge, skills, ability and comfort when caring for the dying patient from an intercultural diverse population.

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)

► Many patients and families suffer from untreated pain at the end of life. Failure to treat pain effectively can result both from a lack of clinician training in palliative care and also from the fear of violating ethical, moral, and legal tenets in the administration of pain medication to the dying patient. Clinicians often have an exaggerated perception of the risk of hastening death by treating pain with opioids. Furthermore, they are frequently unclear about the distinctions between pain management, sedation for intractable symptoms, physician-assisted dying, and euthanasia. Physicians are faced with balancing these concerns with their legal duty and moral obligation to treat pain in the suffering patient.

Studies of patients in their last week of life reveal that up to 35 percent describe pain as severe or intolerable. Quill and Brody define the escalation of pain that is uncontrolled at the end of life as a “medical emergency”. Untreated pain can be devastating to the patient and family not only because of the suffering it produces, but also because it interferes with the ability to complete many important tasks at the end of life. These tasks include, for example, getting legal affairs in order, grieving the loss of his/her life, making amends in strained relationships, and saying goodbye to loved ones.

Most clinicians agree that patients should have their pain treated at the end of life, but many do not treat this pain for fear of the legal repercussions of possibly hastening death. The Court addressed the legality of aggressive palliative care explicitly in the Vacco versus Quill ruling. Justice O’Connor states, “The parties and the amici agree that in the States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate suffering, even to the point of causing unconsciousness and hastening death”.

No legal barrier exists to treating pain; in fact, there is a legal risk to clinicians who do not effectively treat pain. In June 2001, a lawsuit was successfully prosecuted in California against a physician who inadequately treated a patient for pain. The jury decided that the doctor’s failure to treat the older man’s pain violated California’s elder abuse statute and awarded the family $1.5 million dollars.


► American Society for Pain Management Nursing and Hospice and Palliative Nurses Association’s position statement clearly states that nurses have an ethical responsibility to provide clinically excellent care to address a patient’s pain. This involves mutual identification of goals for pain management through interprofessional collaboration, and awareness of professional standards for the assessment and management of different types of pain.


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.)
DESIERED 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, advanced practice providers and nurses are knowledgeable about the various medication management for pain and other symptom management at end of life and provide optimum pain and symptom management.

► Physicians, advanced practice providers and nurses apply professional and regulatory standards of care for appropriate pain management when caring for the patient at end of life.

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
☒ Consensus of experts
☐ Disease prevention (C12)
☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics
☐ National Patient Safety Goals
☐ National/regional data
☐ New diagnostic/therapeutic modality (C12)
☐ New or updated policy/protocol
☐ Patient care data
☐ Peer review data
☐ Process improvement initiatives (C16 & 21)
☐ Regulatory requirement
☐ Research/literature review
☒ Other need identified (Explain): Gaps identified by Palliative Medicine Physicians

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* 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:

- Define the legal and ethical differences between euthanasia, physician assisted-suicide, and natural death.
- Explain how the Principle of Double Effect provides ethical consensus in the standard treatment of pain at the end of life.
- Describe the different classifications of analgesics, their indications and side-effects and determine the most effective route of medication administration for end of life pain management.
- Apply professional and regulatory standards of care for appropriate pain management when caring for the patient at end of life.

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: **Pre and Post Evaluation Questions:**

    - How confident are you in assessing end-of-life pain?
    - How confident are you in prescribing medication for end-of-life pain?

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

Brenda Daniels, M.D.
Palliative Medicine Physician
Baptist Health South Florida

Rose Allen, DNP, MSM/HM, RN, CHPN
Director, Bioethics Program
Baptist Health South Florida

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

Rose Allen, DNP, MSM/HM, RN, CHPN, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Brenda Daniels, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will include off-label or unapproved product usage in her presentation and discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ____________________________________________________________

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

► PRESCRIBING CONTROLLED SUBSTANCES

DATE REVIEWED: __________ 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

CONTINUING MEDICAL EDUCATION ACTIVITY APPLICATION

CME ACTIVITY TITLE: Providing Gender and Orientation Affirming Patient Care: Clinical Care Updates and Ethical Considerations

COURSE APPROVED: November 1, 2019   COURSE EXPIRES: November 1, 2022

CREDIT HOUR(S) APPLIED FOR: 2 Cat. 1 TBD Depend on final video length
TARGET AUDIENCE: Physicians, Physician Assistants, Nurse Practitioners, Nurses, Social Workers, Respiratory Therapists, Clinical Chaplains, Pharmacists, Medical Students, Registered Dietitians and other interest healthcare professionals. **If providing nursing credit, please secure 10 questions.**

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH

CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN, Director, Bioethics Program

CME MANAGER: Katie Deane (Live)/ Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 50-60

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
- [X] 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.

Research reveals health disparities when comparing heterosexual with gay, lesbian and bisexual youth and adults, as well as transgender and non-transgender populations. Gay and bisexual patients are at greater risk for cardiovascular disease, sexually transmitted diseases, obesity, and substance use. Even more dramatic health disparities, including higher incidence of suicidal ideation and feeling rejected by healthcare providers, is found among patients who identify as intersex, transgender, or gender non-binary. What can each medical professional do to help reduce these disparities, and provide more affirming patient care, interpersonally and in the larger health system environment? How can medical professionals navigate ethical dilemmas that can arise when serving these patients? Lauren Abern, OB/GYN from Planned Parenthood of South, East, and North Florida, and Joseph Zolobczuk, MS Ed. from YES Institute, address these topics in a presentation that will include a panel of patients and their families who will share their personal experiences within healthcare settings, and engage in dialogue focused on improving care delivery and health outcomes.
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.

One of the Healthy People 2020 objectives from the Office of Disease Prevention and Health Promotion is to improve the health, safety, and well-being of individuals in the lesbian, gay, bisexual, and transgender (LGBT) population.¹ This population faces health disparities with barriers to healthcare and other issues that include (but are not limited to) discrimination, social stigma, and violations of their rights. In addition, according to the National Alliance on Mental Illness, the LGBT population experiences a higher incidence of a variety of mental and physical disorders that require special attention.² These healthcare concerns include depression, substance abuse, and sexually transmitted infections.

In order to overcome some of the identified obstacles as well as to begin to address obstacles that have not yet been identified—such as barriers to accessing healthcare services—it is necessary to create a healthcare environment that is non-judgmental and welcoming to healthcare consumers with diverse backgrounds. Healthcare professionals must develop cultural competence and sensitivity, not only for the purpose of communicating with diverse patient populations, but also to enhance their capabilities in creating policies and determining the provision of best services.

This Practice Brief provides guidance for enhanced health information management (HIM) practices not only specifically for the LGBT population but also for any of the many varieties of sexual orientation or gender identity groups.

http://bok.ahima.org/doc?oid=302067#.XUHMYrxKiUm

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)

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 and healthcare professionals are able to identify the primary medical and mental health needs and provide optimum patient-centered care for this population of patients.

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): Bioethics Committee Requested
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

► As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

https://pediatrics.aappublications.org/content/142/4/e20182162.short

► One of the Healthy People 2020 objectives from the Office of Disease Prevention and Health Promotion is to improve the health, safety, and well-being of individuals in the lesbian, gay, bisexual, and transgender (LGBT) population. This population faces health disparities with barriers to healthcare and other issues that include (but are not limited to) discrimination, social stigma, and violations of their rights. In addition, according to the National Alliance on Mental Illness, the LGBT population experiences a higher incidence of a variety of mental and physical disorders that require special attention. These healthcare concerns include depression, substance abuse, and sexually transmitted infections.

In order to overcome some of the identified obstacles as well as to begin to address obstacles that have not yet been identified—such as barriers to accessing healthcare services—it is necessary to create a healthcare environment that is non-judgmental and welcoming to healthcare consumers with diverse backgrounds. Healthcare professionals must develop cultural competence and sensitivity, not only for the purpose of communicating with diverse patient populations, but also to enhance their capabilities in creating policies and determining the provision of best services.


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:

- Engage in authentic dialogue on the topic of gender and sexual orientation in medical care.
- Examine unconscious bias and assumptions in the medical care for gay, bisexual, and transgender patient populations.
- Identify the primary medical and mental health concerns for individuals and their families who are dealing with gender transitioning and sexual orientation social stigma.
- Appropriately address common ethical dilemmas that arise when serving this patient population.
- Access primary, community-based, mental health, and medical resources and referrals available to youth, adults, and families in the target populations.

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.)

Lauren Abern, M.D.
Obstetrician-Gynecologist
Planned Parenthood of South, East, and North Florida
Miami, Florida

Joseph Zolobczuk, MS Ed.
Executive Director of Education
YES Institute
Miami, Florida

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

Due to the non-clinical nature of the content discussed, the speakers have no relevant financial relationships to disclose.

This CME activity will not cover content that would involve products or services of commercial interests. Therefore, no opportunity exists for a conflict of interest based on the financial relationships of faculty and those persons in control of content. Since these relationships are not relevant, no disclosure information was collected.

Non-clinical content: All activities that are considered non-clinical must be vetted by the Department Director. If there is no opportunity to affect the content of CME concerning the products or services of a commercial interest, then there can be no relevant financial relationships or conflicts of interest. Both the following statements must apply. Reference SOP “Disclosures for Activities with Non-Clinical Content” for further instructions and necessary steps to ensure compliance.

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

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. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

► ETHICAL AND MEDICAL CHALLENGES: ACCESS TO FERTILITY SERVICES BY TRANSGENDER PERSONS

External:

Provider: 2019IEM173

Course video:

Course handout:

Quiz Questions

DATE REVIEWED: ___________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee

☐ Live Committee

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

COURSE APPROVED: September 1, 2019  COURSE EXPIRES: September 1, 2022

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

TARGET AUDIENCE: Physicians, Physician Assistants, Nurse Practitioners, Nurses, Pharmacists, Nursing Students, Medical Students, and other interest healthcare professionals.

If seeking nursing credits, need 10 questions.

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH
CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN
CME MANAGER: Katie Deane (Live)/ Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 30 - 50  CHARGE: 0

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

- ARS  - Internet Live Course (Live Webcast)
- Case Studies  - Internet point-of-care activity
- Didactic Lecture  - Journal-based CME activity
- Enduring Material (DVD/Booklet)  - Learning from Teaching
- Internet Activity Enduring Material  - 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.*

Pain is the symptom most feared by many patients with a terminal condition. According to the World Health Organization, pain management at the end of life is the right of the patient and the duty of the clinician. However, studies have shown that many patients and families suffer from untreated pain at the end of life. The inability to effectively treat pain often results from lack of clinician training in pain and symptom management as well as fear of violating ethical, legal, and professional standards in the administration of pain management at the end of life. This course will increase clinicians’ knowledge, skills, ability and comfort when caring for the dying patient from an intercultural diverse population.

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)

► Practitioners may not feel confident in their ability to address end of life palliative pain and symptom 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.)

**DESIRMED 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, advanced practice providers and nurses are knowledgeable about the various medication management for pain and other symptom management at end of life and provide optimum pain and symptom management.

► Physicians, advanced practice providers and nurses apply professional and regulatory standards of care for appropriate pain management when caring for the patient at end of life.

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
- □ Consensus of experts
- □ Joint Commission initiatives (C12)
- □ National Patient Safety Goals
- □ New diagnostic/therapeutic modality (C12)
- □ Patient care data
- □ Process improvement initiatives (C16 & 21)
- □ Research/literature review
- □ Other need identified (Explain): Gaps identified by Palliative Medicine Physicians
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

Many patients and families suffer from untreated pain at the end of life. Failure to treat pain effectively can result both from a lack of clinician training in palliative care and also from the fear of violating ethical, moral, and legal tenets in the administration of pain medication to the dying patient. Clinicians often have an exaggerated perception of the risk of hastening death by treating pain with opioids. Furthermore, they are frequently unclear about the distinctions between pain management, sedation for intractable symptoms, physician-assisted dying, and euthanasia. Physicians are faced with balancing these concerns with their legal duty and moral obligation to treat pain in the suffering patient.

Studies of patients in their last week of life reveal that up to 35 percent describe pain as severe or intolerable. Quill and Brody define the escalation of pain that is uncontrolled at the end of life as a “medical emergency”. Untreated pain can be devastating to the patient and family not only because of the suffering it produces, but also because it interferes with the ability to complete many important tasks at the end of life. These tasks include, for example, getting legal affairs in order, grieving the loss of his/her life, making amends in strained relationships, and saying goodbye to loved ones.

Most clinicians agree that patients should have their pain treated at the end of life, but many do not treat this pain for fear of the legal repercussions of possibly hastening death. The Court addressed the legality of aggressive palliative care explicitly in the Vacco versus Quill ruling. Justice O’Connor states, “The parties and the amici agree that in the States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate suffering, even to the point of causing unconsciousness and hastening death”.

No legal barrier exists to treating pain; in fact, there is a legal risk to clinicians who do not effectively treat pain. In June 2001, a lawsuit was successfully prosecuted in California against a physician who inadequately treated a patient for pain. The jury decided that the doctor’s failure to treat the older man’s pain violated California’s elder abuse statute and awarded the family $1.5 million dollars.


American Society for Pain Management Nursing and Hospice and Palliative Nurses Association’s position statement clearly states that nurses have an ethical responsibility to provide clinically excellent care to address a patient’s pain. This involves mutual identification of goals for pain management through interprofessional collaboration, and awareness of professional standards for the assessment and management of different types of pain.


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:

- Define the legal and ethical differences between euthanasia, physician assisted-suicide, and natural death.
- Explain how the Principle of Double Effect provides ethical consensus in the standard treatment of pain at the end of life.
- Differentiate between the classifications of analgesics, their indications and side-effects and determine the most effective route of medication administration for end of life pain management.
- Adhere to professional and regulatory standards of care for appropriate pain management when caring for the patient at end of life.

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: **Pre and Post Evaluation Questions:** Pre course survey for online.
- How confident are you in assessing end-of-life pain?
- How confident are you in prescribing medication for end-of-life pain?

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

Brenda Daniels, M.D.
Palliative Medicine Physician
Baptist Health South Florida
Rose Allen, DNP, MSM/HM, RN, CHPN  
Director, Bioethics Program  
Baptist Health South Florida  

Faculty disclosure statement (as it should appear on course shell):  
Rose Allen, DNP, MSM/HM, RN, CHPN, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Brenda Daniels, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will include off-label or unapproved product usage in her presentation and discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. __ This course is planned in collaboration with the Palliative Care department and is part of a larger initiative addressing end of life pain. 

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

► PRESCRIBING CONTROLLED SUBSTANCES

External:

Provider: 2019IEM174

Course video:

Course handout:

Quiz Questions

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<td>Continuing Psychology Education Credits: # □ N/A</td>
<td>Continuing Dental Education Credits: # □ N/A</td>
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CME ACTIVITY TITLE: Developing a Comprehensive Complex Spine Surgery Program

DATE: August 26, 2019  TIME: 12 – 1 p.m.  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: 5 MCVI (Both Sides)


CONFERENCE DIRECTOR: Felipe de los Rios de la Rosa, M.D.  CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 25-30  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
- [x] 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 underlying pathology and thus the indication for surgery will dictate the urgency of proceeding to the operating room. Dr. Raul A. Vasquez will review the history and evolution of the spine anatomy. Participants will understand the pathophysiology of adult spinal deformity.

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 may not be aware of when to implement diagnostic and therapeutic procedures for low back pain.

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 monitor spine surgery before and after implementation of a surgery treatment plan.

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:

Value in health care is defined as the quotient of outcomes to cost. Both pediatric and adult spinal deformity surgeries are among the most expensive procedures offered today. With high variability in both outcomes and costs in spine surgery today, surgeons will be expected to consider long-term cost effectiveness when comparing treatment options. Without surgeon leadership in this arena, suboptimal solutions may result from the isolated intervention of regulatory bodies or payer groups. The cooperative development of standardized, team-based approaches in complex spine surgery will lead to the high-quality, high-value care for patients.

Spine Deformity. 7(2):228-235, 2019 03.
http://ovidsp dc2.ovid.com/sp-4.01.0a/ovidweb.cgi?&S=FKKPFPQOBEBNKNLPGKJGOGNPOAA00&Complete+Reference=S.sh.24%7c11%7c1&Counter5=SS_view_refound_complete%7c30660216%7cmedf%7cmedline%7cmedl&Counter5Data=30660216%7cmedf%7cmedline%7cmedl

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:

- Assess the pathophysiology of adult spinal deformity.
- Implement treatment plans for spine tumor surgery and explore non-operative management options for spine surgery.
- Discuss the future of spine surgery.

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.)

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

Raul A. Vasquez, M.D.
Director of Complex Spine Neurosurgery
Miami Cancer and Vascular Institute

Raul S. Vasquez, M.D. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ____________________________________________________________

Currently, Baptist Hospital Neuroscience Center continues to collaborate as a system to implement Primary Stroke Center requirements at other BHSF entities. The BHSF Stroke Committee meets bi-monthly to discuss goals and progress on initiative implementation as we partner with EMS Miami-Dade Stroke Coalition as well. As the neuroscience services continue to grow, we will maintain partnership with multidisciplinary departments to enhance quality patient experience and outcomes.
COMMERCIAL SUPPORT: □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: __________ REVIEWED BY: □ Accelerated Approval □ Executive Committee □ Live Committee

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

CME ACTIVITY TITLE: MCI Multispecialty Grand Rounds: The Role of Rehabilitation Medicine in Improving the Quality of Life for Persons with Cancer

DATE: September 9, 2019 TIME: 7:30 – 8:30 a.m. CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: MCI Tumor Board Conference Room – 3N 110

TARGET AUDIENCE: Oncologists, Radiation Oncologists, Hematology Oncologists, Radiation Therapists, General Surgeons, General Practitioners, Obstetrics and Gynecologists, Oncologists, Radiation Oncologists, Nurses, Social Workers, Patient Navigators and all other interested healthcare professionals.

CONFERENCE DIRECTOR: Guillerme Rabinowits, M.D CME MANAGER: Eleanor Abreu
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

EXPECTED NUMBER OF ATTENDEES: 30-40 CHARGE: 0

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

☐ ARS  ☑ Case Studies  ☐ Manuscript review activity
☑ Didactic Lecture  ☐ Panel
☐ Enduring Material (DVD/Booklet)  ☐ PI CME activity
☐ Internet Activity Enduring Material  ☐ Question & 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 that keyword searches will pull from this description.

Exercise and the rehabilitation process can play many roles for the cancer survivor. Despite the many benefits of physical therapy it is often underutilized in an oncology setting. During this conference, Dr. Cristian will describe treatments commonly used for cancer related impairments. Participants will also learn key features of frailty in cancer patients and the impact on cancer care as well as role of rehabilitation medicine in minimizing the impact of frailty.

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 may not be aware of the different impairments associated with specific types of cancer and their treatment.

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 refer patients at high risk for developing cancer-related impairments to rehabilitation medicine early to minimize the impact on the quality of life for the person with cancer.

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
☒ 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 rehabilitation and prehabilitation has grown significantly over the past decade. Advancements in early detection and treatment have resulted in a growing number of cancer survivors in the United States (US), expected to reach 26 million by 2040.¹ Health care professional graduate education is trying to catch up with anticipated clinical demand by increasing the number of cancer rehabilitation fellowship training programs and introducing rehabilitation/prehabilitation concepts earlier in training. Numerous national organizations have issued guidelines for cancer rehabilitation research and posttreatment cancer health care.

J Cancer Rehabil. Author manuscript; available in PMC 2019 Mar 13.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6415687/

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:

• Identify the types of impairments commonly associated with specific typed of cancer.
• Assess patients implementing the “cascade of disability” method seen in cancer patients and the impact of their quality of life.

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.)

Faculty disclosure statement (as it should appear on course shell):
Adrian Cristian, M.D., MCHM
Chief, Cancer Rehabilitation Medicine
Miami Cancer Institute

Adrian Cristian, M.D., MCHM indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ________________________________

COMMERCIAL SUPPORT: ☐ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.
You may also be interested in: List names of up to two courses with similar target audiences. Please list complete course title.

Date Reviewed: ________  Reviewed by: □ Accelerated Approval  □ Executive Committee  □ Live Committee

Approved: □ YES  □ NO  □ Credits: AMA/PRA Category 1 Credits: # __

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

CME Activity Title: Conversations in Ethics – Ethical Challenges with Informed Consent

Date: Friday, September 27, 2019  Time: 12 noon – 1 p.m.  Credit Hour(s) Applied For: 1 Cat. 1

Location: HH Auditorium

Video Conferenced: BHM 5 MCVI Side-A; SMH Cl-F; MH Exec. Conf. Rm

Live Webcast

Target Audience: Physicians, Psychologists, Physician Assistants, Nurse Practitioners, Nurses, Social Workers, Respiratory Therapists, Clinical Chaplains, Pharmacists, Medical Students, Registered Dietitians and other interest healthcare professionals.

Conference Director: Ana Viamonte-Ros, MD, MPH

Conference Coordinator: Rose Allen, DNP, MSM/HM, RN, CHPN, Director, Bioethics Program

CME Manager: Katie Deane
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

EXPECTED NUMBER OF ATTENDEES: 50-60

CHARGE: 0

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 & 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 that keyword searches will pull from this description.

Informed consent is a process that begins when a patient consents to treatment on admission. Historically, informed consent had been influenced by an interpretation of informed decision making as a legal obligation in which the emphasis is full disclosure, rather than an ethical obligation toward mutual decision making by fostering understanding. Recently, the imperative has emerged to reassess and reevaluate how treatment decisions are made between physicians and patients to help improve patient and family outcomes. The healthcare team, patient, and family are sometimes faced with challenges in this process. Join us as we discuss what informed consent means, the process, challenges we face, and give some examples of previous cases and the outcomes while maintaining confidentiality.

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)

► In an era of health system reform, the imperative has emerged to reassess and reevaluate how treatment decisions are made between physician and patient. Numerous studies have demonstrated that current informed consent practices do not adequately serve either patients or physicians, and the increasing focus on patient-centered health care in the medical community has prompted a movement for tangible change. In the past few decades, ethicists and physicians have advocated for shared decision making to form the basis for arriving at treatment decisions with patients. Proponents argue that physicians who adopt this process can maximize the value of physician-patient interactions, foster better patient and physician satisfaction, improve health outcomes, lower malpractice claims, and, above all, realize the highest ideals in the practice of medicine.


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)

► Healthcare professionals apply appropriate steps to obtain optimum informed consent.

► A discussion on the effectiveness of informed consent as representing a patient’s knowledge, understanding, and appreciation of the material risks and benefits of all treatment options should begin with patient health literacy. Health literacy refers to a patient who is sufficiently educated and informed of the most relevant risks and benefits of a proposed course of treatment in order to make a thoughtful decision about consent.38 One might describe health literacy as being concerned with the “informed” part of informed consent, requiring the abilities to read, comprehend, and analyze information; understand instructions, symbols, charts, and diagrams; appropriately weigh risks and benefits; and, ultimately, to make informed, reasoned decisions; and take action.


Indicate what this activity is designed to change.

☒ Designed to change competence
☐ Designed to change performance
Design 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): Bioethics Committee Requested

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* 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:

- Identify what constitutes as informed consent.
- Describe the process for informed consent.
- Identify vulnerable populations and the safeguards in place to protect such individuals.
- Describe the exceptions to the requirements for obtaining informed consent.
- Apply appropriate steps to improve understanding of informed consent

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.)

Christina Edozie, MSN, RN, CCRN
Bioethics & Patient Rights Coordinator
Homestead & West Kendall Baptist Hospitals

Shamma Legrand, MSN
Clinical Risk Manager
Homestead Hospital

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

Due to the non-clinical nature of the content discussed, the speakers have no relevant financial relationships to disclose.

This CME activity will not cover content that would involve products or services of commercial interests. Therefore, no opportunity exists for a conflict of interest based on the financial relationships of faculty and those persons in control of content. Since these relationships are not relevant, no disclosure information was collected.

<table>
<thead>
<tr>
<th>Non-clinical content: All activities that are considered non-clinical must be vetted by the Department Director. If there is no opportunity to affect the content of CME concerning the products or services of a commercial interest, then there can be no relevant financial relationships or conflicts of interest. Both the following statements must apply. Reference SOP “Disclosures for Activities with Non-Clinical Content” for further instructions and necessary steps to ensure compliance.</th>
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</table>

**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. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: ________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee  
☐ Live Committee

APPROVED: ☐ YES ☐ NO □ Credits: AMA/PRA Category 1 Credits: # _1

Continuing Psychology Education Credits: # _1 ☐ N/A □   Continuing Dental Education Credits: # ___ ☐ N/A

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

CME ACTIVITY TITLE: Conversations in Ethics – Providing Gender and Orientation Affirming Patient Care: Clinical Care Updates and Ethical Considerations
DATE: Wednesday, October 23, 2019     TIME: 6pm – 8pm     CREDIT HOUR(S) APPLIED FOR: 2 Cat. 1

LOCATION: BHM 5 MCVI

VIDEO CONFERENCED: WKBH West Wing Conference A & B., MH- Exec. Conf. Rm; SMH Cl. F

LIVE & RECORDED WBECAST

TARGET AUDIENCE: Physicians, Psychologists, Physician Assistants, Nurse Practitioners, Nurses, Social Workers, Respiratory Therapists, Clinical Chaplains, Pharmacists, Medical Students, Registered Dietitians and other interest healthcare professionals.

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH

CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN, Director, Bioethics Program

CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 50-60     CHARGE: 0

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

☐ARS      ☑Live activity
☐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
☐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.

Research reveals health disparities when comparing heterosexual with gay, lesbian and bisexual youth and adults, as well as transgender and non-transgender populations. Gay and bisexual patients are at greater risk for cardiovascular disease, sexually transmitted diseases, obesity, and substance use. Even more dramatic health disparities, including higher incidence
of suicidal ideation and feeling rejected by healthcare providers, is found among patients who identify as intersex, transgender, or gender non-binary. What can each medical professional do to help reduce these disparities, and provide more affirming patient care, interpersonally and in the larger health system environment? How can medical professionals navigate ethical dilemmas that can arise when serving these patients? Join us as Dr. Lauren Abern, OB/GYN from Planned Parenthood of South, East, and North Florida, and Joseph Zolobczuk, MS Ed. from YES Institute, open a conversation about these topics. The presentation will include a panel of patients and their families who will share their personal experiences within healthcare settings, and engage in dialogue focused on improving care delivery and health outcomes.

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.

One of the Healthy People 2020 objectives from the Office of Disease Prevention and Health Promotion is to improve the health, safety, and well-being of individuals in the lesbian, gay, bisexual, and transgender (LGBT) population. This population faces health disparities with barriers to healthcare and other issues that include (but are not limited to) discrimination, social stigma, and violations of their rights. In addition, according to the National Alliance on Mental Illness, the LGBT population experiences a higher incidence of a variety of mental and physical disorders that require special attention. These healthcare concerns include depression, substance abuse, and sexually transmitted infections.

In order to overcome some of the identified obstacles as well as to begin to address obstacles that have not yet been identified—such as barriers to accessing healthcare services—it is necessary to create a healthcare environment that is non-judgmental and welcoming to healthcare consumers with diverse backgrounds. Healthcare professionals must develop cultural competence and sensitivity, not only for the purpose of communicating with diverse patient populations, but also to enhance their capabilities in creating policies and determining the provision of best services.

This Practice Brief provides guidance for enhanced health information management (HIM) practices not only specifically for the LGBT population but also for any of the many varieties of sexual orientation or gender identity groups.

http://bok.ahima.org/doc?oid=302067#.XUHMxYxKiUUm

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)

► As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

https://pediatrics.aappublications.org/content/142/4/e20182162.short

► One of the Healthy People 2020 objectives from the Office of Disease Prevention and Health Promotion is to improve the health, safety, and well-being of individuals in the lesbian, gay, bisexual, and transgender (LGBT) population. This population faces health disparities with barriers to healthcare and other issues that include (but are not limited to) discrimination, social stigma, and violations of their rights. In addition, according to the National Alliance on Mental Illness, the LGBT population experiences a higher incidence of a variety of mental and physical disorders that require special attention. These healthcare concerns include depression, substance abuse, and sexually transmitted infections.

In order to overcome some of the identified obstacles as well as to begin to address obstacles that have not yet been identified—such as barriers to accessing healthcare services—it is necessary to create a healthcare environment that is non-judgmental and welcoming to healthcare consumers with diverse backgrounds. Healthcare professionals must develop cultural competence and sensitivity, not only for the purpose of communicating with diverse patient populations, but also to enhance their capabilities in creating policies and determining the provision of best services.

http://bok.ahima.org/doc?oid=302067#.XUHMYrxKiUm

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 and healthcare professionals are able to identify the primary medical and mental health needs and provide optimum patient-centered care for this population of patients.
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): Bioethics Committee Requested

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* 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:

- Engage in authentic dialogue on the topic of gender and sexual orientation in medical care.
- Examine unconscious bias and assumptions in the medical care for gay, bisexual, and transgender patient populations.
- Identify the primary medical and mental health concerns for individuals and their families who are dealing with gender transitioning and sexual orientation social stigma.
- Appropriately address common ethical dilemmas that arise when serving this patient population.
- Access primary community-based, mental health, and medical resources and referrals available to youth, adults, and families in the target populations.

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.)
Lauren Abern, M.D.
Obstetrician-Gynecologist
Planned Parenthood of South, East, and North Florida
Miami, Florida
Faculty disclosure statement (as it should appear on course shell):

Due to the non-clinical nature of the content discussed, the speakers have no relevant financial relationships to disclose.

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

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. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

► ETHICAL AND MEDICAL CHALLENGES: ACCESS TO FERTILITY SERVICES BY TRANSGENDER PERSONS

DATE REVIEWED:  REVIEWED BY:  □  Accelerated Approval  □  Executive Committee

□  Live Committee

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

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


DATE:  Wednesday, August 21, 2019  TIME:  5pm – 6pm  CREDIT HOUR(S) APPLIED FOR:  1 Cat. 1

LOCATION:  Baptist Hospital of Miami, Auditorium

WEBCAST:  Recorded only – no live participants

TARGET AUDIENCE:  Physicians, Physician Assistants, Nurse Practitioners, Nurses, Pharmacists, Nursing Students, Medical Students, and other interest healthcare professionals.
CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH
CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN
CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 30 - 50
CHARGE: 0

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

- [ ] ARS
- [x] Case Studies
- [x] 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
- [x] Live activity
- [ ] Manuscript review activity
- [ ] Panel
- [ ] PI CME activity
- [x] Question & Answer
- [ ] Regularly Scheduled Series
- [ ] Simulation
- [ ] Test item writing activity
- [ ] Other (specify)
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

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

Pain is the symptom most feared by many patients with a terminal condition. According to the World Health Organization, pain management at the end of life is the right of the patient and the duty of the clinician. However, studies have shown that many patients and families suffer from untreated pain at the end of life. The inability to effectively treat pain often results from lack of clinician training in pain and symptom management as well as fear of violating ethical, legal, and professional standards in the administration of pain management at the end of life. This workshop is coordinated to increase clinicians’ knowledge, skills, ability and comfort when caring for the dying patient from an intercultural diverse population.

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)

► Many patients and families suffer from untreated pain at the end of life. Failure to treat pain effectively can result both from a lack of clinician training in palliative care and also from the fear of violating ethical, moral, and legal tenets in the administration of pain medication to the dying patient. Clinicians often have an exaggerated perception of the risk of hastening death by treating pain with opioids. Furthermore, they are frequently unclear about the distinctions between pain management, sedation for intractable symptoms, physician-assisted dying, and euthanasia. Physicians are faced with balancing these concerns with their legal duty and moral obligation to treat pain in the suffering patient.

Studies of patients in their last week of life reveal that up to 35 percent describe pain as severe or intolerable. Quill and Brody define the escalation of pain that is uncontrolled at the end of life as a “medical emergency”. Untreated pain can be devastating to the patient and family not only because of the suffering it produces, but also because it interferes with the ability to complete many important tasks at the end of life. These tasks include, for example, getting legal affairs in order, grieving the loss of his/her life, making amends in strained relationships, and saying goodbye to loved ones.

Most clinicians agree that patients should have their pain treated at the end of life, but many do not treat this pain for fear of the legal repercussions of possibly hastening death. The Court addressed the legality of aggressive palliative care explicitly in the Vacco versus Quill ruling. Justice O’Connor states, “The parties and the amici agree that in the States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate suffering, even to the point of causing unconsciousness and hastening death”.

No legal barrier exists to treating pain; in fact, there is a legal risk to clinicians who do not effectively treat pain. In June 2001, a lawsuit was successfully prosecuted in California against a physician who inadequately treated a patient for pain. The jury decided that the doctor’s failure to treat the older man’s pain violated California’s elder abuse statute and awarded the family $1.5 million dollars.


► American Society for Pain Management Nursing and Hospice and Palliative Nurses Association’s position statement clearly states that nurses have an ethical responsibility to provide clinically excellent care to address a patient’s pain. This involves mutual identification of goals for pain management through interprofessional collaboration, and awareness of professional standards for the assessment and management of different types of pain.


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, advanced practice providers and nurses are knowledgeable about the various medication management for pain and other symptom management at end of life and provide optimum pain and symptom management.

► Physicians, advanced practice providers and nurses apply professional and regulatory standards of care for appropriate pain management when caring for the patient at end of life.

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       ☑ Consensus of experts
☐ Disease prevention (C12)      ☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics ☐ National Patient Safety Goals
☐ National/regional data        ☐ New diagnostic/therapeutic modality (C12)
☐ New or updated policy/protocol ☐ Patient care data
☐ Peer review data              ☐ Process improvement initiatives (C16 & 21)
☐ Regulatory requirement        ☐ Research/literature review

☑ Other need identified (Explain): Gaps identified by Palliative Medicine Physicians

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* 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:

- Define the legal and ethical differences between euthanasia, physician assisted-suicide, and natural death.
- Explain how the Principle of Double Effect provides ethical consensus in the standard treatment of pain at the end of life.
- Describe the different classifications of analgesics, their indications and side-effects and determine the most effective route of medication administration for end of life pain management.
- Apply professional and regulatory standards of care for appropriate pain management when caring for the patient at end of life.

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: Pre and Post Evaluation Questions:

- How confident are you in assessing end-of-life pain?
- How confident are you in prescribing medication for end-of-life pain?

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

Brenda Daniels, M.D.
Palliative Medicine Physician
Baptist Health South Florida

Rose Allen, DNP, MSM/HM, RN, CHPN
Director, Bioethics Program
Baptist Health South Florida

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

Rose Allen, DNP, MSM/HM, RN, CHPN, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Brenda Daniels, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will include off-label or unapproved product usage in her presentation and discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ________________________________________________________________

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

► PRESCRIBING CONTROLLED SUBSTANCES

DATE REVIEWED: __________  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

CME ACTIVITY TITLE: Providing Gender and Orientation Affirming Patient Care: Clinical Care Updates and Ethical Considerations

COURSE APPROVED: November 1, 2019  COURSE EXPIRES: November 1, 2022

CREDIT HOUR(S) APPLIED FOR: 2 Cat. 1  TBD Depend on final video length
TARGET AUDIENCE: Physicians, Physician Assistants, Nurse Practitioners, Nurses, Social Workers, Respiratory Therapists, Clinical Chaplains, Pharmacists, Medical Students, Registered Dietitians and other interest healthcare professionals. **If providing nursing credit, please secure 10 questions.**

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH

CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN, Director, Bioethics Program

CME MANAGER: Katie Deane (Live)/ Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 50-60  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)

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

Research reveals health disparities when comparing heterosexual with gay, lesbian and bisexual youth and adults, as well as transgender and non-transgender populations. Gay and bisexual patients are at greater risk for cardiovascular disease, sexually transmitted diseases, obesity, and substance use. Even more dramatic health disparities, including higher incidence of suicidal ideation and feeling rejected by healthcare providers, is found among patients who identify as intersex, transgender, or gender non-binary. What can each medical professional do to help reduce these disparities, and provide more affirming patient care, interpersonally and in the larger health system environment? How can medical professionals navigate ethical dilemmas that can arise when serving these patients? Lauren Abern, OB/GYN from Planned Parenthood of South, East, and North Florida, and Joseph Zolobczuk, MS Ed. from YES Institute, address these topics in a presentation that will include a panel of patients and their families who will share their personal experiences within healthcare settings, and engage in dialogue focused on improving care delivery and health outcomes.

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)
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

Form Rev. 030316

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.

One of the Healthy People 2020 objectives from the Office of Disease Prevention and Health Promotion is to improve the health, safety, and well-being of individuals in the lesbian, gay, bisexual, and transgender (LGBT) population.¹ This population faces health disparities with barriers to healthcare and other issues that include (but are not limited to) discrimination, social stigma, and violations of their rights. In addition, according to the National Alliance on Mental Illness, the LGBT population experiences a higher incidence of a variety of mental and physical disorders that require special attention.² These healthcare concerns include depression, substance abuse, and sexually transmitted infections.

In order to overcome some of the identified obstacles as well as to begin to address obstacles that have not yet been identified—such as barriers to accessing healthcare services—it is necessary to create a healthcare environment that is non-judgmental and welcoming to healthcare consumers with diverse backgrounds. Healthcare professionals must develop cultural competence and sensitivity, not only for the purpose of communicating with diverse patient populations, but also to enhance their capabilities in creating policies and determining the provision of best services.

This Practice Brief provides guidance for enhanced health information management (HIM) practices not only specifically for the LGBT population but also for any of the many varieties of sexual orientation or gender identity groups.

http://bok.ahima.org/doc?oid=302067#.XUHMYrxxKiUm

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)

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 and healthcare professionals are able to identify the primary medical and mental health needs and provide optimum patient-centered care for this population of patients.

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): Bioethics Committee Requested
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

► As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

https://pediatrics.aappublications.org/content/142/4/e20182162.short

► One of the Healthy People 2020 objectives from the Office of Disease Prevention and Health Promotion is to improve the health, safety, and well-being of individuals in the lesbian, gay, bisexual, and transgender (LGBT) population.1 This population faces health disparities with barriers to healthcare and other issues that include (but are not limited to) discrimination, social stigma, and violations of their rights. In addition, according to the National Alliance on Mental Illness, the LGBT population experiences a higher incidence of a variety of mental and physical disorders that require special attention.2 These healthcare concerns include depression, substance abuse, and sexually transmitted infections.

In order to overcome some of the identified obstacles as well as to begin to address obstacles that have not yet been identified—such as barriers to accessing healthcare services—it is necessary to create a healthcare environment that is non-judgmental and welcoming to healthcare consumers with diverse backgrounds. Healthcare professionals must develop cultural competence and sensitivity, not only for the purpose of communicating with diverse patient populations, but also to enhance their capabilities in creating policies and determining the provision of best services.


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:

- Engage in authentic dialogue on the topic of gender and sexual orientation in medical care.
- Examine unconscious bias and assumptions in the medical care for gay, bisexual, and transgender patient populations.
- Identify the primary medical and mental health concerns for individuals and their families who are dealing with gender transitioning and sexual orientation social stigma.
- Appropriately address common ethical dilemmas that arise when serving this patient population.
- Access primary, community-based, mental health, and medical resources and referrals available to youth, adults, and families in the target populations.

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.)

Lauren Abern, M.D.
Obstetrician-Gynecologist
Planned Parenthood of South, East, and North Florida
Miami, Florida

Joseph Zolobczuk, MS Ed.
Executive Director of Education
YES Institute
Miami, Florida

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

Due to the non-clinical nature of the content discussed, the speakers have no relevant financial relationships to disclose.

This CME activity will not cover content that would involve products or services of commercial interests. Therefore, no opportunity exists for a conflict of interest based on the financial relationships of faculty and those persons in control of content. Since these relationships are not relevant, no disclosure information was collected.

Non-clinical content: All activities that are considered non-clinical must be vetted by the Department Director. If there is no opportunity to affect the content of CME concerning the products or services of a commercial interest, then there can be no relevant financial relationships or conflicts of interest. Both the following statements must apply. Reference SOP “Disclosures for Activities with Non-Clinical Content” for further instructions and necessary steps to ensure compliance.

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

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. The CME Department and the BHSF Bioethics Committee collaborate to improve healthcare provider competencies and practice by addressing areas of ethical concern or interest (as determined by the Bioethics Committee) through compelling and engaging continuing education activities.

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

(EThos CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

► ETHICAL AND MEDICAL CHALLENGES: ACCESS TO FERTILITY SERVICES BY TRANSGENDER PERSONS

External:

Provider: 2019IEM173

Course video:

Course handout:

Quiz Questions

DATE REVIEWED: ___________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee

☐ Live Committee

APPROVED: ☐ YES ☐ NO  Credits: AMA/PRA Category 1 Credits: # _1

COURSE APPROVED: September 1, 2019 COURSE EXPIRES: September 1, 2022

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

TARGET AUDIENCE: Physicians, Physician Assistants, Nurse Practitioners, Nurses, Pharmacists, Nursing Students, Medical Students, and other interest healthcare professionals.

If seeking nursing credits, need 10 questions.

CONFERENCE DIRECTOR: Ana Viamonte-Ros, MD, MPH
CONFERENCE COORDINATOR: Rose Allen, DNP, MSM/HM, RN, CHPN
CME MANAGER: Katie Deane (Live)/ Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 30 - 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)
- [x] 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.*

Pain is the symptom most feared by many patients with a terminal condition. According to the World Health Organization, pain management at the end of life is the right of the patient and the duty of the clinician. However, studies have shown that many patients and families suffer from untreated pain at the end of life. The inability to effectively treat pain often results from lack of clinician training in pain and symptom management as well as fear of violating ethical, legal, and professional standards in the administration of pain management at the end of life. This course will increase clinicians’ knowledge, skills, ability and comfort when caring for the dying patient from an intercultural diverse population.

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)
► Practitioners may not feel confident in their ability to address end of life palliative pain and symptom 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.)

DESIRE 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, advanced practice providers and nurses are knowledgeable about the various medication management for pain and other symptom management at end of life and provide optimum pain and symptom management.
► Physicians, advanced practice providers and nurses apply professional and regulatory standards of care for appropriate pain management when caring for the patient at end of life.

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
☐ Consensus of experts
☐ Joint Commission initiatives (C12)
☐ National Patient Safety Goals
☐ New diagnostic/therapeutic modality (C12)
☐ Patient care data
☐ Process improvement initiatives (C16 & 21)
☐ Research/literature review
✓ Other need identified (Explain): Gaps identified by Palliative Medicine Physicians
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

Many patients and families suffer from untreated pain at the end of life. Failure to treat pain effectively can result both from a lack of clinician training in palliative care and also from the fear of violating ethical, moral, and legal tenets in the administration of pain medication to the dying patient. Clinicians often have an exaggerated perception of the risk of hastening death by treating pain with opioids. Furthermore, they are frequently unclear about the distinctions between pain management, sedation for intractable symptoms, physician-assisted dying, and euthanasia. Physicians are faced with balancing these concerns with their legal duty and moral obligation to treat pain in the suffering patient.

Studies of patients in their last week of life reveal that up to 35 percent describe pain as severe or intolerable. Quill and Brody define the escalation of pain that is uncontrolled at the end of life as a “medical emergency”. Untreated pain can be devastating to the patient and family not only because of the suffering it produces, but also because it interferes with the ability to complete many important tasks at the end of life. These tasks include, for example, getting legal affairs in order, grieving the loss of his/her life, making amends in strained relationships, and saying goodbye to loved ones.

Most clinicians agree that patients should have their pain treated at the end of life, but many do not treat this pain for fear of the legal repercussions of possibly hastening death. The Court addressed the legality of aggressive palliative care explicitly in the Vacco versus Quill ruling. Justice O’Connor states, “The parties and the amici agree that in the States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate suffering, even to the point of causing unconsciousness and hastening death”.

No legal barrier exists to treating pain; in fact, there is a legal risk to clinicians who do not effectively treat pain. In June 2001, a lawsuit was successfully prosecuted in California against a physician who inadequately treated a patient for pain. The jury decided that the doctor’s failure to treat the older man’s pain violated California’s elder abuse statute and awarded the family $1.5 million dollars.


American Society for Pain Management Nursing and Hospice and Palliative Nurses Association’s position statement clearly states that nurses have an ethical responsibility to provide clinically excellent care to address a patient’s pain. This involves mutual identification of goals for pain management through interprofessional collaboration, and awareness of professional standards for the assessment and management of different types of pain.


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:

- Define the legal and ethical differences between euthanasia, physician assisted-suicide, and natural death.
- Explain how the Principle of Double Effect provides ethical consensus in the standard treatment of pain at the end of life.
- Differentiate between the classifications of analgesics, their indications and side-effects and determine the most effective route of medication administration for end of life pain management.
- Adhere to professional and regulatory standards of care for appropriate pain management when caring for the patient at end of life.

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: Pre and Post Evaluation Questions: Pre course survey for online.

- How confident are you in assessing end-of-life pain?
- How confident are you in prescribing medication for end-of-life pain?

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

Brenda Daniels, M.D.

Palliative Medicine Physician

Baptist Health South Florida
Rose Allen, DNP, MSM/HM, RN, CHPN
Director, Bioethics Program
Baptist Health South Florida

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

Rose Allen, DNP, MSM/HM, RN, CHPN, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Brenda Daniels, M.D., indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will include off-label or unapproved product usage in her presentation and discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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.  
This course is planned in collaboration with the Palliative Care department and is part of a larger initiative addressing end of life pain. 

COMMERCIAL SUPPORT:  

☐ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN:  
List names of up to two courses with similar target audiences. Please list complete course title.

► PRESCRIBING CONTROLLED SUBSTANCES

External:

Provider: 2019IEM174

Course video:

Course handout:

Quiz Questions

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DATE REVIEWED:  _August 9, 2019_  

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
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

CME ACTIVITY TITLE: Developing a Comprehensive Complex Spine Surgery Program

DATE: August 26, 2019  TIME: 12 – 1 p.m.  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: 5 MCVI (Both Sides)


CONFERENCE DIRECTOR: Felipe de los Rios de la Rosa, M.D.  CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 25-30  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)
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

The underlying pathology and thus the indication for surgery will dictate the urgency of proceeding to the operating room. Dr. Raul A. Vasquez will review the history and evolution of the spine anatomy. Participants will understand the pathophysiology of adult spinal deformity.

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 may not be aware of when to implement diagnostic and therapeutic procedures for low back pain.

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 monitor spine surgery before and after implementation of a surgery treatment plan.

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:

Value in health care is defined as the quotient of outcomes to cost. Both pediatric and adult spinal deformity surgeries are among the most expensive procedures offered today. With high variability in both outcomes and costs in spine surgery today, surgeons will be expected to consider long-term cost effectiveness when comparing treatment options. Without surgeon leadership in this arena, suboptimal solutions may result from the isolated intervention of regulatory bodies or payer groups. The cooperative development of standardized, team-based approaches in complex spine surgery will lead to the high-quality, high-value care for patients.

Spine Deformity. 7(2):228-235, 2019 03.
http://ovidsp dc2.ovid.com/sp-4.01.0a/ovidweb.cgi?&S=FKPFPBBEBNKNIPCKJGOGNPOAA00&Complete+Reference=S.sh.24%7c11%7c1&Counter5=SS_view_found_complete%7c30660216%7cmedf%7cmedline%7cmedl&Counter5Data=30660216%7cmedf%7cmedline%7cmedl

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:

- Assess the pathophysiology of adult spinal deformity.
- Implement treatment plans for spine tumor surgery and explore non-operative management options for spine surgery.
- Discuss the future of spine surgery.

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.)

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

Raul A. Vasquez, M.D.
Director of Complex Spine Neurosurgery
Miami Cancer and Vascular Institute

Raul S. Vasquez, M.D. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ____________________________________________________

Currently, Baptist Hospital Neuroscience Center continues to collaborate as a system to implement Primary Stroke Center requirements at other BHSF entities. The BHSF Stroke Committee meets bi-monthly to discuss goals and progress on initiative implementation as we partner with EMS Miami-Dade Stroke Coalition as well. As the neuroscience services continue to grow, we will maintain partnership with multidisciplinary departments to enhance quality patient experience and outcomes.
COMMERCIAL SUPPORT:  □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: __________ REVIEWED BY: □ Accelerated Approval □ Executive Committee

□ Live Committee

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

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

CME ACTIVITY TITLE: MCI Multispecialty Grand Rounds: The Role of Rehabilitation Medicine in Improving the Quality of Life for Persons with Cancer

DATE: September 9, 2019   TIME: 7:30 – 8:30 a.m.   CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: MCI Tumor Board Conference Room – 3N 110

TARGET AUDIENCE: Oncologists, Radiation Oncologists, Hematology Oncologists, Radiation Therapists, General Surgeons, General Practitioners, Obstetrics and Gynecologists, Oncologists, Radiation Oncologists, Nurses, Social Workers, Patient Navigators and all other interested healthcare professionals.
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

CONFERENCE DIRECTOR: Guillerme Rabinowits, M.D
CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 30-40
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)

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

Exercise and the rehabilitation process can play many roles for the cancer survivor. Despite the many benefits of physical therapy it is often underutilized in an oncology setting. During this conference, Dr. Cristian will describe treatments commonly used for cancer related impairments. Participants will also learn key features of frailty in cancer patients and the impact on cancer care as well as role of rehabilitation medicine in minimizing the impact of frailty.

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.
DESIABLE 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 may not be aware of the different impairments associated with specific types of cancer and their treatment.

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 refer patients at high risk for developing cancer-related impairments to rehabilitation medicine early to minimize the impact on the quality of life for the person with cancer.

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
- Consensus of experts
- Disease prevention (C12)
- Joint Commission initiatives (C12)
- Mortality/morbidity statistics
- National Patient Safety Goals
- National/regional data
- New diagnostic/therapeutic modality (C12)
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Regulatory requirement
- Other need identified (Explain): _____________________________
The field of cancer rehabilitation and prehabilitation has grown significantly over the past decade. Advancements in early detection and treatment have resulted in a growing number of cancer survivors in the United States (US), expected to reach 26 million by 2040. Health care professional graduate education is trying to catch up with anticipated clinical demand by increasing the number of cancer rehabilitation fellowship training programs and introducing rehabilitation/prehabilitation concepts earlier in training. Numerous national organizations have issued guidelines for cancer rehabilitation research and posttreatment cancer health care.

J Cancer Rehabil. Author manuscript; available in PMC 2019 Mar 13.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6415687/

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:

- Identify the types of impairments commonly associated with specific typed of cancer.
- Assess patients implementing the “cascade of disability” method seen in cancer patients and the impact of their quality of life.

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.)

Faculty disclosure statement (as it should appear on course shell):
Adrian Cristian, M.D., MCHM
Chief, Cancer Rehabilitation Medicine
Miami Cancer Institute

Adrian Cristian, M.D., MCHM indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ______________________________________________________

COMMERCIAL SUPPORT: ☐ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.
(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: __________  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

CME ACTIVITY TITLE: Autism Spectrum Disorder Conference, 17th Annual

DATES: Thursday, October 10, 2019  TIME: 6 - 8 p.m.  CREDIT HOUR(S) APPLIED FOR: 2 Cat. 1

LOCATION: Baptist Hospital of Miami, Auditorium

CONFERENCE CO-DIRECTORS: Ian Nisonson, M.D. and Nina Sanchez, M.D.

CME MANAGER: Gabriela Fernandez

TARGET AUDIENCE: Pediatricians, Neurologists, Family Practice Physicians, Psychologists, Psychiatrists, Hospitalists, Nurses, Pharmacists, Social Workers, Occupational and Physical Therapists

EXPECTED NUMBER OF ATTENDEES: 50-70  CHARGE: 0
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 & 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 that keyword searches will pull from this description.

Our increased ability to identify and diagnose children with autism spectrum disorders (ASD) at ever earlier ages provides us with both an opportunity and a challenge. The last 20 years of research have demonstrated both methods for identifying ASD in even younger children, and also methods for improving outcomes of those children through specific early intervention practices. These advances now allow us the opportunity to begin intervention much earlier in life. Our challenge, however, is to design and adapt our interventions to very young children in order to achieve optimal outcomes. Join Dr. Meaghan Parladé and Ms. Cecilia Alvarez-Tabio as they discuss Parent-Child Interaction Therapy and Naturalistic Developmental Behavioral Interventions for children with ASD.

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

Physicians may not be aware of all the current research on Parent-Child Interaction Therapy and Naturalistic Developmental Behavioral Interventions for children with ASD.

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

Physicians consider all current research on Parent-Child Interaction Therapy and Naturalistic Developmental Behavioral Interventions for children with ASD, which may help their patients’ development and behavioral outcomes.

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

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

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

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

- Physicians will consider all available research developments that may influence early detection and optimal management of autism spectrum disorders to improve patient outcomes.

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


Autism spectrum disorders (ASDs), including high functioning autism (HFA), Asperger’s Disorder (AS), and Pervasive Developmental Disorder not Otherwise Specified (PDDNOS) are neurodevelopmental disorders with a prevalence of 1 in 150 (CDC Morbidity and Mortality Weekly Report 2007). The precise prevalence of clinically significant behavioral problems in this population is not known since most empirical work has been conducted in clinically referred samples. However, empirical research and clinical observation suggest that a relatively large number of high functioning individuals with ASDs exhibit behavioral problems at some point during development (Brereton et al. 2006; Gadow et al. 2005).
Finding effective interventions for these problems is an important clinical priority. 
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5519301/

Earlier autism diagnosis, the importance of early intervention, and development of specific interventions for young children have contributed to the emergence of similar, empirically supported, autism interventions that represent the merging of applied behavioral and developmental sciences. “Naturalistic Developmental Behavioral Interventions (NDBI)” are implemented in natural settings, involve shared control between child and therapist, utilize natural contingencies, and use a variety of behavioral strategies to teach developmentally appropriate and prerequisite skills. We describe the development of NDBIs, their theoretical bases, empirical support, requisite characteristics, common features, and suggest future research needs. We wish to bring parsimony to a field that includes interventions with different names but common features thus improving understanding and choice-making among families, service providers and referring agencies. 


Autism, or autism spectrum disorder (ASD), refers to a broad range of conditions characterized by challenges with social skills, repetitive behaviors, speech and nonverbal communication. According to the Centers for Disease Control, autism affects an estimated 1 in 59 children in the United States today.

We know that there is not one autism but many subtypes, most influenced by a combination of genetic and environmental factors. Because autism is a spectrum disorder, each person with autism has a distinct set of strengths and challenges. The ways in which people with autism learn, think and problem-solve can range from highly skilled to severely challenged. Some people with ASD may require significant support in their daily lives, while others may need less support and, in some cases, live entirely independently.

Several factors may influence the development of autism, and it is often accompanied by sensory sensitivities and medical issues such as gastrointestinal (GI) disorders, seizures or sleep disorders, as well as mental health challenges such as anxiety, depression and attention issues.

Indicators of autism usually appear by age 2 or 3. Some associated development delays can appear even earlier, and often, it can be diagnosed as early as 18 months. Research shows that early intervention leads to positive outcomes later in life for people with autism. https://www.autismspeaks.org/what-autism

EDUCATIONAL OBJECTIVES:

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

- Identify the key components of Parent-Child Interaction Therapy (PCIT) and assess ways in which PCIT addresses behavioral challenges in children with ASD.
- Distinguish behavioral outcomes associated with PCIT for children with ASD and their parents.
- Describe the key components of Naturalistic Developmental Behavioral Interventions (NDBIs) and analyze how it addresses behavioral and developmental skills in children with ASD.
• Assess the outcomes associated with NDBIs and identify few models that can be applied to improve patient development.
• Introduce the Autism Adaptive Community-based Treatment to Improve Outcomes Using Navigators (ACTION) Network.

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.)

Meaghan V. Parladé, Ph.D.
Licensed Psychologist | PCIT International Level I Trainer
Clinical Supervisor, UM Autism Spectrum Assessment Clinic
Clinical Supervisor, UM Parent-Child Interaction Therapy Program
Coordinator of Intervention Services, UM-NSU Center for Autism and Related Disabilities
University of Miami, Department of Psychology

Cecilia Alvarez-Tabio, M.S., BCBA
Manager, Autism Intervention Services
University of Miami-Nova Southeastern University Center for Autism and Related Disabilities (UM-NSU CARD)

Michael Alessandri, Ph.D.
Executive Director of the University of Miami-Nova Southeastern University Center for Autism and Related Disabilities (UM-NSU CARD)

Clinical Professor of Psychology and Pediatrics

Assistant Chairman, Department of Psychology for Community Outreach and Engagement

University of Miami Miller School of Medicine

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

Dr. Parlade indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussions.

Ms. Alvarez-Tabio indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will include off-label or unapproved product usage in her presentation or discussions.

Dr. Alessandri indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will include off-label or unapproved product usage in his presentation or discussions.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. **UM Card**

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

DATE REVIEWED: **August 20, 2019**  REVIEWED BY: ☑ Accelerated Approval  ☐ Executive Committee  ☐ Live Committee

APPROVED: ☐ YES ☐ NO  ■ Credits: AMA/PRA Category 1 Credits: # 2

Continuing Psychology Education Credits: # 2 ☐ N/A  ■ Continuing Dental Education Credits: # 1 ☐ N/A

**Agenda**

6 p.m.  Welcome and Introductions  
Ian Nisonson, M.D.

6:10 p.m.  Parent-Child Interaction Therapy for Children with ASD and Disruptive Behaviors  
Meaghan Parlade, Ph.D.

6:45 p.m.  Naturalistic Developmental Behavioral Interventions for Young Children with ASD  
Cecilia Alvarez-Tabio, M.S., BCBA

7:20 p.m.  Autism Adaptive Community-based Treatment to Improve Outcomes Using Navigators (ACTION) Network  
Michael Alessandri, Ph.D.

7:40 p.m.  PANEL Discussion

8:00 p.m.  Adjourn
CME ACTIVITY TITLE: Pediatric Multispecialty Conference: Emerging and Re-Emerging Pathogens in Pediatric Medicine

DATE: September 10, 2019    TIME: 6-7 p.m.    CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: BHM Auditorium


CONFERENCE DIRECTOR: Jennifer Cheney, M.D.    CME MANAGER: Katie Deane

EXPECTED NUMBER OF ATTENDEES: 40-50    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)

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

There is a growing threat in the emergence and re-emergence of infectious diseases that can have significant impact the pediatric patient population. Many providers have never seen these emerging and re-emerging infectious diseases in clinical practice. Join us to hear infectious disease expert, Prof. Aileen M. Marty, M.D., provide practitioners with essential information on prevention, detection and treatment or these infections diseases.
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)*

- There is a growing threat in the re-emergence of diseases that impact pediatric demographics.
- Practitioners may have never seen these emerging and re-emerging infectious diseases in clinical practice and are unsure of clinical presentation.

**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 are familiar with potential infectious diseases, and their symptom presentation, that are a threat to the pediatric population in south Florida.
- Practitioners are able to quickly identify, confirm diagnosis and triage pediatric patients presenting with symptoms of Zika, Dengue, Hepatitis A, Ebola, Measles, Pertussis, congenital syphilis, XDR TB, Candida auris, Flaccid Paralysis, or other emerging infectious diseases.

**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
- Consensus of experts
<table>
<thead>
<tr>
<th>Disease prevention (C12)</th>
<th>Joint Commission initiatives (C12)</th>
</tr>
</thead>
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<tr>
<td>Mortality/morbidity statistics</td>
<td>National Patient Safety Goals</td>
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<tr>
<td>National/regional data</td>
<td>New diagnostic/therapeutic modality (C12)</td>
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<td>New or updated policy/protocol</td>
<td>Patient care data</td>
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<tr>
<td>Peer review data</td>
<td>Process improvement initiatives (C16 &amp; 21)</td>
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<tr>
<td>Regulatory requirement</td>
<td>Other need identified (Explain): _____________________________</td>
</tr>
<tr>
<td>Research/literature review</td>
<td></td>
</tr>
</tbody>
</table>

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

► Emerging pathogens with pandemic potential are a growing threat to human health throughout the world, including in the United States. Zoonotic and arthropod-borne infections have caused unprecedented epidemics and pandemics, exemplified by the 2014-2015 Ebola outbreak. We must acknowledge a new reality for pediatric health care professionals who must consider travel and other exposures when evaluating patients and, therefore, include in their differential diagnosis diseases such as Ebola virus, Zika virus, Middle Eastern respiratory syndrome coronavirus, Enterovirus D68, and measles, to name a few. ([https://jamanetwork.com/journals/jamapediatrics/article-abstract/2611947](https://jamanetwork.com/journals/jamapediatrics/article-abstract/2611947))


► There is a growing threat in the re-emergence of diseases that impact pediatric demographics. While major strides have been made in the field of childhood cancers, there are still more questions than answers. In addition, public resistance to recommended practices related to childhood vaccinations fueled by misinformation has allowed infectious diseases to resurface in developed nations. Meanwhile, climate change and other destabilizing factors are shifting vector populations and driving the emergence of new diseases. Herein we call upon the community of human health researchers to confront the evolving specter of pediatric disease. ([https://www.mdpi.com/2079-9721/5/3/18](https://www.mdpi.com/2079-9721/5/3/18))


► Factors such as urbanization, global warming, and dense human and animal populations may have contributed to the emergence of some viruses. The recent epidemics caused by Zika virus and Middle East respiratory syndrome coronavirus (MERS-CoV) clearly illustrate the ability of emerging viruses to pose huge public health problems within a short time. Much more research effort is needed to understand the evolution and pathogenesis of these emerging viruses, as well as the development of diagnostics and therapeutics to combat existing and future epidemics. ([https://www.mdpi.com/1422-0067/19/2/398/htm](https://www.mdpi.com/1422-0067/19/2/398/htm))

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:

- Outline and prioritize emerging and re-emerging pediatric infectious disease threats in south Florida
- Describe and evaluate factors contributing to the emergence and re-emergence of infections
- Utilize strategies to reduce the risks from emerging infections both in their practice and for their communities.

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.)

Prof. Aileen M. Marty, M.D., FCAP
Director, FIU Health Travel Medicine Program and Vaccine Clinic Commander, Emergency Response Team Development Professor, Infectious Diseases, Dept. of Humanities, Health and Society
Herbert Wertheim College of Medicine, Florida International University
Miami, Florida

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

Prof. Aileen M. Marty, M.D., FCAP, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.
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. This activity is planned in collaboration with Baptist Children’s Hospital to meet the educational needs they have identified.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: __________  REVIEWED BY: ☐ Accelerated Approval  ☐ Executive Committee
□ Live Committee

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

Continuing Psychology Education Credits: # __  ☑ N/A  ■ Continuing Dental Education Credits: # __  ☑ N/A
CME ACTIVITY TITLE: Differential Diagnosis of Depression and Dementia: A Neuropsychological Perspective

COURSE APPROVAL: September 2019                    COURSE EXPIRATION: September 2020

CREDIT HOUR(S) APPLIED FOR:

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

CONFERENCE DIRECTOR: A. Ruben Caride, M.D.

CME MANAGER: Isabel Rodriguez Morgan (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 0

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)
- [x] 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
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

☐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 presentation will address typical cognitive and behavioral presentation for the most common dementias and the evidence that supports how neuropsychological testing can assist in the differential diagnosis of dementia and depression.

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. Primary Care Physician's limited time and high patient volume

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

Primary Care Physicians are burdened and challenged with maintaining competencies and adopting best practice models across a variety of medical subspecialty areas. Short of being an expert on everything, there are common knowledge gaps of best practices - resulting in some inconsistencies in quality of care.

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

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)

- Clinicians are not differentiating the diagnosis between dementia and depression.

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)

- Clinicians will implement neuropsychological testing in their clinical practice that will assist them in differentiating the diagnosis between dementia and depression.

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

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

► https://www.ahajournals.org/doi/pdf/10.1161/STR.0000000000000024

Bibliography and Additional Resources:


Hamilton, R.A. Assessment and Treatment of Anxiety and Depression: A Primer for Medical Professionals. Audio-Digest Internal Medicine, Vol. 57, Is. 19, October 7, 2010.


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:

• Identify the typical cognitive and behavioral presentation for the most common dementias.
• Describe how depression can mimic and be differentiated from dementia.
• Recognize how neuropsychological testing can assist in the differential diagnosis.

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.)
Richard A. Hamilton, Ph.D.
Clinical Director, Baptist Hospital of Miami Brain Injury and Concussion Rehabilitation Programs
Neuropsychologist, Miami Cancer Institute
Miami, Florida

Faculty disclosure statement (as it should appear on course shell):
Richard A. Hamilton, Ph.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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 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. ___________________________________________________________

► This symposium was planned in collaboration with the Baptist Health Quality Network (BHQN) and Baptist Health Medical Group (BHMG). The groups identified topics of need that are implemented in this year’s programming.
COMMERCIAL SUPPORT: □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider:

Course video:

Course handout:

Quiz Questions

DATE REVIEWED: __________ REVIEWED BY: □ Accelerated Approval □ Executive Committee
□ Live Committee

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

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

Continuing Medical Education
ACTIVITY APPLICATION

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

CME ACTIVITY TITLE: Newer Diabetes Medications and Cardiovascular Outcomes
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

COURSE APPROVAL: September 2019  COURSE EXPIRATION: September

CREDIT HOUR(S) APPLIED FOR:

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

CONFERENCE DIRECTOR: A. Ruben Caride, M.D.
CME MANAGER: Isabel Rodriguez Morgan (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 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)

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

This lecture will review recent cardiovascular outcomes trials in type 2 diabetes that provide strong evidence for cardiovascular benefit for several medications and reassurance about the lack of cardiovascular risk for many others.

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

Primary Care Physicians are burdened and challenged with maintaining competencies and adopting best practice models across a variety of medical subspecialty areas. Short of being an expert on everything, there are common knowledge gaps of best practices - resulting in some inconsistencies in quality of care.

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

**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)

► Recent data indicates that because of advances in research and clinical care…morbidity and mortality have decreased significantly in both type 1 and type 2 diabetes. However, individuals with diabetes still have greater cardiovascular risk than those without diabetes. Thus, additional strategies to reduce this risk continue to be evaluated.

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)

► Clinicians will keep current on future cardiovascular trials in order to provide their diabetic patients with optimal strategies to reduce cardiovascular risk.

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
- Consensus of experts
- Joint Commission initiatives (C12)
- National Patient Safety Goals
- New diagnostic/therapeutic modality (C12)
- Patient care data
REFERENCES


EDUCATIONAL OBJECTIVE: 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:

- Discuss rationale and background for cardiovascular outcome trials in diabetes.
- Review results of cardiovascular outcomes trials with diabetes medication.

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______________________
Priyathama Vellanki, M.D.
Division of Endocrinology, Metabolism and Lipids
Emory University
Clinical Director, Endocrinology Clinic
Grady Memorial Hospital
Atlanta, Georgia

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

Priyathama, Vellani, M.D., indicated that she is a co-investigator with Boehringer-Ingelheim, Novo Nordisk and Sanofi. She is also a consultant with Boehringer Engelheim and Merck. She will include off-label or unapproved product usage in her presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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 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

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

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider:

Course video:

Course handout:

Quiz Questions

DATE REVIEWED: __________ 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
CME ACTIVITY TITLE: Suicide: Risk Factors and How to Identify Them

COURSE APPROVAL September 2019         COURSE EXPIRATION September

CREDIT HOUR(S) APPLIED FOR:

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

CONFERENCE DIRECTOR: A. Ruben Caride, M.D.

CME MANAGER: Isabel Rodriguez Morgan (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES:         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)

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

This lecture will aim to assist clinicians identify risk factors and warming signs for suicide attempts.
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. Primary Care Physician’s limited time and high patient volume

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

Primary Care Physicians are burdened and challenged with maintaining competencies and adopting best practice models across a variety of medical subspecialty areas. Short of being an expert on everything, there are common knowledge gaps of best practices - resulting in some inconsistencies in quality of care.

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

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)

► Suicidal behavior remains challenging for clinicians to predict, with few established risk factors and warning signs.

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)

► Clinicians will identify risk factors and warning signs for suicide attempts.

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

☒ Consensus of experts

☐ Disease prevention  

☐ Mortality/morbidity statistics

☐ National/regional data

☐ New or updated policy/protocol

☐ Peer review data

☐ Regulatory requirement

☐ Joint Commission initiatives  

☐ National Patient Safety Goals

☒ New diagnostic/therapeutic modality  

☐ Patient care data

☐ Process improvement initiatives  

☐ Other need identified (Explain):
EDUCATIONAL OBJECTIVE: 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:

- Identify risk factors for attempted or completed suicide.
• Identify warning signs for suicide attempts.
• Examine the relationship between suicide risk and different life stages.
• Conduct a comprehensive suicide risk assessment using interview techniques and assessment measures.
• Assist patients develop a safety plan.

**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.)

Larry Brooks, Ph.D., ABPP-CN

Board-certified in Clinical Neuropsychology

Hollywood and Miami, Florida

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

Larry Brooks, Ph.D., ABPP-CN, indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

**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.) __________________________________________________________
CONTINUING MEDICAL EDUCATION

ACTIVITY APPLICATION

Form Rev. 030316

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

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:

Provider: 2019IEM176

Course video:

Course handout:

Quiz Questions
DATE REVIEWED: __________ 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: Infections of the Ear, Nose and Throat

COURSE APPROVAL: September 2019 COURSE EXPIRATION: September

CREDIT HOUR(S) APPLIED FOR:

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

CONFERENCE DIRECTOR: A. Ruben Caride, M.D.

CME MANAGER: Isabel Rodriguez Morgan (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 0 CHARGE: 0

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

☐ ARS ☐ Internet Live Course (Live Webcast)

☐ Case Studies ☐ Internet point-of-care activity

☐ Didactic Lecture ☐ Journal-based CME activity

☐ Enduring Material (DVD/Booklet) ☐ Learning from Teaching

☒ Internet Activity Enduring Material ☐ Live activity
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

☐ Manuscript review activity  ☐ Regularly Scheduled Series
☐ Panel  ☐ Simulation
☐ PI CME activity  ☐ Test item writing activity
☐ Question & Answer  ☐ Other (specify)

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

This lecture will address the presentation, diagnosis and appropriate and effective treatment of common ENT infections.

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. Primary Care Physician's limited time and high patient volume

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

Primary Care Physicians are burdened and challenged with maintaining competencies and adopting best practice models across a variety of medical subspecialty areas. Short of being an expert on everything, there are common knowledge gaps of best practices - resulting in some inconsistencies in quality of care.

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

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)

► While most common ENT conditions can be evaluated and treated in the primary care setting; signs of acute or severe ENT conditions prompt a referral to a specialist.

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)

► Clinicians will appropriately refer patients to a specialist when signs of acute or severe ENT conditions occur.

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 ☑ Consensus of experts

☐ Disease prevention (C12) ☐ Joint Commission initiatives (C12)

☐ Mortality/morbidity statistics ☐ National Patient Safety Goals

☑ National/regional data ☐ New diagnostic/therapeutic modality (C12)

☐ New or updated policy/protocol ☐ Patient care data
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:

- Identify and diagnose common infections of the ears, nose, throat and neck.
- Formulate a management plan that includes proper and timely use of diagnostic tests including laboratory studies and imaging.
- Determine appropriate and effective use of antibiotics and adjunctive measures.
- Describe proper patient follow-up and recognize when referral to a consultant is necessary.
- Appropriately document findings and prior treatments.
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.)

Alberto D. Fernandez, M.D., FACS
South Florida ENT Associates, PA
Otolaryngologist
Baptist, South Miami, Homestead, Doctors and West Kendall Baptist Hospitals
Miami, Florida

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

Alberto D. Fernandez, M.D., FACS, indicated that neither he is a stock shareholder in South Florida ENT Associates, and he will not include off-label or unapproved product usage in his presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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 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.
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

☐ 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. __________________________________________________________

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider:

Course video:

Course handout:

Quiz Questions

DATE REVIEWED: __________ REVIEWED BY: ☐ Accelerated Approval ☐ Executive Committee
☐ Live Committee
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

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

CME ACTIVITY TITLE:  Sleep Medicine Pearls: Update on Sleep Apnea, Restless Leg Syndrome and Parasomnias

COURSE APPROVAL  September 2019  COURSE EXPIRATION  September

CREDIT HOUR(S) APPLIED FOR:

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

CONFERENCE DIRECTOR:  A. Ruben Caride, M.D.
CME MANAGER:  Isabel Rodriguez Morgan (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES:  CHARGE: 0

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

☒ ARS  ☐ Internet point-of-care activity
☐ Case Studies  ☐ Journal-based CME activity
☒ Didactic Lecture  ☐ Learning from Teaching
☐ Enduring Material (DVD/Booklet)  ☐ Live activity
☒ Internet Activity Enduring Material  ☐ Manuscript review activity
☐ Internet Live Course (Live Webcast)  ☐ Panel
This lecture will cover the importance of diagnostic classification of sleep disorders, which will assist to standardize definitions, improve awareness of the conditions, promote a broad differential diagnosis and facilitate a systematic diagnostic approach.

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. Primary Care Physician’s limited time and high patient volume

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

Primary Care Physicians are burdened and challenged with maintaining competencies and adopting best practice models across a variety of medical subspecialty areas. Short of being an expert on everything, there are common knowledge gaps of best practices - resulting in some inconsistencies in quality of care.

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

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)

► Clinicians do not routinely evaluate patients for sleep disorders in clinical practice. Sleep disorders are important to recognize, as acute illness and other aspects of hospital admission may aggravate chronic symptoms or bring to light previously unrecognized symptoms.

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)

► Clinicians will routinely evaluate patients for sleep disorders to assist them in establishing more consistent sleep patterns. And will know when a referral to a specialist is required.

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
- Consensus of experts
- Disease prevention (C12)
- Joint Commission initiatives (C12)
- Mortality/morbidity statistics
- National Patient Safety Goals
- National/regional data
- New diagnostic/therapeutic modality (C12)
- New or updated policy/protocol
- Patient care data
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 and appropriately diagnose sleep apnea, restless leg syndrome and parasomnias.
- Delineate the best available treatment options to date for these sleep disorders.
- Differentiate between these sleep disorders and comorbid medical illnesses.

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.)

Timothy L. Grant, M.D., FAASM
Medical Director, Baptist Health Sleep Center at Sunset
Neurologist, affiliated with Baptist and South Miami Hospitals
Miami, Florida

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

Timothy L. Grant, M.D., FAASM, indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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 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. ______________________ ______________________ ______________________ ______________________ ______________________

______________________________ ______________________ ______________________ ______________________ ______________________

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

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

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider:

Course video:

Course handout:

Quiz Questions

DATE REVIEWED: __________ 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: The New Frontier in Aortic Stenosis

COURSE APPROVAL September 2019 COURSE EXPIRATION September

CREDIT HOUR(S) APPLIED FOR:

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

CONFERENCE DIRECTOR: A. Ruben Caride, M.D.

CME MANAGER: Isabel Rodriguez Morgan (Live)/Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES: 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)

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

This lecture will aim to define the pathophysiology of aortic stenosis and identify the most effective treatment.
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. Primary Care Physician’s limited time and high patient volume

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

Primary Care Physicians are burdened and challenged with maintaining competencies and adopting best practice models across a variety of medical subspecialty areas. Short of being an expert on everything, there are common knowledge gaps of best practices - resulting in some inconsistencies in quality of care.

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

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)

► It is essential that clinicians consider aortic stenosis in adults who present with any of the classic symptoms accompanied by a systolic murmur in order to properly manage the condition.

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)

► Clinicians will consider aortic stenosis in adults who present with any of the classic symptoms accompanied by a systolic murmur in their clinical practice, and will properly manage the condition.

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
- ☒ Consensus of experts
- ☐ Joint Commission initiatives (C12)
- ☐ National Patient Safety Goals
- ☐ New diagnostic/therapeutic modality (C12)
- ☐ Patient care data
EDUCATIONAL OBJECTIVE: 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:

- Define the pathophysiology of aortic stenosis.
- Identify and diagnose the different types of aortic stenosis.
- Recognize when a patient needs a TAVR or a SAVR.

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______________________
Elliott J. Elias, M.D.
Cardiologist
Baptist and West Kendall Baptist Hospitals, Baptist Health Medical Group and Baptist Health Quality Network
Miami, Florida

Faculty disclosure statement (as it should appear on course shell):
Elliott J. Elias, M.D., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

Non-faculty contributors and others involved in the planning, development and editing/review of the content have no relevant financial relationships to disclose.

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 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. ________________________________________________________________

► This symposium was planned in collaboration with the Baptist Health Quality Network (BHQN) and Baptist Health Medical Group (BHMG). The groups identified topics of need that are implemented in this year’s programming.
COMMERCIAL SUPPORT: □ Indicate here if support will come from the Foundation’s general Continuing Medical Education fund.

ETHOS CONTENT

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider:

Course video:

Course handout:

Quiz Questions

DATE REVIEWED: __________ REVIEWED BY: □ Accelerated Approval □ Executive Committee □ Live Committee

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

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: MCI Oncology Academic Educational Series: Death Awareness, Dying, Grief and Bereavement
DATE: September 13, 2019          TIME:  6 – 7:30 p.m.          CREDIT HOUR(S) APPLIED FOR:  1.5 Cat. 1

LOCATION: Miami Cancer Institute – 3W280

TARGET AUDIENCE: Oncology Nurses, Oncologists, Radiation Oncologists, Hematology Oncologists, Radiation Therapists, Social Workers, Patient Navigators and other interested healthcare providers.

CONFERENCE DIRECTOR: Minesh Mehta, M.D.          CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 25-50          CHARGE: 0

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

[A]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.

Journey with us as we discuss the natural and spiritual components of death and the impact of grief and bereavement on the healing process.

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)

► Clinicians regard death as an adversary, so when it occurs, it represents defeat and failure. Likewise, the feelings associated with death and dying are often avoided or postponed indefinitely, thus delaying the normal grief and bereavement process. Grief feelings are then disenfranchised and unattended, thereby possibly leading to complicated grieving, compassion fatigue or burnout.

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)

► Any chronic illness is replete with successive losses and consequent grief. An understanding of this process will equip healthcare providers to be more empathic and proficient providers of bereavement care for patients, families and colleagues.

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
☐ Consensus of experts
☐ Disease prevention (C12)
☐ Joint Commission initiatives (C12)
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:

- Identify the physical, emotional, cognitive, behavioral, social and spiritual manifestations of grief.
- Identify factors affecting the grief process and the tasks of grief.
- Distinguish between the dynamics of healthy and dysfunctional grieving.
- Distinguish between the myths and the realities of grief.
- Demonstrate empathy for the dying and the grieving through a death awareness exercise.

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

The investigation of the situation of bereaved family caregivers following caregiving during the end-of-life phase of illness has not received enough attention.

This study investigated the extent to which using the Carer Support Needs Assessment Tool (CSNAT) intervention during the caregiving period has affected bereaved family caregivers' perceptions of adequacy of support, their grief and well-being, and achievement of their preferred place of death.

All family caregivers who participated in a stepped-wedge cluster trial of the CSNAT intervention in Western Australia (2012-2014) and completed the pre-bereavement study (n = 322) were invited to take part in a caregiver survey by telephone four to six months after bereavement (2015). The survey measured the adequacy of end-of-life support, the level of grief, the current physical and mental health, and the achievement of the preferred place of death.


http://ovidsp.dc2.ovid.com/sp-4.0.1.0a/ovidweb.cgi?S=BOKMFPGOPJEBLJKLJPKCHGHDMPKAA00&Complete+Reference=S.sh.24%7c10%7c1&Counter5=SS_view_found_complete%7c29030206%7cmedl%7cmedline%7cmedl&Counter5Data=29030206%7cmedl%7cmedline%7cmedl
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.)

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

Rev. Guillermo Escalona, MDIV, BCC

Director of Pastoral Care
Baptist Health South Florida

Rev. Guillermo Escalona indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ______________________________________________________

Miami Cancer Institute – Department of Radiation Oncology.

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

*(ETHOS CONTENT)* **YOU MAY ALSO BE INTERESTED IN:** List names of up to two courses with similar target audiences. *Please list complete course title.*

DATE REVIEWED: ___________ 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: Advance Practice Providers – Orthopedic Conference Series

DATE: Once a month TIME: 6 – 7 p.m. CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 each
April 2019 – April 2020

LOCATION: Sabal Palm Room – First Floor Doctors Hospital

TARGET AUDIENCE: Physician Assistants, Advanced Registered Nurse Practitioners, Athletic Trainers and Orthopedists.

CONFERENCE DIRECTOR: John Zvijac, M.D. CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 0 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)

COURSE DESCRIPTION: Children are not just small adults. Their growing bones are different than adult bones and need special care. During this advance practice providers orthopedic conference, APP’s will learn how to assess and treat orthopedic fractures including pediatric fractures. This short summary will be used on course shell. Please note that keyword searches will pull from this description.

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)

► Advanced practice providers (APP) in orthopedics provide a wide range of treatment for pediatric patients. Therefore, APP’s may not be aware of when they are over treating or under treating common pediatric injuries.

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)

► APP’s will implement appropriate orthopedic pediatric treatment plans that may differ from adult treatment plans.

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
☒ Consensus of experts
☐ Disease prevention (C12)
☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics
☐ National Patient Safety Goals
☐ National/regional data
☐ New diagnostic/therapeutic modality (C12)
☐ New or updated policy/protocol
☐ Patient care data
☐ Peer review data
☐ Process improvement initiatives (C16 & 21)
☐ Regulatory requirement
☐ Other need identified (Explain): _____________________________
Upper and lower extremity injuries are common in children, with an overall risk of fracture estimated at just under 1 in 5 children. Pediatric bone anatomy and physiology produce age specific injury patterns and conditions that are unique to children, which can make accurate diagnosis difficult for emergency clinicians. This issue reviews the etiology and pathophysiology of child-specific fractures, as well as common injuries of the upper and lower extremities. Evidence-based recommendations for management of pediatric fractures, including appropriate diagnostic studies and treatment, are also discussed.

**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:

- Accurately examine pediatric x-rays.
- Discuss and identify pediatric growth plate fractures.
- Describe pediatric fractures and assess when casting is appropriate.
- Identify radius/ulna fractures – when to cast, reduce or recommend surgery.
- Discuss and identify the most common pelvic injuries, recognizing the anatomy, x-ray interpretations and treatment options.
- Identify fractures, when to treat and how to treat.
- Describe the anatomy of the achilles tendon.
- Identify Achilles tendonitis and Achilles tendon ruptures.

**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.)

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

Jessica Hixon, P.A.
Jessica Hixon, P.A. indicated that neither she nor his spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Ricky Lo, P.A.
Ricky Lo, P.A. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Brian Goldmark, P.A.
Brian Goldmark, P.A., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Frank Garcia, P.A.
Francisco Garcia, P.A., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Claudia Hodgson, APRN
Claudia Hodgson, APRN, indicated that neither she nor his spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Ervin Pohja, P.A.
Ervin Pohja, P.A., indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).
April Traina, P.A.

April Traiana, P.A. indicated that neither she nor his spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Wilfredo Pinero, P.A.

Wilfredo Pinero, P.A. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Phil de Paola, P.A.

Philip De Paola, P.A. indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Zuzette Heathcote, P.A.

Zuzette Heathcote, P.A. indicated that neither she nor his spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ________________________________________________________

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

CME ACTIVITY TOPICS

CME activities may include, but are not limited to, the following topics.

- Common pediatric orthopedic fractures and how to treat them.
- Shoulder dislocations.
- Hip reconstruction.
- PA updates/ ARNP updates.
- Upper extremity sports injuries.
- Lower extremity sports injuries.
- Foot and ankle injuries and treatment options.
- Suturing techniques.
- Proper casting and splinting techniques.

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

☑ 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: MCI Radiation Oncology Grand Rounds- Pancreatic Cancer and Radiotherapy: Progress and Future Direction

DATE: August 9, 2019 TIME: 12 – 1 p.m. CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: Miami Cancer Institute – Radiation Oncology Conference Room – 1 N 612

TARGET AUDIENCE: Radiation Oncologists, Medical Oncologists, Oncology surgeons and Radiologists

NOTE: Due to limited space, this conference is open to Baptist Health affiliated Medical Staff and Clinical Employees.

CONFERENCE DIRECTOR: Michael D. Chuong, M.D. CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 20-30 CHARGE: 0

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

☐ ARS ☐ Internet Activity Enduring Material
☒ Case Studies ☐ Internet Live Course (Live Webcast)
☒ Didactic Lecture ☐ Internet point-of-care activity
☐ Enduring Material (DVD/Booklet) ☐ Journal-based CME activity
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description

Pancreatic adenocarcinoma is the most lethal of the solid tumors and the fourth leading cause of cancer-related death in North America. Most patients present with locally advanced or metastatic disease that precludes curative resection. During this conference Dr. Tuli will discuss the emerging treatment strategies in pancreatic cancer, including the role of immunotherapy.

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)

► Evidence is mixed regarding the clinical benefit of radiation therapy in the management of non-metastatic pancreatic cancer thus presenting management challenges especially given the evolving systematic therapy landscape.

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 refer patients to the appropriate specialists for radiotherapy assessment.

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 ☑ Consensus of experts
☐ Disease prevention (C12) ☐ Joint Commission initiatives (C12)
☐ Mortality/morbidity statistics ☐ National Patient Safety Goals
☐ National/regional data ☐ New diagnostic/therapeutic modality (C12)
☐ New or updated policy/protocol ☐ Patient care data
☐ Peer review data ☐ Process improvement initiatives (C16 & 21)
☐ Regulatory requirement ☐ Other need identified (Explain): _____________________________
REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:

The overall 5-year survival for pancreatic cancer has changed little over the past few decades, and pancreatic cancer is predicted to be the second leading cause of cancer-related mortality in the next decade in Western countries. The past few years, however, have seen improvements in first-line and second-line palliative therapies and considerable progress in increasing survival with adjuvant treatment. The use of biomarkers to help define treatment and the potential of neoadjuvant therapies also offer opportunities to improve outcomes. This Review brings together information on achievements to date, what is working currently and where successes are likely to be achieved in the future. Furthermore, we address the questions of how we should approach the development of pancreatic cancer treatments, including those for patients with metastatic, locally advanced and borderline resectable pancreatic cancer, as well as for patients with resected tumours. In addition to embracing newer strategies comprising genomics, stromal therapies and immunotherapies, conventional approaches using chemotherapy and radiotherapy still offer considerable prospects for greater traction and synergy with evolving concepts.


http://ovidsp.dcm2.ovid.com/sp-4.01.0a/ovidweb.cgi?&S=ENHIFPKFLOEBOLLKJPCKLEBFBNDEA00&Complete+Reference=S.sh.24%7c2%7c1&Countert5=SS_viewFound_complete%7c29717230%7cmedf%7cmedline%7cmeddl&Counter5Data=29717230%7cmedf%7cmedline%7cmeddl

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:

- Describe the genomic complexity and molecular heterogeneity of pancreatic cancer.
- Identify multimodality treatment strategies for localized resectable, borderline and unresectable pancreatic cancer.
- Implement emerging treatment strategies in pancreatic cancer, including the role of immunotherapy.

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.
CONTINUING MEDICAL EDUCATION
ACTIVITY APPLICATION

Form Rev. 030316

☐ Other _______________________

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

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

Richard Tuli, M.D., Ph.D.
Associate Attending
Director of Development Therapeutics
Radiation Oncology
Memorial Sloan Kettering Cancer Center

Richard Ruli, M.D., Ph.D., indicated that neither he is a consultant with Astra Zeneca. He has received grant/research support from Abbvie and Phase One. He will not include off-label or unapproved product usage in his presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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.

__________________________

Collaboration with the Miami Cancer Institute – Radiation Oncology Department.

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: __________  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: MCI Oncology Academic Educational Series: Managing Oncologic Emergencies

DATE: Saturday, September 14, 2019 TIME: 10 a.m. – 5 p.m.

CREDIT HOUR(S) APPLIED FOR: 6.50 Cat. 1

LOCATION: Miami Cancer Institute – Café

TARGET AUDIENCE: Oncology Nurses, Oncologists, Radiation Oncologists, Hematology Oncologists, Radiation Therapists, Social Workers, Patient Navigators and other interested healthcare providers.

CONFERENCE DIRECTOR: Minesh Mehta, M.D. CME MANAGER: Eleanor Abreu

EXPECTED NUMBER OF ATTENDEES: 0 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
COURSE DESCRIPTION: This short summary will be used on course shell. Please note that keyword searches will pull from this description.

This conference is designed to further enhance the clinical knowledge of oncology nurses in recognizing oncologic emergencies so they can institute appropriate care and interventions.

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)

► Care and management of a patient with an oncologic emergency is complex and frequently updated with new treatments/interventions. Clinicians require additional knowledge surrounding the principles of safe care and management for the patient who has an oncologic emergency.

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)

► Further enhance the clinical knowledge of oncologic clinicians in recognizing oncologic emergencies and institute appropriate care and interventions.

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
☐ Consensus of experts
☐ Joint Commission initiatives (C12)
☐ National Patient Safety Goals
☐ New diagnostic/therapeutic modality (C12)
☐ Patient care data
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:

- Discuss signs, symptoms and management of metabolic emergencies.
- Discuss signs, symptoms and management of respiratory emergencies. Define sepsis, shock and disseminated intravascular coagulation (DIC).
- Describe incidence and mortality of sepsis.

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.)

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

Elizabeth McNulty, M.A., R.N., OCN
Nurse Leader
Nursing Professional Development
Memorial Sloan Kettering

Elizabeth McNulty, M.A., R.N., OCN, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Kameelah Brown, MSN
Nursing Professional Development Specialist
Memorial Sloan Kettering

Kameelah Brown, MSN, indicated that neither she nor her spouse/partner has relevant financial relationships with commercial interest companies, and she will not include off-label or unapproved product usage in her presentation(s) or discussion(s).

Non-faculty contributors and others involved in the planning, development, and editing/review of the content have no relevant financial relationships to disclose.

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. ________________________________________________

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

(ETHOS CONTENT) YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

DATE REVIEWED: ___________ 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

Managing Oncologic Emergencies

Saturday September 13, 2019
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
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</thead>
<tbody>
<tr>
<td>8:00 – 8:45</td>
<td><strong>Metabolic Emergencies</strong></td>
<td>Kameelah Brown MSN, RN, OCN</td>
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<td>SIADH/Hypercalcemia &amp; Tumor Lysis Syndrome</td>
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<tr>
<td>8:45 – 10:00</td>
<td><strong>Respiratory Emergencies</strong></td>
<td>Liz McNulty MA, RN, OCN</td>
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<td>10:00 – 10:15</td>
<td>Break</td>
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<tr>
<td>10:15 – 11:30</td>
<td><strong>Neurological Emergencies:</strong></td>
<td>Kameelah Brown MSN, RN, OCN</td>
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<td>Spinal Cord Compression</td>
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<td>11:30 – 12:15</td>
<td><strong>Neurological Emergencies:</strong></td>
<td>Kameelah Brown MSN, RN, OCN</td>
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<tr>
<td></td>
<td>Increased Intracranial Pressure</td>
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<td>12:15 – 1:15</td>
<td>Lunch</td>
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<tr>
<td>1:15 – 2:30</td>
<td><strong>Systemic and Hematologic Emergencies:</strong></td>
<td>Liz McNulty MA, RN, OCN</td>
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<td></td>
<td>Shock/Sepsis/DIC</td>
<td>Kameelah Brown MSN, RN, OCN</td>
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<td>2:30 – 2:45</td>
<td>Break</td>
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<td>2:45 – 3:45</td>
<td><strong>Cardiovascular Emergencies</strong></td>
<td>Liz McNulty MA, RN, OCN</td>
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<td>Superior Vena Cava Syndrome/</td>
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<td></td>
<td>Cardiac Tamponade</td>
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<tr>
<td>3:45 – 4:00</td>
<td>Evaluation</td>
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</table>
Applicable Credits: AMA Category 1 □  □ Continuing Psychology Education □  □ Continuing Dental Education □

CME ACTIVITY TITLE:  The Role of Rehabilitation Medicine in Improving the Quality of Life for Persons with Cancer

COURSE APPROVAL    September 2019    COURSE EXPIRATION    September

CREDIT HOUR(S) APPLIED FOR:

TARGET AUDIENCE: Oncologists, Radiation Oncologists, Hematology Oncologists, Radiation Therapists, General Surgeons, General Practitioners, Obstetrics and Gynecologists, Oncologists, Radiation Oncologists, Nurses, Social Workers, Patient Navigators and all other interested healthcare professionals

No – Nurses – not 10 questions. Social Workers – must have 1 credit hours.

CONFERENCE DIRECTOR: Guillerme Rabinowits, M.D.
CME MANAGER: Eleanor Abreu/Live; Marie Vital Acle (Online)

EXPECTED NUMBER OF ATTENDEES:  0  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)
- [x] 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)
Exercise and the rehabilitation process can play many roles for the cancer survivor. Despite the many benefits of physical therapy it is often underutilized in an oncology setting. During this conference, Dr. Cristian will describe treatments commonly used for cancer related impairments. Participants will also learn key features of frailty in cancer patients and the impact on cancer care as well as role of rehabilitation medicine in minimizing the impact of frailty.

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 may not be aware of the different impairments associated with specific type of cancer and their treatment.

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 refer patients at high risk for developing cancer related impairments to rehabilitation medicine early to minimize the impact on the quality of life for the person with cancer.

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
- Consensus of experts
- Disease prevention *(C12)*
- Joint Commission initiatives *(C12)*
- Mortality/morbidity statistics
- National Patient Safety Goals
- National/regional data
- New diagnostic/therapeutic modality *(C12)*
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives *(C16 & 21)*
- Regulatory requirement
- Other need identified (Explain): ________________________________
The field of cancer rehabilitation and prehabilitation has grown significantly over the past decade. Advancements in early detection and treatment have resulted in a growing number of cancer survivors in the United States (US), expected to reach 26 million by 2040. Health care professional graduate education is trying to catch up with anticipated clinical demand by increasing the number of cancer rehabilitation fellowship training programs and introducing rehabilitation/prehabilitation concepts earlier in training. Numerous national organizations have issued guidelines for cancer rehabilitation research and posttreatment cancer health care.

J Cancer Rehabil. Author manuscript; available in PMC 2019 Mar 13.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6415687/

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:

- Identify the types of impairments commonly associated with specific types of cancer.
- Assess patients implementing the “cascade of disability” method seen in cancer patients and the impact of their quality of life.

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.)
Adrian Cristian, M.D., MCHM
Adrian Cristian, M.D., MCHM, indicated that neither he nor his spouse/partner has relevant financial relationships with commercial interest companies, and he will not include off-label or unapproved product usage in his presentation or discussion.

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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. _______________________________________________________

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

YOU MAY ALSO BE INTERESTED IN: List names of up to two courses with similar target audiences. Please list complete course title.

External:
Provider: 2019IEM177

Course video:

Course handout:

Quiz Questions

1. Which of the following is not a cancer-related impairment associated with breast cancer?
   a. Adhesive capsulitis of the shoulder.
   b. Lymphedema of the arm.
   c. Peripheral neuropathy.
   d. Aromatase inhibitor-related arthralgia.
   e. Lymphedema of the leg.

2. Which of the following is not a cancer-related impairment associated with gynecological cancer?
   a. Impaired balance
   b. Lymphedema of the arm.
   c. Peripheral neuropathy.
   d. Pelvic floor dysfunction.
   e. Lymphedema of the leg.

3. Which of the following best describes the benefits of rehabilitation medicine for the cancer patient with peripheral neuropathy?
   a. Physical therapy can improve the balance.
   b. Speech therapy can help improve neck movement.
   c. Occupational therapy can improve hand function.
   d. A and c.

4. Which of the following is not true with respect to lymphedema following breast cancer?
   a. Radiation therapy and axillary lymph node dissection are risk factors for the development of lymphedema of the arm.
   b. Manual lymphatic drainage, compression bandages and garments and patient education are integral parts of a rehabilitation program for lymphedema following breast cancer.
c. Exercise of the affected arm has not been shown to be beneficial in the treatment of lymphedema.
d. Lymphedema can develop months to years following breast cancer treatment in high-risk patients.

DATE REVIEWED: __________  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