Enduring Patient-centered Medical Home: What It Means to Your Practice (1 Cat. 1)
Enduring Cardiorenal Syndromes: New Insights into Management of Patients with Combined Heart and Kidney Failure (1 Cat. 1)

RSS PALS (7 and 14 Cat. 1) - RENEWAL
RSS ACLS (7 and 14 Cat. 1) - RENEWAL
RSS 2015 Thoracic Oncology Weekly Tumor Boards (1 Cat. 1/ ea.) - RENEWAL
RSS 2015 Pelvic Health Study Group (1 Cat. 1/ ea) RENEWAL
RSS 2015 Neuroscience Focus Series: Case Review Presentations (1 Cat. 1/ ea.) RENEWAL
RSS 2015 Cardiac Cath and Cardiac Surgery Cases Review (1 Cat. 1/ ea.) RENEWAL
RSS 2015 SMH and DH Schwartz Center Rounds (1 Cat. 1/ea)
RSS Head and Neck Tumor Board (1.5 Cat. 1 ea) RENEWAL
RSS South Miami Hospitalist Lecture Series (1 Cat. 1 ea.) RENEWAL
RSS SMH Echo Lab Committee - Cases Review (1 Cat. 1 ea.) RENEWAL

01.09.15 Conversations in Ethics: Ethical Challenges in Providing Psychiatric Services for Patients in the Emergency Department (1 Cat. 1)

01.14.15 Homestead Hospital Conference Series: Acute Care of the Elderly: Pearls and Pitfalls (1 Cat. 1)

01.15.15 The Center for Research & Grants -The Life Cycle of a Research Study - From Data Analysis to Publication (1 Cat. 1)

01.21.15 WKBH Grand Rounds: Acute Treatment of Hypertension (1 Cat. 1)

01.23.15 BHQN Collaborative - PCP Task Force Lecture: Smoking Cessation - Management Strategies for Complex Patients Who Use Tobacco (1 Cat. 1)

02.10.15 MCVI Research Grand Rounds - Current Research Advances on Peripheral Artery Disease Therapy (2 Cat. 1)

02.28.15 Mental and Behavioral Health Symposium (4.5 Cat. 1)

03.04.15 Spirituality and Medicine: Self- Forgiveness and the Promotion of Better Healthcare (1 Cat. 1)

03.11.15 Homestead Hospital: Anticoagulation to Prevent DVT and Stroke (1 Cat. 1)

03.12.15 Ob/Gyn Conference Series: Infectious Diseases (1 Cat. 1)

04.08.15 Homestead Hospital Series: Anemia (1 Cat 1)
CME ACTIVITY TITLE: Patient-centered Medical Home: What It Means to Your Practice

DATE: Release Date: December 19, 2014    Expiration: November 2016

Recorded on 11.05.14

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

CONFERENCE DIRECTOR: Hector Delgado, D.O.
Coordinator: Janisse Post

TARGET AUDIENCE: Family physicians, general internists, allied health professionals.

EXPECTED NUMBER OF ATTENDEES: 50    CHARGE: $0.00

TYPE OF MEETING (FORMAT):

☐ Live    ☑ Panel
☐ Didactic Lecture    ☑ Enduring Material
☐ ARS    ☑ Internet-Home Study
☐ Question & Answer    ☑ Other
☐ Case Studies

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

☐ Survey of target audience
☒ Department/division requests
☐ Practice parameters
☐ Patient care audit
☐ Quality improvement data
☐ Evaluation response data

☒ Research/literature review
☐ Mortality/morbidity statistics
☐ National/regional data
☒ Consensus of experts
☐ Other method:

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

CURRENT PRACTICE: (What are they not doing or doing that needs to change?)
BHQN primary care physicians have not implemented the patient-centered medical home model into their practice.

OPTIMAL PRACTICE: BHMG primary care members effectively implement the PCMH model into their practice.

WHAT IS THE REASON FOR THE GAP? What do we need to address in order to close the practice gap? (The Educational Need) Check one or more of the following: ☒ Knowledge ☐ Competence ☐ Performance

PRACTICE GAP: BHQN primary care physicians do not clearly understand the value and importance of implementing a PCMH model into their current practice.

DESIRED OUTCOMES (GOAL): What is this CME Activity designed to change? (Check all that apply.)
☒ Competence ☒ Performance ☐ Patient Outcomes - Must have an achievable measurement plan.

BHMG primary care physicians will formulate successful strategies in to implement PCMH model into their practice.

REFERENCES
The patient centered medical home (PCMH is rapidly gaining popularity as way to make primary care more accessible, comprehensive and coordinated to improve patient outcomes and to lower overall healthcare costs. Since 2008, the NCQA has begun recognizing practices as PCMH, more than 26000 clinicians at more than 500 practices have received the NCQA designation and numbers are rising steadily. Done correctly, not only do
PCMHs’ enable physician’s to practice better medicine, but they even give a jump start to a practices bottoms line. The PCMH is based on a team approach that may include physicians advanced practice nurses, physician assistants, nurses, pharmacists, nutritionist, social workers and coordinate with hospital, home health care and community services. (http://www.medscape.com/viewarticle/812670)

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

1. Assess how the patient-centered medical home (PCMH) model can improve patient outcomes.
2. Identify foundational concepts to incorporate into practice before embarking on PCMH transformation.
3. Successfully implement strategies to maintain a patient-centered medical home model in clinical practice.

SPEAKER
Hector M. Delgado, D.O.
Med Director, BHQN Primary Care Physicians
Baptist Health South Florida

COMPETENCIES (Desirable Physician Attributes as per IOM, ACGM and AGMS):

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

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

OUTCOMES MEASUREMENT: (List strategy measurement questions.)

- Competence
- Performance
- Patient Outcomes

- As a result of what was discussed at this activity what do you intend to do differently? Identify at least two learnings that could be incorporated into your practice:

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

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? Yes No

- CME Program Manager: Gabriela Fernandez
- Conference Director (see above)
- Medical Director
- Corporate Director
- Medical Education Committee
- Others (i.e.: Conference Coordinator, Department representative, etc.) Janisse Post - Coordinator

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

NON-EDUCATION STRATEGIES: List strategies that are currently being used to address the needed change(s) in our learners, and/or list possible approaches that could be used to promote change(s)—beyond this CME activity alone.

COLLABORATION: Are there other initiatives within our institution that are also working to address the professional practice gaps or quality gaps we have identified?

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.

BHMG physicians will participate regularly in a journal club educational activity to remain current with up-to-date information on evidence-based practice and research findings.

DATE REVIEWED: October 17, 2014 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: Cardiorenal Syndromes: New Insights into Management of Patients with Combined Heart and Kidney Failure

DATE: Thursday, October 23, 2014
(Recorded Live)

EXPIRATION: December 2016
CREDIT HOUR(S) APPLIED FOR: 1 cat. 1

CONFERENCE DIRECTOR: Jonathan Roberts, M.D.

AMA/PRA LEARNING FORMAT:
- Live activity
- Didactic Lecture
- ARS
- Enduring material
- Question & Answer
- Case Studies
- Panel
- Journal-based CME activity
- PI CME activity
- Test-item writing activity
- Manuscript review activity
- Internet point-of-care activity
- Internet-home study
- Other (specify)

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

EXPECTED NUMBER OF ATTENDEES: 40-50 CHARGE: 0

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

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

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

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
- Physicians do not consistently consider all cardiac and renal interactions in order to properly diagnose and treat patients with kidney disease.

WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
- Physicians consider all factors that may influence cardiorenal syndrome to accurately classify the interaction and determine best treatment plan to improve patient outcomes.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
- Knowledge (Doctors do not know that they need to be doing something.)
- Competence (Doctors do not know how to do it)
DESIRABLE 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 Performance? -or- Patient Outcomes*? (Check all that apply.) *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)

- Physicians will utilize most appropriate diagnostic testing and treatment plan to improve outcomes of the cardiorenal syndrome patient.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
- Chronic kidney disease (CKD) is an independent risk factor for the development of coronary artery disease, and for more severe coronary heart disease (CHD). CKD is also associated with adverse outcomes in those with existing cardiovascular disease. This includes increased mortality after an acute coronary syndrome, after percutaneous coronary intervention (PCI) with or without stenting, and after coronary artery bypass. In addition, patients with CKD are more likely to present with atypical symptoms, which may delay diagnosis and adversely affect outcomes.
- Numerous observational studies have shown that a reduced glomerular filtration rate (GFR) and proteinuria are both independently associated with an increased risk of cardiovascular events in community-based populations of patients who were not selected based upon the presence of known kidney or cardiovascular disease. The above evidence that mild to moderate CKD is associated with an adverse cardiovascular prognosis led both the National Kidney Foundation and the American College of Cardiology/American Heart Association to recommend that CKD be considered a CHD risk equivalent.

The term “cardiorenal syndrome” (CRS) has been applied to these interactions, but the definition and classification have not been clear. The different interactions that can occur led to the following classification of CRS that was proposed:

- Type 1 (acute) – Acute HF results in acute kidney injury (previously called acute renal failure).
- Type 2 – Chronic cardiac dysfunction (eg, chronic HF) causes progressive CKD (previously called chronic renal failure).
- Type 3 – Abrupt and primary worsening of kidney function due, for example, to renal ischemia or glomerulonephritis causes acute cardiac dysfunction, which may be manifested by HF.
- Type 4 – Primary CKD contributes to cardiac dysfunction, which may be manifested by coronary disease, HF, or arrhythmia.
- Type 5 (secondary) – Acute or chronic systemic disorders (eg, sepsis or diabetes mellitus) that cause both cardiac and renal dysfunction

Given the limitations imposed by impaired renal function on the ability to correct volume overload and the frequent association between impaired or worsening renal function and mortality in patients with heart failure (HF), it is possible that effective treatment of the cardiorenal syndrome (CRS) could improve patient outcomes. On the other hand, the worse prognosis in patients with HF and impaired renal function could primarily reflect a reduced glomerular filtration rate (GFR) being a marker of more severe cardiac disease. Evidence suggesting that improvement in cardiac function is associated with improved renal function in patients with types 1 and 2 CRS comes from studies of left ventricular assist devices (LVADs) and cardiac resynchronization therapy.

There are no medical therapies that have been shown to directly increase GFR in patients with the CRS. On the other hand, improving cardiac function can produce increases in GFR, indicating that types 1 and 2 CRS have substantial reversible components.

EDUCATIONAL OBJECTIVES
Upon completion of this conference, participants should be better able to:
- Define cardiorenal syndrome and the classification of cardiac and renal interactions.
- Examine the latest outcomes data for patients with Acute Kidney Injury (AKI).
- Determine the most appropriate diagnostic testing and treatment plan for patients with cardiorenal syndromes.

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter A. McCullough, M.D., MPH, FACC, FACP, FAHA, FCCP, FNKF</td>
</tr>
<tr>
<td>Vice Chief of Medicine</td>
</tr>
<tr>
<td>Baylor University Medical Center</td>
</tr>
<tr>
<td>Dallas, Texas</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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? |
| ☒ |

DATE REVIEWED: December 18, 2014 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: Thoracic Oncology Tumor Board

DATE: First Wednesday of the Month  TIME: 7:30-8:30 a.m.

Approvals: Original approval: June 2010 to June 2011; Course renewed: January 2011; December 2011; December 2012; November 2013; November 2014

Course expires: November 2016

CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 per tumor board  CHARGE: 0

LOCATION: Baptist Hospital, BCVI, Side B videoconference South Miami Hospital, Classroom F

TARGET AUDIENCE: Medical Oncologists, Radiation Oncologists, Cardiothoracic Surgeons, Pathologists, Pulmonologists, Pharmacists, Nurses, Social Workers, Radiologic Technologists and Patient Care Facilitators and all personnel involved in the care of the lung cancer patient.

EXPECTED NUMBER OF ATTENDEES: 20-25 per tumor board

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

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

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

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

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

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

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

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

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

- Other:

PROFESSIONAL PRACTICE GAP (C2)

WHAT IS/ARE THE CURRENT PRACTICE* and/or THE PRACTICE GAP*? 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.

WHAT IS THE OPTIMAL PRACTICE*? Physicians collaborate in a multidisciplinary team in the management of their thoracic oncology patients to streamline optimal patient care.

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*?

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

► Physicians present cases through the Thoracic Oncology Tumor Board when developing treatment plans for their thoracic oncology patients collaborating in multidisciplinary team approach.
The thoracic oncology multidisciplinary teams (MDT) are playing an increasing role in the management of thoracic malignancies. These teams have a great potential to improve the patient care and the health care system, however, they are faced by many challenges. To realize the full potential of these teams, a better understanding of their functions, roles, benefits and challenges from all involved including teams members and leadership is crucial. The multidisciplinary approach has become very 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. Furthermore, the development of sub-specialization in very narrow medical disciplines has made specialist expertise and input more valuable. The MDT plays a critical role in the whole spectrum of cancer management including diagnosis, staging, treatment and palliative care. (Ann Thorac Med. 2008 Jan–Mar; 3(1): 34–37., Thoracic oncology multidisciplinary teams: Between the promises and challenges, doi: 10.4103/1817-1737.38395.) Baptist South Miami Regional Cancer Center received 294 new cases of lung cancer in 2009.

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

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

- Implement optimal course of treatment for thoracic cancer patients.
- Utilize multiple disciplinary approaches to determine diagnosis and treatment options, including radiological findings.
- Determine cancer staging using various imaging modalities of thoracic cancers.
- Promote a multidisciplinary team approach by bridging gaps across the continuum of care in order to enhance the overall quality of patient-centered thoracic cancer care.

MODERATOR: Paul Kaywin, M.D.

Radiologist: Juan Carlos Battle, M.D., Hao Vuong, M.D. and Lawrence Elgarresta, M.D. Radiation Oncologist: Andre Abitbol, M.D., Allie Garcia-Serra, M.D. Cardiothoracic Surgeon: Mark Dylewski, M.D., John DeRosimo, M.D. Medical Oncologist: Federico Albrecht, M.D., Frances Behrmann, M.D., Fernando de Zarraga, M.D., Steven Fein, M.D., Leonard Kalman, M.D., Alberto Larcada, M.D., Antonio Muina, M.D., Lisa Reale, M.D., Michael Troner, M.D., Grace Wang, M.D. and Siddhartha Venkatappa M.D.

- Physician moderator takes responsibility for facilitating the discussion and ensuring that conversations are evidence-based and do not promote commercial interests. They are also responsible for disclosing when off-label treatment approaches have been addressed.
- Annual disclosures are secured from core group of contributors.
- Continuing Medical Education Department representatives attend at least one tumor board per quarter.

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

COMPETENCIES (Desirable Physician Attributes as per IOM, ACCGME and ABMS):

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

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

- Baptist Health CME Evaluation Form (post-Conference)
- Follow-up Survey
- Review of Hospital, Health System or Other Data
- Other 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 Head and Neck Tumor Board.
  - 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 Head and Neck Conference Series? What new strategies have you 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 Head and Neck Tumor Boards?
  - Comments about these Tumor Board meetings.
  - Comments/Suggestions about the OVERALL Baptist Health CME Program.
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  
☐ 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)

COMMERCIAL SUPPORT: The Baptist Health Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. Please indicate here 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. Lack of Insurance

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

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

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

DATE REVIEWED: Original Approval: June 4, 2010  
Course renewal approval: November 15, 2013  
Reviewed January 5, 2011  
Revised December 6, 2011  
Revised November 13, 2012  
Revised November 15, 2013  
Revised November 20, 2014

Applicable Credits: AMA Category 1 ☑  □ Continuing Psychology Education ☐ □ Continuing Dental Education ☐
CME ACTIVITY TITLE: Pelvic Health Study Group

DATE/S: January 20, 2015
April 21, 2015
September 15, 2015
November 10, 2015

TIME: 6-7 p.m.

CONFERENCE DIRECTOR: Jaime Sepulveda-Toro, M.D.

LOCATION: South Miami Hospital, Classroom F

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

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

TARGET AUDIENCE: Gynecologists, Urologists, Neurologists, Gastroenterologists, Colorectal Surgeons, Family Physicians, General Internists, Radiologists, Physical Medicine and Rehabilitation Physicians, Radiologic Technologists, Pelvic Health Specialists and Nurses.

EXPECTED NUMBER OF ATTENDEES: 20-25

CHARGE: 0

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

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

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

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

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

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

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

PROFESSIONAL PRACTICE GAP (C2)

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

WHAT IS/ARE THE CURRENT PRACTICE* and/or THE PRACTICE GAP*?? Standard of care may not always include a multidisciplinary approach to diagnosis and treatment of pelvic health concerns including pelvic organ prolapsed (POP), stress urinary incontinence, fecal incontinence, etc. Gaps in communication between healthcare providers and key specialists can at times delay optimal delivery of care. Physicians may not know when it is appropriate to recommend enhanced imaging, such as MRI, for evaluation of pelvic health concerns.

WHAT IS THE OPTIMAL PRACTICE*?? Physicians collaborate within a multidisciplinary team to manage patients with pelvic health concerns and determine indications for enhanced imaging, including MRI, based on initial patient evaluation.

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.)*

► Based on a multidisciplinary case-based discussion, physicians will be able to determine comprehensive evaluation and treatment of pelvic health concerns, implementing recommendations from the pelvic health study group to provide optimal patient care.

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

► Given the number of patients with pelvic health concerns seen locally for diagnostic testing at the Center for Women and Infants at South Miami Hospital, physicians need to be able to clearly identify optimal course of treatment. In FY 2013, a total of 829 patients were seen for pelvic health and continence testing.

Pelvic organ prolapse (POP) and stress urinary incontinence (SUI) are common conditions, with prevalence rates of 25 to 65 and 20 to 55 percent, respectively. (Vaginal pessary treatment of prolapse and incontinence, May 20120, uptodate.com) Treatment for pelvic organ prolapse is individualized according to each patient’s symptoms and their impact on quality of life. Studies have demonstrated that patient satisfaction after pelvic reconstructive surgery correlates highly with achievement of self-described, preoperative surgical goals, but poorly with objective outcome measures. (An overview of the epidemiology, risk factors, clinical manifestations, and management of pelvic organ prolapse in women, January 2012, uptodate.com)

**EDUCATIONAL OBJECTIVES:**
Upon completion of this *multidisciplinary team-based case review and discussion*, participants should be better able to:

- Implement enhanced imaging protocols based on clinical indications for patients with pelvic health concerns as well as for surgical planning and evaluation of recurrence.
- Select and appropriately implement optimal course of treatment for patients with pelvic health concerns given patients’ symptoms.
- Bridge communication gaps across the continuum of care to enhance patient’s quality of life and improve delivery of care.

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

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

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

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

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

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

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

**MODERATOR**
Jaime Sepulveda-Toro, M.D.
Obstetrician and Gynecologist
South Miami Hospital

**CORE GROUP OF CONTRIBUTORS:** Rafael Perez, M.D., Claudia Penalba, M.D., Antonio Mesa, M.D., Michael Hellinger, M.D. and Sujata Yavagal, M.D.

► Moderator takes responsibility for facilitating the discussion and ensuring that conversations are evidenced-based and *do not promote commercial interests*. Moderator is also responsible for disclosing when off-label treatment approaches have been addressed.

► Annual disclosures are secured from core group of contributors.

► Continuing Medical Education Department representatives attend at least one study group meeting per year.
Activity discussion will cover the multidisciplinary approach to the care of patients with pelvic health concerns including the role of enhanced imaging in diagnosis and surgical planning through case presentations and group discussion. The moderator will provide patient clinical history and determine optimal course of treatment including optional imaging.

Magnetic resonance imaging (MRI) of pelvic organ prolapse is technically feasible and has several advantages when compared with fluoroscopic cystoproctography. Organ descent and the supportive structures of the pelvic floor can be assessed with MRI. The role of MRI in evaluating patients with pelvic floor dysfunction is evolving, and there have been many developments in the past few years. (Abdominal Imaging. 27(6):660-73, 2002 Nov-Dec.)

Contemporary fast magnetic resonance imaging techniques allow dynamic evaluation of the entire female pelvic floor with excellent visualization of pelvic organs and muscular and fascial supportive structures in a single noninvasive study that does not expose the patient to ionizing radiation. This article focuses on the role of magnetic resonance imaging in defining pelvic floor defects that can guide surgical management of women with pelvic organ prolapse, especially those who undergo evaluation for symptoms of multicompartmental involvement before a complex pelvic floor reconstruction or those who have failed previous repairs. (Topics in Magnetic Resonance Imaging. 17(6):417-426, December 2006.)
DATE: 3rd. Tuesday of the month
LOCATION: BHM, 5BCVI Conference Room - Side B
TIME: 7:30 - 8:30 a.m. - Tuesday
CONFERENCE DIRECTORS: Kevin Abrams, M.D., Italo Linfante, M.D. and Sergio Gonzalez-Arias, M.D.
CREDIT HOUR(S) APPLIED FOR: 1 category 1 each (Tuesday)
This activity addresses professional practice gaps relevant to physicians in the practice of neurology and neurosurgery. In addition, physicians that identify conditions and refer patients to a neurologist or neurosurgeon, and those specialists to whom a neurologist or neurosurgeon might refer for further evaluation or treatment, are also included in the target audience, as are members of the hospital care team, i.e.: nurses, etc. (C4).

TYPE OF MEETING (FORMAT): (Must be appropriate to the setting, objectives and desired results.)
- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- Other (specify)_________
The series will provide an intensive, practical focus on evidence-based approaches to complex everyday problems that span the realm of neurology with emphasis on recent advances in the diagnosis and treatment strategies needed to improve clinical performance at the Neuroscience Center. An interactive format will include a didactic presentation with case reviews, and question and answer panel discussions. Clinical case correlations will be discussed during the presentations.

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

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

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

Provide reference(s) in this section that support the current practice, the optimal practice and/or the practice gap(s).
WHAT IS THE CURRENT PRACTICE? (What are doctors not doing or doing that needs to change?)
The Baptist Health Neuroscience Center of Excellence continues to expand its clinical performance in the areas of stroke, neuro oncology, epilepsy management, and other neuro specialties. In September 2014, Baptist Hospital was certified by the Joint Commission as a Comprehensive Stroke Center being the 2nd hospital in the state of Florida and 1st hospital in South Florida. Some of the metrics included for certification are shown on the stroke dashboard below. The metrics include outcome measures for stroke patients receiving IV TPA, IA TPA, mechanical endovascular reperfusion therapy, or surgical intervention (coiling, clipping, and craniotomy). Physicians are not consistently following all metrics to support optimal care and compliance with the new measures. Physician and clinical education is necessary to increase compliance.
In order to continue improving performance, three different Team Refocus Imagine Measure (TRIM) projects are scheduled in FY 2015 to improve results on length of stay (LOS), door to needle for IV t-PA and door to groin/reperfusion. The Stroke Committee is a multidisciplinary, collaborative, patient-centered, and focused on decisions that were in the best interest of the stroke patients.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Compliance Goal</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
<th>FY 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke Orders Compliance</td>
<td>&gt; 90%</td>
<td>84%</td>
<td>91%</td>
<td>93%</td>
<td>93%</td>
<td>94%</td>
</tr>
<tr>
<td>Overall Stroke ALOS</td>
<td>&lt; 4.6 days</td>
<td>5.2</td>
<td>4.7</td>
<td>4.8</td>
<td>4.7</td>
<td>5.0</td>
</tr>
<tr>
<td>Total # of B.E.S.T. Calls</td>
<td></td>
<td>628</td>
<td>684</td>
<td>652</td>
<td>715</td>
<td>754</td>
</tr>
<tr>
<td>% of Coded Strokes from B.E.S.T. Calls</td>
<td></td>
<td>61%</td>
<td>56%</td>
<td>56%</td>
<td>59%</td>
<td>55%</td>
</tr>
<tr>
<td>Door to Needle</td>
<td></td>
<td>1hr 30 min</td>
<td>1hr 28 min</td>
<td>1hr 23 min</td>
<td>60 min</td>
<td>57 min</td>
</tr>
</tbody>
</table>

**Primary Stroke Center - Core Measures**

| STK 1 - VTE (DVT) prophylaxis                      | > 90%           | 94%     | 98.6%   | 100%    | 100%    | 100%    |
| STK 2 - Discharge on antithrombotics therapy      | > 90%           | 99%     | 100%    | 100%    | 100%    | 100%    |
| STK 3 - Patients w/ afib discharged on anticoagulation therapy | > 90%       | 96%     | 100%    | 100%    | 100%    | 100%    |
| STK 4 - Thrombolytic therapy administered (tPA)   | > 90%           | 94%     | 100%    | 100%    | 100%    | 100%    |
| STK 5 - Antithrombotic therapy administered by end of day 2 | > 90%       | 99%     | 99.1%   | 98%     | 99%     | 100%    |
| STK 6 - Discharge on statin medication            | > 90%           | 96%     | 99.5%   | 100%    | 99%     | 100%    |
| STK 8 - Stroke Education                          | > 90%           | 91%     | 100%    | 98%     | 100%    | 100%    |
| STK 10 - Assessed for Rehabilitation              | > 90%           | 98%     | 99.9%   | 100%    | 100%    | 100%    |

**Comprehensive Stroke Center – Outcomes Metrics**

<table>
<thead>
<tr>
<th>CSTK-01 NIH for CVA Patients prior any recanalization or w/in 12hrs hosp arrival</th>
<th>&gt; 55%</th>
<th>50%</th>
<th>75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSTK-02 Modified Rankin Score (mRS) for IV, IA, MR</td>
<td>&gt; 55%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>CSTK-03 Severity Measurement Performed for SAH and ICH Patients (Overall Rate) w/in 6hrs</td>
<td>&gt; 55%</td>
<td>29%</td>
<td>58%</td>
</tr>
<tr>
<td>CSTK-04 INR Reversal Achieved</td>
<td>&gt; 55%</td>
<td>82%</td>
<td>100%</td>
</tr>
<tr>
<td>CSTK-05 Hemorrhagic Complications (Overall Rate)</td>
<td>&gt; 55%</td>
<td>95%</td>
<td>1%</td>
</tr>
<tr>
<td>CSTK-06 Nimodipine Treatment Administered within 24hrs</td>
<td>&gt; 55%</td>
<td>73%</td>
<td>92%</td>
</tr>
<tr>
<td>CSTK-07a Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade</td>
<td>&gt; 55%</td>
<td>89%</td>
<td>91%</td>
</tr>
</tbody>
</table>

**WHAT IS THE OPTIMAL PRACTICE?** (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?) The Neuroscience Center will consistently meet the target mark for comprehensive performance indicators.

There are a number of key areas supported by evidence-based medicine that are important for a comprehensive stroke center and its ability to deliver the wide variety of specialized care needed by patients with serious cerebrovascular disease. These areas include: (1) health care personnel with specific expertise in a number of disciplines, including neurosurgery and vascular neurology; (2) advanced neuroimaging capabilities such as MRI and various types of cerebral angiography; (3) surgical and endovascular techniques, including clipping and coiling of intracranial aneurysms, carotid endarterectomy, and intra-arterial thrombolytic therapy; and (4) other specific infrastructure and programmatic elements such as an intensive care unit and a stroke registry. Integration of these elements into a coordinated hospital-based program or system is likely to improve outcomes of patients with strokes and complex cerebrovascular disease who require the services of a comprehensive stroke center. ([http://stroke.ahajournals.org/cgi/content/full/36/7/1597](http://stroke.ahajournals.org/cgi/content/full/36/7/1597))
The specific outcomes metrics for Comprehensive Stroke Center pilot study includes documentation of NIHSS, Hunt & Hess Scale Score, ICH Score, Modified Rankin Score (mRS) at 90 days post discharge, and outcomes measures on hemorrhagic complications, INR reversal, nimodipine treatment administration, and times for recanalization. Optimal practice will be determined by meeting compliance at or above 80% for the new measures. Action plans will be developed and monitored monthly throughout the fiscal year. The success of compliance will be as a result of a multidisciplinary team including ED, Neurology, Neurosurgery, Neuroradiology, Interventional Neuroradiology, Nursing, Lab, Pharmacy, and Neuroscience Leadership.

The goal is to continue improving compliance to maintain Comprehensive Stroke Certification status for the next 2 years. Monitoring performance will allow us to participate in potential research studies and publications for stroke outcomes. BHM participates in the American Heart/Stroke Association (AHA/ASA) Get with the Guidelines (GWTG), which is a stroke quality improvement initiative that allows to benchmark against local and national hospitals. For the last 3 years, BHM has received the GWTG Gold Plus Award and for 2 consecutive years the Target Stroke award. For 2015, AHA/ASA will incorporate a higher level Target Stroke award to encourage hospitals to improve measures compliance at a higher level. BHSF has completed agreements with EMS Miami-Dade Stroke Coalition to enroll in Get with the Guidelines to collect data and share information to benchmark blinded data against other hospitals.

In 2015, Baptist Health Neuroscience Center will expand the scope telemedicine for neurosurgery to provide consultation for sister hospitals who do not have neurosurgery services. This will help with appropriate transfer of patients within BHSF entity to BHM and provide the best treatment option for patient care.

The Baptist Neuro Oncology program continues to expand with two (2) neurosurgeons onboard in 2014 and the collaboration with the Miami Cancer Institute. Even though, the Neuro Tumor Board conferences were implemented in spring 2014, this will be another venue to educate physicians, clinical and professional staff.

WHAT IS THE PRACTICE GAP? (C2) PRACTICE GAP:
Physicians are not aware of the clinical performance guidelines for the Comprehensive Stroke Center certification. Monthly compliance reports will continue to be developed to communicate the gaps in practice. As the telemedicine program at BHSF expands, physicians may not be aware of the available services, standards, and protocols. In addition, other hospitals may not be aware of the expansion of the Neuro Oncology program with its growth in surgery technology, new neurosurgery techniques, and much more. CME programs will focus on topics and case reviews in relation to the outcomes of patients being treated and discuss any opportunity of improvement in practice care.

WHAT IS THE REASON FOR THIS GAP? (Educational needs.) (C2) What kind of gap is causing this deviation from optimal practice? Is this a Knowledge Gap? -or- Competence Gap? -or- Performance Gap? (Check one or more.)

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

►Neuroscience Center will standardize patient care by following practice guidelines resulting in improvements in the overall Clinical Performance (PI) for fiscal year 2015.

This series will serve as a review and update on the most recent advances in the diagnosis and treatment of common neurological clinical problems that face neurologists, neurosurgeons, intensivists, and nurse practitioners in their daily practices.

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

Upon completion of this conference, participants should be better able to:
- Follow evidence-based best practice parameters for the diagnosis and treatment of the neurovascular and/or neurosurgery patient, utilizing multiple approaches, including neuro imaging findings.
- Utilize optimal clinical management protocol for a variety of cranial and spinal conditions.
- Describe the indications for the practical applications of and the potential complications of advanced endovascular techniques, such as those used in the treatment of cerebrovascular disease and tumors.
• Implement novel surgical techniques for the treatment of common and complex conditions, including spinal tumors and deformity, and apply complication avoidance/management.

**Topics to be discussed:**

i. Stroke management and prevention  
ii. Extracranial and Intracranial stenting in acute stroke  
iii. Raptured vs. unraptured cerebral aneurysms  
iv. Imaging in neurovascular disease  
v. Subarachnoid hemorrhage and intracerebral hematomas - Treatment options  
vi. Seizure management  
vii. Epilepsy management  
viii. Brain tumors  
ix. Minimally invasive spine surgery  
x. Deformity spine surgery  
xi. Radiological diagnosis of lumbar spine  
 xii. Normal pressure hydrocephalus  
xiii. Dementia update  
xiv. Kyphoplasty for benign and malignant spinal fractures  
 xv. Outpatient spine surgery  
xvi. Arteriovenous fistulas  
xvii. Cerebral vasospasm

**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

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

- 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:**

TBD

**MONITORING SYSTEM**

**CONFERENCE DIRECTORS:**
Physician moderators and/or Conference Directors take responsibility for facilitating the discussion and ensuring that conversations do not promote commercial interests. They are also responsible for disclosing when off-label treatment approaches have been addressed.

**EVALUATION METHOD(S):**
- [ ] Baptist Health CME Evaluation Form (post-Conference)  
- [ ] Review of Hospital, Health System or Other Data  
- [ ] Follow-up Survey  
- [ ] Other All Neuroscience Focus Series participants will be asked to evaluate each activity and an annual series evaluation quarterly.

**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.

**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?**  
- [ ] Yes  
- [ ] No  

- CME Program Manager: Eleanor Abreu  
- Conference Directors (see above)  
- Medical Director  
- Corporate Director  
- Medical Education Committee  
- Others (i.e.: Conference Coordinator, Department representative, etc.) Cris Alegria-Agroto

Annual disclosure forms are required from all attendees, moderators, CME program manager and on-site coordinator with department. All participants’ relevant financial relationships (or lack thereof) are disclosed to
participants at the beginning of the neuroscience conference. These are listed on the sign-in sheet that all attendees are required to sign. (Criterion 7)

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

COMMERCIAL SUPPORT: The Baptist Health Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. Please indicate here 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)? ☑ 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 internal or external stakeholders that are related to this CME activity? (C20) Are we collaborating in partnership with other organizations in a purposeful manner to achieve common interests? List collaborative efforts related to this CME activity that support achievement of our CME Mission.

Currently, BHM continues to collaborate as a system to implement Primary Stroke Center requirements at other BHSF entities. The System 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.

DATE REVIEWED: 12/22/2014 REVIEWED BY: ☑ Executive Committee ☑ Chairman

APPROVED: ☑ YES ☐ NO □ Continuing Education Credits: AMA/PRA Category 1 Credits: # 1/ea (Tue); Continuing Psychology Education Credits: # 1/ea (Tue) □N/A □ Continuing Dental Education Credits: # □N/A

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Topic &amp; Presenter</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 27</td>
<td>5 MCVI – Side B</td>
<td>Update of stenting procedures in cerebro-vascular disease</td>
<td>Dr. Linfante</td>
</tr>
<tr>
<td>*4th Tue.</td>
<td></td>
<td>switched with Neuro DAC</td>
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<td>Feb. 17</td>
<td>5 MCVI – Side B</td>
<td>Current trends in the surgical management of movement disorders</td>
<td>Dr. Sporrer</td>
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<td>Mar. 17</td>
<td>5 MCVI – Side B</td>
<td>Multidisciplinary management of skull base tumors</td>
<td>Drs. Siomin/Pernas</td>
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<td>Apr. 21</td>
<td>5 MCVI – Side B</td>
<td>Clinical assessment of the comatose patient</td>
<td>Dr. Fuentes</td>
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<td>May 19</td>
<td>5 MCVI – Side B</td>
<td>Current trends in medical oncology management of brain tumors</td>
<td>Dr. Guardiola</td>
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<td>June 16</td>
<td>5 MCVI – Side B</td>
<td>Current trends in the assessment and management of Cerebral Concussions</td>
<td>Dr. Whiting</td>
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<td>July 21</td>
<td>5 MCVI – Side B</td>
<td>Update in current strategies for the rehabilitation of stroke patients</td>
<td>Dr. Aiken</td>
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<tr>
<td>Aug. 18</td>
<td>5 MCVI – Side B</td>
<td>Intra-operative multimodality imaging in Neurosurgery</td>
<td>Dr. Gonzalez-Arias</td>
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<tr>
<td>Sept. 15</td>
<td>5 MCVI – Side B</td>
<td>Efficient use of imaging modalities in patients with stroke symptoms</td>
<td>Dr. Abrams</td>
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<tr>
<td>Oct. 20</td>
<td>5 MCVI – Side B</td>
<td>Surgical indications in the management of cerebrovascular disease</td>
<td>Dr. Klem</td>
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<tr>
<td>Nov. 17</td>
<td>5 MCVI – Side B</td>
<td>Current trends in the multidisciplinary management of epilepsy</td>
<td>Dr. Pinzon</td>
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<tr>
<td>Dec. 15</td>
<td>5 MCVI – Side B</td>
<td>Neuropathology update</td>
<td>Dr. Rubin or Gould (Tentative)</td>
</tr>
</tbody>
</table>
CME ACTIVITY TITLE: Cardiac Cath and Cardiac Surgery Clinical Review

DATE/TIME:  Jan-Dec 2015, 7:30-8:30 a.m.  
LOCATIONS: 5MCVI – Side B (Lourdes Santiago) 
MCVI Conf. Room at SMH (Stacy Miller)

1/22/15  5/28/15  9/24/15
2/26/15  6/25/15  10/22/15
3/26/15  7/23/15  11/24/15
4/23/15  8/27/15  12/14/15

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

CONFERENCE DIRECTOR: Ramon Lloret, M.D. and Alvaro Montoya, M.D. (LloretMD@gmail.com and conalvaro2@yahoo.com)
CONFERENCE COORDINATOR: Lourdes Santiago/ Stacy Miller

TARGET AUDIENCE: Invited Baptist Health Cardiologists, Cardiovascular Surgeons and Cardiac Cath Lab nurses and radiology technologists.
In addition, describe how the content of the activity is aligned with the target learners’ current or potential scope of practice (C4). This activity addresses professional practice gaps relevant to physicians in the practice of cardiology. In addition, physicians that identify conditions and refer patients to a cardiovascular surgeon and those specialists to whom a cardiologist might refer for further evaluation or treatment.

EXPECTED NUMBER OF ATTENDEES:  10-15  
CHARGE:  0

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

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

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

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

WHAT IS/ARE THE CURRENT PRACTICE* and/or THE PRACTICE GAP*? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
Physicians 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 cardiologists and cardiac surgeons 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 cardiologists and cardiac surgeons will participate regularly in a clinical review educational activity to remain current with up-to-date information on evidence-based practice and research findings.

**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)

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**EDUCATIONAL OBJECTIVES:**

Upon completion of this conference, participants should be better able to:
- Review results from various cath and cardiac surgery cases.
- Implement evidence-based strategies into clinical practice to improve care of the cardiac patient.

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

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

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

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

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

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

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

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

Moderators

**Ramon Lloret, M.D.**  
Cardiologist  
Baptist and West Kendall Baptist Hospitals

**Alvaro Montoya, M.D.**  
Cardiothoracic Surgeon  
Baptist and South Miami Hospitals
## RELEVANT FINANCIAL RELATIONSHIPS:
List individuals in control of the content of this CME activity (other than faculty).

<table>
<thead>
<tr>
<th>Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Yes ☐ No Medical Education Dept. Leadership and Staff ☑ Medical Education Committee</td>
</tr>
<tr>
<td>☐ Conference Director (see above) ☐ Others (i.e.: Conference Coordinator, Planning Group etc.)</td>
</tr>
</tbody>
</table>

## 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? (C15)
☐ Yes ☑ No  If yes, please describe the related CME program change. _________________________

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

## NON-EDUCATION STRATEGIES:
Explain what we are doing (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. ______________

BCVI and SMHC Cardiac Cath/ Cardiac Surgery staff

## DATE REVIEWED: December 12, 2014 REVIEWED BY: ☑ Executive Committee ☐ Chairman

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

Continuing Psychology Education Credits: # ___ ☑ N/A  ■ Continuing Dental Education Credits: # ___ ☐ N/A
CME ACTIVITY TITLE: South Miami Hospital Schwartz Center Rounds (RSS)

DATE: Tuesday, January 13, 2015
Tuesday, March 10
Tuesday, May 12
Tuesday, July 14
Tuesday, September 8
Tuesday, November 10

TIME: 12 noon – 1 p.m.

Location: South Miami Hospital
Auditorium 1 & 2 - January 2015
Classrooms E & F for remaining dates

CONFERENCE DIRECTOR: Erik B. Bernstein, M.D.

CREDIT HOUR(S) APPLIED FOR: 1 Category 1 each

FACILITATOR: Arnold Fonticiella, Supervisor – Palliative Care Services, SMH Nursing Administration

TARGET AUDIENCE: Physicians, Psychologists, Nurses, Social Workers, Pharmacists, Respiratory Therapists, Dieticians and all other interested healthcare providers.

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

This activity addresses professional practice gaps in effective communication relevant to healthcare professionals who interact with other healthcare professionals as well as with patients and family members as are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 90-100

CHARGE: 0

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

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

Schwartz Center Rounds are a multidisciplinary forum where caregivers discuss difficult emotional and social issues that arise in caring for patients. A case is presented by a panel of ~3 healthcare professionals representing multiple disciplines and points of view. A facilitator then engages the audience in an interactive discussion about the case and participants' shared experiences. Thousands of clinicians across the country participate in the Schwartz Center Rounds at 182 sites in 30 states (as of December 1, 2009).

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

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

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

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

Other:__________________________________________________________

PROFESSIONAL PRACTICE GAP (C2)

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

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

WHAT IS THE CURRENT PRACTICE? (What are doctors not doing or doing that needs to change?)

Current physician practices does not include effective models of communication and relationships with patients, families and other healthcare providers. Physicians may not be familiar with the research that forms the evidence that effective communication and relationships have a impact on patients, families, and healthcare providers.

Fostering effective communication and relationships among healthcare providers and with patients and families is a significant challenge in our complex healthcare system. A large body of evidence supports the impact of effective communication and relationships on patients, families, and healthcare providers. Some progress has been made in teaching and assessing

Page 23 of 73
communication and caring and compassionate attitudes in undergraduate and graduate medical education. However, the healthcare community has not systematically addressed the need to foster compassion, teamwork, support and relationship-centered care across the continuum of health professional education.

http://www.theschwartzcenter.org/programs/CME_credit.htm

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

Physicians engage in health systems that foster compassion, teamwork, support and relationship-centered care across the continuum of health professional education.

References supporting optimal practice:

The Rounds provide an opportunity to enhance relationships and communication between patients, family members and providers, and among providers across disciplines and professions.

http://www.theschwartzcenter.org/programs/CME_credit.htm

WHAT IS THE REASON FOR THIS GAP? (Educational needs.) (C2) What kind of gap is causing this deviation from optimal practice? Is this a Knowledge Gap? -or- Competence Gap? -or- Performance Gap? (Check one or more.)

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

► The Schwartz Center Rounds national evaluation study demonstrated the following self-reported healthcare provider outcomes:

- Improved understanding of the patient “as a whole person” within his/her unique context, and the impact of illness on the patient and family.
- Increased insight into the psychosocial and emotional aspects of care.
- Enhanced empathy.
- Enhanced understanding of the perspectives of colleagues within and across disciplines and professions.
- Improved teamwork.
- Improved sense of support and decreased sense of work stress and isolation.

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

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

- Address the social, emotional, ethical, and personal issues that arise during the care of patients, and examine their impact on caregivers.
- Demonstrate enhanced communication with patients, family members and colleagues.
- Identify opportunities to explore and apply multiple perspectives across professions and disciplines in order to provide and receive professional support.
- Develop a model for behaviors of nonjudgmental listening and respect.

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

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

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

- Baptist Health CME Evaluation Form (post-Conference)
- Review of Hospital, Health System or Other Data
- Schwartz Center Rounds Evaluation Form – Part of a National Study Report

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:
TBD

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.) The SMH Schwartz Center Committee

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

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on ‘overcoming, addressing, or removing barriers to physician change’ applicable to our learners? ☑ Yes ☐ No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.
However, the healthcare community has not systematically addressed the need to foster compassion, teamwork, support and relationship-centered care across the continuum of health professional education.

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 internal or external stakeholders that are related to this CME activity? (C20) Are we collaborating in partnership with other organizations in a purposeful manner to achieve common interests? ☑ Yes ☐ No
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. The Kenneth B. Schwartz Center and the South Miami Hospital Schwartz Center Rounds Planning committee.

DATE REVIEWED: January 6, 2015 REVIEWED BY: ☑ COMMITTEE ☐ CHAIRMAN ☑ EXECUTIVE COMMITTEE

APPROVED: ☑ YES ☐ NO Category 1 Credits: 1/ea Continuing Psychology Education credits: 1/ea

CME ACTIVITY TITLE: Doctors Hospital Schwartz Center Rounds (RSS)
CONFERENCE DIRECTOR: Richard Whittington, M.D.  CREDIT HOUR(S) APPLIED FOR: 1 Category 1 each
FACILITATOR: Luisa Pacheco, Psy D,LCSW,CCM,CPHM, Director of Social Work/Case Management

TARGET AUDIENCE: Physicians, Psychologists, Nurses, Social Workers, Pharmacists, Respiratory Therapists, Dieticians and all other interested healthcare providers.

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

This activity addresses professional practice gaps in effective communication relevant to healthcare professionals who interact with other healthcare professionals as well as with patients and family members as are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 40-50 CHARGE: 0

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

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

Schwartz Center Rounds are a multidisciplinary forum where caregivers discuss difficult emotional and social issues that arise in caring for patients. A case is presented by a panel of ~ 3 healthcare professionals representing multiple disciplines and points of view. A facilitator then engages the audience in an interactive discussion about the case and participants’ shared experiences. Thousands of clinicians across the country participate in the Schwartz Center Rounds at 182 sites in 30 states (as of December 1, 2009).

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

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

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

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

PROFESSIONAL PRACTICE GAP (C2)

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

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

WHAT IS THE CURRENT PRACTICE? (What are doctors not doing or doing that needs to change?)

Current physician practices does not include effective models of communication and relationships with patients, families and other healthcare providers. Physicians may not be familiar with the research that forms the evidence that effective communication and relationships have a impact on patients, families, and healthcare providers.

Fostering effective communication and relationships among healthcare providers and with patients and families is a significant challenge in our complex healthcare system. A large body of evidence supports the impact of effective communication and relationships on patients, families, and healthcare providers. Some progress has been made in teaching and assessing
communication and caring and compassionate attitudes in undergraduate and graduate medical education. However, the healthcare community has not systematically addressed the need to foster compassion, teamwork, support and relationship-centered care across the continuum of health professional education.

http://www.theschwartzcenter.org/programs/CME_credit.htm

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

Physicians engage in health systems that foster compassion, teamwork, support and relationship-centered care across the continuum of health professional education.

References supporting optimal practice:

- The Rounds provide an opportunity to enhance relationships and communication between patients, family members and providers, and among providers across disciplines and professions.

http://www.theschwartzcenter.org/programs/CME_credit.htm

**WHAT IS THE REASON FOR THIS GAP?** (Educational needs.) (C2) What kind of gap is causing this deviation from optimal practice? Is this a ✓ Knowledge Gap? -or- ✓ Competence Gap? -or- ✓ Performance Gap? (Check one or more.)

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

- The Schwartz Center Rounds national evaluation study demonstrated the following self-reported healthcare provider outcomes:
  - Improved understanding of the patient “as a whole person” within his/her unique context, and the impact of illness on the patient and family.
  - Increased insight into the psychosocial and emotional aspects of care.
  - Enhanced empathy.
  - Enhanced understanding of the perspectives of colleagues within and across disciplines and professions.
  - Improved teamwork.
  - Improved sense of support and decreased sense of work stress and isolation.

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

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

- Address the social, emotional, ethical, and personal issues that arise during the care of patients, and examine their impact on caregivers.
- Demonstrate enhanced communication with patients, family members and colleagues.
- Identify opportunities to explore and apply multiple perspectives across professions and disciplines in order to provide and receive professional support.
- Develop a model for behaviors of nonjudgmental listening and respect.

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

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

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

- Baptist Health CME Evaluation Form (post-Conference)
- Follow-up Survey
- Review of Hospital, Health System or Other Data
- Other Schwartz Center Rounds Evaluation Form – Part of a National Study Report

**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:
TBD

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.) The SMH Schwartz Center Committee

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

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on ‘overcoming, addressing, or removing barriers to physician change’ applicable to our learners? ☐ Yes  ☐ No  If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.
However, the healthcare community has not systematically addressed the need to foster compassion, teamwork, support and relationship-centered care across the continuum of health professional education.

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 internal or external stakeholders that are related to this CME activity? (C20) Are we collaborating in partnership with other organizations in a purposeful manner to achieve common interests? ☐ Yes  ☐ No
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.
The Kenneth B. Schwartz Center and the South Miami Hospital Schwartz Center Rounds Planning committee.

DATE REVIEWED:  January 6, 2015  REVIEWED BY:  ☐ COMMITTEE  ☐ CHAIRMAN  ☒ EXECUTIVE COMMITTEE

APPROVED:  ☒ YES  ☐ NO  Category 1 Credits:  1/ea  Continuing Psychology Education credits:  1/ea

Applicable Credits: AMA Category 1 ☒  ☐ Continuing Psychology Education ☐  ☐ Continuing Dental Education
**CME ACTIVITY TITLE:** Breast Cancer Tumor Board

**DATE:** Weekly, Friday  
**TIME:** 7:30-8:30 a.m.

**ORIGINAL APPROVAL:** July 2010 - July 2011  
**Renewed:** July 2012; March 26, 2012; November 2013; July 2014  
**Expiration:** July 2016

**CREDIT HOUR(S) APPLIED FOR:** 1.5 Cat. 1 each  
**CHARGE:** 0

**LOCATION:** Baptist Hospital, BCVI, Side B videoconference  
South Miami Hospital, BHSF Breast Center, Medical Arts Buildings,  
Suite 302 and Doctors Hospital, Capri conference room

**TARGET AUDIENCE:** Medical Oncologists, Radiation Oncologists, Breast Cancer Surgeons, General Surgeons, Pathologists,  
Radiologists, Gynecologists, Pharmacists, Nurses, Social Workers, Radiologic Technologists, Patient Care Facilitators and all personnel involved in the care of the breast cancer patient.

**EXPECTED NUMBER OF ATTENDEES:** 20-25 per tumor board

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

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

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

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

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

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

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

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

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

- **Other:** ____________________________________________

**PROFESSIONAL PRACTICE GAP (C2)**

**WHAT IS/ARE THE CURRENT PRACTICE** and/or **THE PRACTICE GAP**? 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 for cancer patients.

**WHAT IS THE OPTIMAL PRACTICE**? Physicians collaborate in a multidisciplinary team in the management of their breast cancer patients to achieve optimal patient care.

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

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

**DESIZED 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**?

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

► Physicians present cases to the Breast Cancer Tumor Board when developing treatment plans for their breast cancer patients collaborating in multidisciplinary team approach. A Quarterly Evaluation Summary of all attendees will assess impact on patient outcomes.

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

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Page 29 of 73
A multidisciplinary focus entails prevention, diagnosis and treatment had led to significant strides in the reduction of breast cancer incidence and mortality. Additionally, breast cancer management has become increasingly complex, requiring comprehensive assessment and review of multiple issues that include the role of genetic testing, imaging and breast magnetic resonance imaging, surgical and reconstructive options, and a variety of new adjuvant therapies. It has become more evident that a multidisciplinary team approach that involves a spectrum of breast experts is necessary to provide optimal care to patients. This team includes medical oncologists, breast radiologists, breast pathologists, surgical breast specialists, radiation oncologists, geneticists, and primary care physicians. (Mayo Clin Proc. A Multidisciplinary Approach to the Management of Breast Cancer, Part 1: Prevention and Diagnosis, 2007;82(8):999-1012)


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

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

- Implement optimal course of treatment for breast cancer patients.
- Utilize multiple disciplinary approaches to diagnosis and treatment options, including radiological findings, pathological findings and immunohistochemical testing.
- Determine cancer staging using various breast imaging modalities.
- Promote a multidisciplinary team approach by bridging gaps across the continuum of care in order to enhance the overall quality of patient-centered breast cancer care.

CONTENT: Case-based, tumor board presentation and discussion. Each meeting includes presentation of patient cases, diagnostic findings and a peer-to-peer discussion to determine optimal treatment plan.

- Treatment modalities to be discussed include surgery, chemotherapy and radiation both in combination or alone based on patient prognosis.
- The entire breast cancer multidisciplinary team will discuss their specialty area as it pertains to the diagnosis and treatment of breast cancer including discussion of test findings. The team includes oncologists, radiologists, surgeons, radiation oncologists and pathologists.
- Breast cancer is staged according to American Joint Commission on Cancer guidelines which use Primary Tumor (T), Regional Lymph Nodes (N), and Distant Metastasis (M) to establish a Stage Grouping.
- A team approach to care is fostered through peer-to-peer discussion and collaboration for treatment plan development and follow-up through participation in tumor boards.

Potential Topics for Breast Cancer Tumor Board

- Multidisciplinary approach to breast cancer care
- Radiation therapy in breast cancer treatment
- Surgical interventions for breast cancer treatment
- Bilateral breast malignancy
- Lumpectomy
- Mastectomy complications
- Lumpectomy, wide excision
- Chemotherapy
- Tamoxifen
- Breast cancer staging
- Breast reconstruction
- Breast cancer with lymph node involvement
- Ductal carcinoma in situ
- Prognosis
- Paget's Disease
- Invasive breast cancer
- Breast cancer with distal metastasis
- Breast MRI
- Breast Ultrasound
- Tumor pathology
- Breast biopsy results
- Papillary carcinomas
- Colloid carcinomas
- Breast sarcoma
- Bilateral breast mastectomy
- Interventions for early stage breast cancer
- Interventions for advanced breast cancer
- Hormone receptor (estrogen or progesterone receptor) positive
- Phyllodes Tumor
- HER2 positive
- Triple negative, not positive to receptors for estrogen, progesterone, or HER2.
- Lobular carcinoma
- Angiosarcoma

FORMAT

- Case presentation/s: Findings from patients’ diagnostic tests are shared with the group as well as pertinent patient history.
- Peer-to-peer discussion: Treatment plans are developed based on multispecialty discussion.
MODERATORS: Gladys Giron, M.D.

CORE GROUP OF CONTRIBUTORS
Pathologists: Norberto Cartagena, M.D., Ronald Goerss, M.D., Edwin Gould, M.D., Niloofar Nasser Nik, M.D., Rajshri Shah, M.D. Douglas Reale, M.D., Christian Otrakji, M.D., Andrew Renshaw, M.D. and Daniel Rubin, M.D., Andrea Subhawong, MD, Sherry Thompson, MD and Ana Viciana, M.D.
Radiologists: Hao Vuong, M.D., Maria-Pilar Martinez, M.D., Joanna Tewlik, D.O., Lawrence Elgarresta, MD and Cristina Vieira, M.D.
Radiation Oncologists: Alan Lewin, M.D., Andre Abitbol, M.D., Maria-Amelia Rodrigues, M.D., Allie Garcia Serra, M.D.
Surgeons: Michael Canning, M.D., Robert Derhagopian, M.D., Gladys Giron, M.D., Cristina Lopez-Penalver, M.D., Manuel Torres Salichs, M.D., Jaime Flores, M.D., Deidre Marshall, M.D., Max Polo, M.D., Robert Tershakovec, M.D.
Medical Oncologists: Grace Wang, M.D., Frances Behrmann, M.D., Sara Garrido, M.D., Michael Troner, M.D.
Nursing: Dora Escobedo, ARNP

► Physician moderators take responsibility for facilitating the discussion and ensuring that conversations are evidenced-based and do not promote commercial interests. They are also responsible for disclosing when off-label treatment approaches have been addressed.

► A Continuing Medical Education Department representative attend at least one tumor board per quarter.

► A department coordinator supports these efforts.

► Annual disclosures are secured from core group of contributors.

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)

COMPETENCIES (Desirable Physician Attributes as per IOM, ACGME and ABMS):

☐ Patient Care  ☒ Medical Knowledge  ☐ Interpersonal and Communications Skills

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

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

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

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

► The post-conference evaluation question are included in quarterly evaluations to access impact on performance and patient outcomes.

Have you changed/adjusted your treatment plans based on tumor board discussions?  ☐ Yes  ☐ No

Have you implemented any strategies discussed at the Breast Cancer Tumor Board?  ☐ Yes  ☐ No

Please tell us about any success you may have had in implementing strategies discussed at this tumor board.

Please tell us about any setback you may have had in implementing strategies discussed at this tumor board.

Has your participation in this tumor board helped your delivery of patient care?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
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</thead>
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<tr>
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<td>Little</td>
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<tr>
<td>1</td>
<td>Not at all</td>
</tr>
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</table>
MONITORING SYSTEM

PROMOTIONAL MATERIALS: Created in compliance with ACCME criteria by Continuing 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 for moderators and core group of contributors 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 ☒ Continuing Medical Education Committee
☒ Others (i.e.: Conference Coordinator, Department representative, etc.) Vanessa Garcia, Secretary, Mercy Mena, Moderator and Core Contributors (See Page 2)

Annual disclosure forms are required from moderators, core group of contributors, CME program manager and on-site coordinator with department. (Criterion 7)

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

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

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.

This tumor board is planned in collaboration with the Baptist and South Miami Regional Cancer Program. Tumor boards foster collaboration across multiple specialties treating specific medical conditions. Patient care and interdisciplinary communication are improved through these types of educational meetings.

DATE REVIEWED: July 12, 2010 REVIEWED BY: ☒ EXECUTIVE COMMITTEE ☒ CHAIRMAN
Revised: June 24, 2011; March 26, 2012; February 20, 2013; November 2013
APPROVED: ☒ YES ☐ NO
Credits: AMA/PRA Category 1 Credits: #__ Continuing Psychology Education Credits: #__ N/A Continuing Dental Education Credits: #__ N/A
CME ACTIVITY TITLE: South Miami Hospitalist Lecture Series

DATE: Varies (2015) TIME: 12-1pm

LOCATION: 3 East Tower Conference Room CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1/each

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

CONFERENCE DIRECTOR: Tina C. Sanjar, M.D.

TARGET AUDIENCE: Hospitalist Physicians, General Internists, Family Physicians, Cardiologists, Interventional Cardiologists, Interventional Radiologists, Nurse Practitioners, Physician Assistants, Pharmacists, Nurses, Dietitians, Radiologic Technologists and Respiratory Therapists

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

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

EXPECTED NUMBER OF ATTENDEES: 20 CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- Live
- Didactic Lecture
- Question & Answer
- Panel
- Internet point-of-care activity
- Enduring material
- Case Studies
- Patient care data
- Other (specify)

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

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

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

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

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

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

Other: ____________________________________________________________

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP***?
Current physician practice does not include consistent implementation of quality and performance strategies that have been shown to reduce length of stay and hospital acquired infections while optimizing overall patient care.

WHAT IS THE OPTIMAL PRACTICE**?
Hospitalists utilize appropriate strategies, resources and programs to optimize patient care while reducing readmissions, hospital acquired diseases, length of stay and treatment costs.

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 X Competence? -or- X Performance? -or- X Patient Outcomes**? (Check all that apply.) *(NOTE: If 'patient outcomes' is selected, there must be an achievable measurement plan.)
► Hospitalists utilize appropriate strategies, resources and programs to optimize patient care while reducing readmissions, hospital acquired diseases, length of stay and treatment costs.

Topics for discussion will include (but not limited to):
- Cardiovascular Disease Management
  - Risk Reduction
  - Atrial Fibrillation and other Tachycardial Conditions
- Metabolic Syndrome
- Cardiac Imaging
- Inpatient Echocardiography and STAT Echocardiography
- Heart Failure: A Perspective for the Hospitalist

- Neurological Disease
  - Stroke Management/ Protocol
  - Aneurysms
  - Stroke is treatable: Advancements in Endovascular Therapy of Cerebral Ischemia, Aneurysms and Vascular Malformations
- Management of Lung Disease
- Minimal Access Surgery
- Gastrointestinal Disease
- Infectious Disease Management
- Update on Ovarian Cancer for the Hospitalist
- Therapeutic Hypothermia
- Macrophage Activating Syndrome in the Adult: Missed Diagnosis

*REFERENCES* supporting the current practice and/or the optimal practice and/or practice gap:
► Education for the hospitalists is focused on providing resources, programs and mentoring for quality improvement program for reducing readmissions and hospital acquired diseases while optimizing transitions of care, glycemic control and overall patient care.
Research shows that utilization of hospitalists programs reduces length of stay and treatment costs and improves the overall efficiency of care for hospitalized patients. A medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients, practitioners of hospital medicine include physicians ("hospitalists") and non-physician providers who engage in clinical care, teaching, research, or leadership in the field of general hospital medicine. In addition to their core expertise managing the clinical problems of acutely ill hospitalized patients, hospital medicine practitioners work to enhance the performance of hospitals and healthcare systems by providing prompt and complete attention to all patient care needs including diagnosis, treatment, and the performance of medical procedures (within their scope of practice); employing quality and process improvement techniques; collaboration, communication, and coordination with all physicians and healthcare personnel caring for hospitalized patients; safe transitioning of patient care within the hospital, and from the hospital to the community, which may include oversight of care in post-acute care facilities; and efficient use of hospital and healthcare resources.

http://www.hospitalmedicine.org/AM/Template.cfm?Section=Practice_Resources&Template=/CM/HTMLDisplay.cfm&ContentID=45

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
1. Provide prompt and complete attention to all patient care needs including diagnosis, treatment, and the performance of medical procedures (within their scope of practice).
2. Utilize quality and process improvement techniques to improve patient care outcomes.
3. Implement strategies to optimize collaboration, communication, and coordination of all physicians and healthcare professionals caring for hospitalized patients.

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

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

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

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. __________________________________________
The hospitalist group at South Miami Hospital requested tailored education to meet their needs. Education for the hospitalists will focus on providing resources, programs and mentoring on quality improvement strategies to reduce readmissions and hospital acquired diseases while optimizing overall patient care.

DATE REVIEWED: January 7, 2015 REVIEWED BY: Executive Committee Chairman

APPROVED: □ YES  □ NO  □ Credits: AMA/PRA Category 1 Credits: # 1.0
Continuing Psychology Education Credits: # 1  □ N/A  □ Continuing Dental Education Credits: # ___  □ N/A
CME ACTIVITY TITLE: 2015 SMH Echo Lab Conference Series - Case Studies Review

DATE: 2014 TIME: 12 noon  Location: SMH
Friday, 3/13/15 Classroom F
Friday, 6/05/15 Classroom E
Friday, 8/14/15 Classroom F
Friday, 10/02/15 Classroom E
Friday, 12/11/2015 Classroom F

CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 /ea  EXPECTED NUMBER OF ATTENDEES: 25-30

CONFERENCE DIRECTOR: Harry Aldrich, M.D.  CONFERENCE COORDINATOR: Anne Bello

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

TARGET AUDIENCE: Echo Lab Committee Members and participating staff (Radiology Technologists, Nurses, Sonographers)
This activity addresses professional practice gaps relevant to physicians in the practice of cardiology. In addition, physicians that identify conditions and refer patients to a cardiologist, and those specialists to whom a cardiologist might refer for further evaluation or treatment, are also included in the target audience, as are members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 25-30  CHARGE: 0

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

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

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

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

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

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

CURRENT PRACTICE: (What are they not doing or doing that needs to change?)
Current practice shows that physicians and sonographers are struggling to apply best practices in echocardiography examinations for the cardiac patient.

The rapid growth of echocardiography is a classic “good news/bad news” scenario. The bad news is that the examination has become quite sophisticated, and physicians and sonographers must struggle to keep up to date to provide state-of-the-art examinations. There is a learning curve for every new echocardiographic application. Physicians must put in sufficient time and effort to become expert in these new techniques. Like every other aspect of the practice of medicine, echocardiography must be taken seriously. Because the examination apparently does not produce any physical harm and is essentially painless,
there is a tendency to let inadequately trained people perform and interpret echocardiograms. Having an echocardiographic expert and a clinical expert examine the same recording only provides added value to the test.

(http://www.circ.ahajournals.org/cgi/content/full/93/7/1321)

OPTIMAL PRACTICE:
Physicians and sonographers will correlate clinical data and other modalities with echo results.

Echocardiography provides information about both the structure and the function of the heart, and this information is useful for establishing a diagnosis; assessing prognosis; and determining optimal therapy for several indications, including heart failure, ischemic heart disease, and valve disease. Echocardiography is noninvasive, is relatively inexpensive, and has few risks. http://www.acponline.org/clinical_information/journals_publications/eeptmarapr99/echocard.htm

The evolution of echocardiography has been interesting and dramatic. The technology has grown and has become an integral part of the practice of cardiology. As with all technology, there are advantages and disadvantages. The principal disadvantage is the fact that education and training are imperative to provide high-quality examinations and proper interpretations. In addition, many of the diagnoses are still qualitative and subjective. The principal advantage is the amazing versatility of this technology. The wealth of information that can be provided both noninvasively with a transthoracic examination and invasively with either transesophageal or intravascular ultrasound is tremendous. The anatomic and physiological data provided frequently give definitive diagnoses. If performed properly and for the right reason, this test should be very cost effective and should be a major asset in the coming era of medical cost containment. There are many technological advances that should enhance this information. With technology such as digital recordings, it is hoped that the clinicians will have better access to these data and will be more comfortable in interacting with this important diagnostic tool.

(http://www.circ.ahajournals.org/cgi/content/full/93/7/1321)

WHAT IS THE REASON FOR THE GAP?  What do we need to address in order to close the practice gap? (The Educational Need) Check one or more of the following:  ☒ Knowledge ☒ Competence ☐ Performance

WHAT IS THE PRACTICE GAP? (C2) We need to improve physicians and sonographers competence to correlate clinical data and other modalities with echo results.

DESIRED OUTCOMES (GOAL): What is this CME Activity designed to change? (Check all that apply.) ☒ Competence ☐ Performance ☐ Patient Outcomes- Must have an achievable measurement plan.

Physicians will correlate clinical data and other modalities with echo results.

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

• Describe the roles of transesophageal echocardiography, stress echocardiography, 3-Dimensional echocardiography and contrast echocardiography in clinical practice.
• Examine new technologies in the field of echocardiography.
• Discuss current controversies in echocardiography.
• Apply echocardiographic best practices strategies in clinical practice for routine and complex cardiovascular disorders.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DATE REVIEWED: January 7, 2015 REVIEWED BY: ☒ Executive Committee ☐ Chairman
APPROVED: ☐ YES ☒ NO ☐ Credits: AMA/PRA Category 1 Credits: # 1 / ea.
Continuing Psychology Education Credits: # ___ ☐ N/A ☐ Continuing Dental Education Credits: # ___ ☐ N/A

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

Page 38 of 73
CME ACTIVITY TITLE: Conversations in Ethics: Ethical Challenges in Providing Psychiatric Services for Patients in the Emergency Department

DATE: January 9, 2015
TIME: 12:00 Noon – 1:00 p.m.

LOCATION: DH Coco Plum CL
CREDIT HOUR(S) APPLIED FOR: 1.0

Videoconferenced to: BHM CL # 5, HH Auditorium, MH Educ Conf Room & WKBH CL 4 & 5, SMH CL E

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

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

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

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

In addition, describe how the content of the activity is aligned with the target learners’ current or potential scope of practice (C4). This activity addresses professional practice gaps relevant to physicians who may seek ethics consultations as are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 25-35
CHARGE: 0

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

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

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

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

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

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

PROFESSIONAL PRACTICE GAP (C2)

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

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

► Emergency physicians assume more specific ethical obligations that arise out of the special features of emergency practice. The clinician-patient relationship is the defining element that categorizes the emergency physician's ethical responsibilities. The emergency physician-patient relationship is usually episodic and dictated by the patient's urgent need for care. The patient's willingness to seek emergency care and to trust the clinician is based on institutional and professional assurances rather than on an established personal relationship. The emergency physician's ethical duties in these relationships may be categorized into those dealing with
beneficence, autonomy, fairness and nonmaleficence. (Approved by the ACEP Board of Directors June 1997. Reaffirmed October 2001 by ACEP Board of Directors)

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

► Physicians serve the best interest of their patients by treating or preventing disease or injury and by informing patients about their conditions. Emergency physicians respond quickly to acute illnesses and injuries to prevent or minimize pain and suffering, loss of function, and loss of life. (Approved by the ACEP Board of Directors June 1997. Reaffirmed October 2001 by ACEP Board of Director) In this case, there is an apparent need to balance the benefits of hospitalization for an unstable psychiatric patient against the risks of discharging him to a homeless shelter or holding him in an ED overnight. If the goal, according to the Code, is to minimize suffering, it is believed that this patient would be best served on an inpatient psychiatric unit.

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.)

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

► The Ethical Management of a Psychiatric Patient Disposition in the Emergency Department Mellen Lovrin MSN, APRN, BC, Dr.NP.c Columbia University Private Practice Courtney Reinisch MSN, APN-C, Dr. NP.c Overlook Hospital Emergency Department http://aquila.usm.edu/cgi/viewcontent.cgi?article=1038&context=ojhe

EDUCATIONAL OBJECTIVES

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

1. Identify the moral principles which supports the psychiatric patient disposition in the Emergency Department.
2. Understand, through case example, how safety, quality of patient assessment, monitoring, and quality of communication affect the outcomes of the patient discharged from the Emergency Department.
3. Describe several future improvement changes we can make to improve the management of psychiatric patients when they are ready to be discharged from the Emergency Department.

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

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

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

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

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

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

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

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

SPEAKERS:
Manuel Rodriguez-Garcia, MD        Luisa Pacheco-Zayas, Psy D, LCSW, CCM, CPHM
Psychiatry
Doctors Hospital

Director Social Work & Case Management Services
Doctors Hospital

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

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

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

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

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

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

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

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

Explain: __________________________________________ _____________________________________

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

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

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

DATE REVIEWED: __________ REVIEWED BY: ☐ Executive Committee ☐ Chairman

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

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

Script:
Psychiatric patients that are admitted to our emergency rooms are one of the most challenging, vulnerable and difficult of patients; their medical condition may need immediate treatment yet our hospitals do not have the facilities for in-patient psychiatric treatment. What to do with those patients whose medical condition has been stabilized but the need for psychiatric care continues but there are no psychiatric facilities available and able to treat them?

Applicable Credits: AMA Category 1 ☒ ☐ Continuing Psychology Education ☐ ☐ Continuing Dental Education ☐
CME ACTIVITY TITLE: Homestead Hospital Conference Series: Acute Care of the Elderly: Pearls and Pitfalls

DATE: Wednesday, January 14, 2015
TIME: 12 noon - 1 p.m.

LOCATION: Homestead Hospital, Physicians' Dining Room
CREDIT HOUR(S) APPLIED FOR: 1 Cat 1

CONFERENCE DIRECTOR: Andrew Renshaw, M.D.

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

TARGET AUDIENCE: Emergency medicine physicians, critical care medicine physicians, hospitalists, radiologic technologists and nurses.

EXPECTED NUMBER OF ATTENDEES: 20-25
CHARGE: 0

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

EXPECTED NUMBER OF ATTENDEES: 20-25
CHARGE: 0

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

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

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
► Physicians may not be aware of the unique physiology and needs of the elderly that contribute to atypical clinical presentations of common acute care problems such as delirium, chest pain and the evaluation of abdominal pain.

WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
► Physicians consider the unique physiology and needs of the elderly when assessing common acute care problems as they are seen through the emergency room.
WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
- ☑️ Knowledge (Doctors do not know that they need to be doing something.)
- ❌ Competence (Doctors do not know how to do it)
- ☑️ Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☑️ Competence? -or- ❌ Performance? -or- ☐ Patient Outcomes*? *(Check all that apply.)
*(NOTE: If 'patient outcomes' is selected, there must be an achievable measurement plan.)
► Physicians implement tools to improve delivery of care in the elderly.

REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Older adults represent a large and growing segment of hospitalized patients and are at high risk of complications during hospitalization, including falls, delirium, adverse drug events. The assessment of older hospitalized adults should extend beyond the traditional history and physical to include assessment of physical function and cognition, social supports, and living situation as well as evaluation for possible polypharmacy and attention to advance directives. Since many older adults live on the brink between independence and functional dependence, even a small decline in function during hospitalization can place them in a position of newly-acquired dependence. However, many adverse outcomes encountered by older adults during hospitalization can be prevented.
(Hospital management of older patients, upToDate.com, Literature review current through: Nov 2014)

EDUCATIONAL OBJECTIVES
Upon completion of this conference, participants should be better able to:
- Assess common acute care problems in the elderly patient commonly seen in the emergency department such as delirium, chest pain and abdominal pain and implement appropriate, timely first-line treatment interventions.

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

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

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

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)
Mark Weinstein, M.D.
Emergency Medicine Physician
Homestead Hospital

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

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

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

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

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

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

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

☐ Other tools or tactics

Explain: __________________________________________

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

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

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

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

DATE REVIEWED: December 15, 2014 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: The Center for Research & Grants - The Life Cycle of a Research Study - From Data Analysis to Publication

DATE: Thursday, January 15, 2015
TIME: 7:30 a.m. – 8:30 a.m.

LOCATION: Baptist Hospital, Classroom 5 & Webcast
CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTOR: Thinh Tran, M.D.
CONFERENCE CORRDINATOR: Debbie Eyerdam, BA, CCRC, CCRP

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

TARGET AUDIENCE:
All Research Investigators, including physicians, physician assistants and ARNPs.

In addition, describe how the content of the activity is aligned with the target learners’ current or potential scope of practice (C4). This activity addresses professional practice gaps relevant to physicians in the practice of investigative healthcare as well as other members of the investigative research team such as nurses, clinical research coordinators, research assistants and medical students.

EXPECTED NUMBER OF ATTENDEES: 25-30
CHARGE: 0

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

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

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

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**: What are physicians doing (or not doing) that needs to change? Describe the practice gap.
► Physicians receive limited instruction in research methods during the course of their medical training and little guidance on how to become a successful author of peer reviewed research publications to properly disseminate quantitative research findings that could result in better patient outcomes.

Page 45 of 73
WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
► Physicians execute successful dissemination of quantitative research findings resulting in better patient outcomes.

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

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☒ Competence? -or- ☒ Performance? -or- ☐ Patient Outcomes*? *(Check all that apply.) *(NOTE: If 'patient outcomes' is selected, there must be an achievable measurement plan.)
► Physicians will execute successful dissemination of quantitative research findings which will result in better patient outcomes.

REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Writing and publishing scientific papers is the core business of every researcher. Original research papers form the culmination of a usually long trajectory, which starts with the development of a research idea and continues with acquiring funding and collecting and analyzing data. Besides original research articles, there are many other types, including systematic reviews, commentaries, and editorials. The scientific output medical researchers generate is not only important for society to improve health through advancement of knowledge but also for the individual researcher's career. Effective scientific writing, however, is not easy. Many novice academic researchers, and even senior researchers, may struggle with writing papers. Researchers often learn to write by doing it and receiving feedback on drafts from their supervisors, coauthors, and journals. However, such guidance is not always optimal, and many useful tips and tricks may remain disregarded for too long. Various factors impact on successful writing and publishing. Good scientific content of a paper alone does not guarantee its publication in a good journal. Many variables in the writing process determine whether a paper will be accepted for publication, but the good news is that authors can influence most of these. Anticipation and modification of such determinants will increase an author's effectiveness, enabling them to get more done in less time; offering editors, reviewers, and readers a clear storyline; increasing enjoyment and reducing frustration; and raising the likelihood of having a paper accepted by a good journal. http://www.jclinepi.com/article/S0895-4356(13)00017-6/fulltext

EDUCATIONAL OBJECTIVES
Upon completion of this conference, participants should be better able to:
• Assess research data analysis requirements and effectively utilize statistical service.
• Evaluate the effectiveness of tables and graphs conveying quantitative research findings.
- Develop a well-structured research manuscript for peer-reviewed journals.
- Discriminate between effective and ineffectual presentations of analytic results from the medical literature.

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

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

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

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

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

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

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

Emir Veledar, Ph.D.
Biostatistician
Baptist Health South Florida
Center for Research and Grants

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

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

- Yes
- No

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

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

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

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

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

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

Explain:

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

- Yes
- No

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

- Yes
- No

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

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. The Center for Research & Grants has undertaken an initiative to provide regular continuing medical education lectures on current medical research issues.

**DATE REVIEWED:** August 22, 2014

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: WKBH Grand Rounds: Acute Treatment of Hypertension

DATE: Wednesday, January 21, 2015  TIME: 12noon – 1p.m.

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

CONFERENCE DIRECTOR: Javier Perez-Fernandez, M.D.

AMA/PRA LEARNING FORMAT:
- Live activity
- Didactic Lecture

TARGET AUDIENCE: Family Medicine Physicians, Pediatricians, General Internists, Emergency Medicine Physicians, Ob/Gyns, Neurologists, Hospitalists, Physicians Assistants, Nurses, Social Workers and other interested healthcare professionals. In addition, describe how the content of the activity is aligned with the target learners’ current or potential scope of practice (C4). This activity addresses professional practice gaps relevant to physicians in the practice of family medicine, general medicine and emergency medicine.

EXPECTED NUMBER OF ATTENDEES: 20-25  CHARGE: 0

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

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

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

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

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

Resources: Institutional Capabilities  Physician Practice Limitations  Community Service Limitations

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

Other: _____________________________

PROFESSIONAL PRACTICE GAP (C2)

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

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

► Current physician practice doesn’t consistently consider the recent history and symptoms of the patient when differentiating between hypertensive emergency and hypertensive urgency, resulting in overly aggressive treatment.

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

► Physicians acknowledge abnormal blood pressure results, consider patients recent history and symptoms before initiating therapy. Therapy for asymptomatic patients will be directed at long-term hypertension control and not short-term correction of blood pressure reading.
WHAT IS THE REASON FOR THIS GAP?  Indicate if the gap is related to either/or:

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

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☒ Competence? -or- ☒ Performance? -or- ☐ Patient Outcomes*?  *(Check all that apply.) *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)

► Physicians will consider patients recent history and symptoms before initiating therapy for hypertension.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Hypertensive crises, which include hypertensive emergencies and urgencies, are frequently encountered in the emergency department, and require immediate attention as they can lead to irreversible end-organ damage. Normal blood pressure (BP) regulation is altered during acute rises in BP, leading to end-organ damage. Multiple organs can be injured. Special considerations should be given to hypertensive pregnant patients and patients with postoperative hypertension. Treatment should be individualized to each patient based on the type and extent of end-organ damage, degree of BP elevation, and the specific side effects that each medication could have on a patient's preexisting comorbidities.


http://ovidsp.tx.ovid.com/sp-3.13.1a/ovidweb.cgi?&S=BBDAFPJ0OHDDEHGKNCLKODLBEFAPAA00&Complete+Reference=S.sh.46%7c5%7c1

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

- Differentiate a hypertensive emergency from a hypertensive urgency.
- Implement appropriate medical management for a hypertensive emergency and a hypertensive urgency.
- Apply rapid and successful adoption of new WKBH protocol for blood pressure management.
- Initiate strategies for long term hypertensive control.

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

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

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

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

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

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

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

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)
Joseph Scott, M.D., FACEP, FAAEM
Chair and Medical Director
Department of Emergency Medicine
West Kendall Baptist Hospital

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

☒ Yes ☐ No ☐ CME Dept. Leadership and Staff ☐ CME Committee
COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program’s commitment to be independent and free of the influence of commercial interests. Indicate here if support will come from the Foundation general Continuing Medical Education fund.

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

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

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

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

Explain: ____________________________________________________________

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

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

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

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

DATE REVIEWED: 12/16/2014 REVIEWED BY: Executive Committee ☐ Chairman ☒

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

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

Applicable Credits: AMA Category 1 ☒ Continuing Psychology Education ☐ Continuing Dental Education ☐
PERFORMANCE PRACTICE GAP

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

CURRENT PRACTICE: (What are they not doing or doing that needs to change?)
BHQN primary care physicians are not optimizing management & pharmacotherapy strategies for complex patients who use tobacco their practice

OPTIMAL PRACTICE: The patient centered medical home (PCMH is rapidly gaining popularity as way to make primary care more accessible, comprehensive and coordinated; to improve patient outcomes; and to lower overall healthcare costs. Since 2008, the NCQA has begun recognizing practices as PCMH, more than 26000 clinicians at more than 500 practices have received the NCQA designation and numbers are rising steadily. Done correctly, not only do PCMHs’ enable physicians to practice better medicine, but they even give a jump start to a practices bottoms line. The PCMH is based on a team approach that may include physicians advanced practice nurses, physician assistants, nurses, pharmacists, nutritionist, social workers and coordinate with hospital, home health care and community services. (http://www.medscape.com/viewarticle/812670)

BHMG primary care physicians who participate in this cme program will remain current with up-to-date information management strategies for complex patients who use tobacco as well as the benefits and efficacy of pharmacotherapy in high risk patients who use tobacco.

WHAT IS THE REASON FOR THE GAP? What do we need to address in order to close the practice gap? (The Educational Need) Check one or more of the following: ☒ Knowledge ☐ Competence ☐ Performance

PRACTICE GAPB: BHQN primary care physicians do not clearly understand the value and importance of implementing management strategies for complex patients who use tobacco as well as the benefits and efficacy of pharmacotherapy in high risk patients who use tobacco.
**DESIRED OUTCOMES (GOAL):** What is this CME Activity designed to change? (Check all that apply.)
- [x] Competence
- [ ] Performance
- [x] Patient Outcomes - Must have an achievable measurement plan.

BHMG primary care physicians will formulate successful strategies in to implement management & pharmacotherapy strategies for complex patients who use tobacco in their practice.

**EDUCATIONAL OBJECTIVES**

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

1. Identify potential management strategies for complex patients who use tobacco products.
2. Describe the safety and efficacy of tobacco pharmacotherapy in patients with a history of cardiovascular disease or mental illness.
3. Describe the safety and efficacy of extended treatment duration using pharmacotherapy for tobacco use treatment.

**COMPETENCIES (Desirable Physician Attributes as per IOM, ACGM and AGMS):**

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

**EVALUATION METHOD(S):**

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

**SPEAKER**

**Hector M. Delgado, D.O.**
Med Director, BHQN Primary Care Physicians
Baptist Health South Florida

**Juan Batlle, M.D.**
Radiologist
Radiology Associates of South Florida

**Janisse Post, R.N.**
Baptist Health Quality Network
Interim Director of Quality

**Jennifer A. Miles Nguyen**
Baptist Health Quality Network
Clinical Pharmacist

**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?  
- [x] Yes
- [ ] No

CME Program Manager: Gabriela Fernandez
Conference Director (see above)

Medical Director
Corporate Director
Medical Education Committee

Others (i.e.: Conference Coordinator, Department representative, etc.) Janisse Post - Coordinator

**COMMERCIAL SUPPORT:** The Baptist Health Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. Please indicate here if support will come from the Foundation general medical education fund.
NON-EDUCATION STRATEGIES: List strategies that are currently being used to address the needed change(s) in our learners, and/or list possible approaches that could be used to promote change(s)—beyond this CME activity alone.

COLLABORATION: Are there other initiatives within our institution that are also working to address the professional practice gaps or quality gaps we have identified?
- 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.
- BHMG physicians will participate regularly in a journal club educational activity to remain current with up-to-date information on evidence-based practice and research findings.

DATE REVIEWED: January 9, 2015 REVIEWED BY: ☑ Executive Committee ☐ Chairman

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

CME ACTIVITY TITLE: MCVI Research Grand Rounds: Current Research Advances on Peripheral Artery Disease Therapy
DATE: February 10, 2015
TIME: 5:30 – 7:30 p.m.

LOCATION: BHM, MCVI Conf. Room
CREDIT HOUR(S) APPLIED FOR: 2 Cat. 1

CONFERENCE DIRECTOR: Raul Herrera, M.D.

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

TARGET AUDIENCE: Physicians, nurses interested in or active in research, clinical research coordinators, research assistants and medical students and other interested healthcare professionals.

EXPECTED NUMBER OF ATTENDEES: 30-40
CHARGE: 0

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

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

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18)
Patient:
- Non-compliance
- Lifestyle
- Resistance-to-change
- Financial/Lack of Insurance

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

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

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

Other: ____________________________________________________________

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
► Physicians may not be aware of all factors that may influence the best available peripheral artery disease (PAD) therapies for their patients.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like'?)
► Physicians consider all factors that may influence the best available PAD therapies for the cardiac patient.

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

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☐ Competence? -or- ☐ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.)
*(NOTE: If 'patient outcomes' is selected, there must be an achievable measurement plan.)
► Physicians will consider all PAD treatments available and current research when making treatment options for the cardiac patient.
**REFERENCES** supporting the current practice and/or the optimal practice and/or practice gap:

► An estimated 10 million Americans have peripheral artery disease (PAD). How can something so common be so serious? One reason is that people with PAD often don’t know they have it until they have a heart attack or stroke. Peripheral artery disease progresses slowly, as arteries in your legs become clogged and blood flow is restricted. PAD can be an indicator that the same process is happening in other areas of your body. Sometimes, peripheral artery disease happens for other reasons, such as trauma to the arms or legs, anatomical irregularities or infection. [http://baptisthealth.net/en/health-services/miami-cardiac-and-vascular-institute/pages/peripheral-artery-disease.aspx?gclid=CIGSxt-e_cCFUsR7AodknaAnQ](http://baptisthealth.net/en/health-services/miami-cardiac-and-vascular-institute/pages/peripheral-artery-disease.aspx?gclid=CIGSxt-e_cCFUsR7AodknaAnQ)

Tremendous advances have occurred in therapies for peripheral vascular disease (PVD); however, until recently it has not been possible to examine the entire clinical trial portfolio of studies for treatment of PVD (both arterial and venous disease). [http://circ.ahajournals.org/content/early/2014/09/19/CIRCULATIONAHA.114.011021.abstract](http://circ.ahajournals.org/content/early/2014/09/19/CIRCULATIONAHA.114.011021.abstract)

Pharmacologic therapies used in the treatment of patients with lower extremity peripheral artery disease (PAD) are primarily aimed at improving symptoms or slowing the progression of the disease. Therapies under investigation that may become useful for improving symptoms of claudication to avoid the need for revascularization, promote healing of ischemic ulcers, or alter perception of ischemic pain in patients who are poor candidates or who have failed revascularization attempts are reviewed here. The clinical use of these agents is not yet recommended.

The pathophysiology of the impairments associated with ischemia is complex and provides multiple potential targets for novel drug therapies. Potential future pharmacologic therapies that remain to be proven beneficial for the treatment of symptoms associated with lower extremity peripheral artery disease, including claudication, are presented below in alphabetical order. These therapies may be targeted either to improving symptoms of claudication or to more severe manifestations of ischemia, such as ischemic rest pain, ulceration, or gangrene.

The best therapeutic option for patients with advanced peripheral artery disease (eg, rest pain, ischemic ulceration, gangrene) is revascularization (percutaneous or surgical). Therapies under investigation for advanced peripheral artery disease, primarily for patients who are poor candidates for revascularization due to severe medical comorbidities, are aimed at promoting healing of ischemic ulcers or altering the perception of ischemic pain. The clinical use of these agents is not yet recommended. [http://www.uptodate.com/contents/investigational-therapies-for-treating-symptoms-of-lower-extremity-peripheral-artery-disease](http://www.uptodate.com/contents/investigational-therapies-for-treating-symptoms-of-lower-extremity-peripheral-artery-disease)

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**EDUCATIONAL OBJECTIVES**

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

- Evaluate current peripheral artery disease (PAD) clinical research at MCVI.
- Assess some of the new therapies poised to impact immediate future of PAD treatment.
- Implement new PAD therapies that will improve patient outcomes.

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

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

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

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

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

► 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.)

**James F. Benenati, M.D.**
Fellowship Program Director
Medical Director, Peripheral Vascular Laboratory
Miami Cardiac & Vascular Institute
Clinical Professor of Radiology
Florida International University Herbert Wertheim College of Medicine
Miami, Florida

**Ripal T. Gandhi, M.D., FSVM**
Vascular and Interventional Radiologist
Miami Cardiac & Vascular Institute
Assistant Clinical Professor, University of South Florida College of Medicine, (Tampa, Florida)
Associate Clinical Professor, FIU Herbert Wertheim College of Medicine  
Miami, Florida

Constantino S. Peña, M.D.  
Diagnostic, Vascular and Interventional Radiologist  
Miami Cardiac & Vascular Institute, Baptist, Doctors, Homestead, South Miami and West Kendall Baptist Hospitals and  
Baptist Outpatient Services  
Miami, Florida

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

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

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

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

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

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

**DATE REVIEWED:** January 5, 2015  
**REVIEWED BY:** ☐ Executive Committee ☐ Chairman

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

**Applicable Credits:** AMA Category 1 ☒  
Continuing Psychology Education ☒  
Continuing Dental Education ☒

**CME ACTIVITY TITLE:** Seventh Annual Mental & Behavioral Health Symposium: Resilience
DATE: Saturday, February 28, 2015

LOCATION: Baptist Hospital, Auditorium

CREDIT HOURS APPLIED FOR: 4 Cat. 1

CONFERENCE DIRECTORS: Barry Crown, Ph.D., and Richard Hamilton, Ph.D.

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


EXPECTED NUMBER OF ATTENDEES: 200-215

CHARGE: 0

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

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

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

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

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

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

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

Other:

PROFESSIONAL PRACTICE GAP (C2)

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

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

► See attached.

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

► See attached.

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

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

And will this result in a change in ☑ Competence? -or- ☑ Performance? -or- ☑ Patient Outcomes*? (Check all that apply.) *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.) ▶ Physicians will implement preventive interventions that enhance resilience factors and reduce risk factors.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
The Director of Continuing Education for Psychology has determined that this conference addresses aspects of the ICD and DSM-IV which describes mental disorders due to general medical conditions. This conference addresses ICD, DSM-IV and DSM-V diagnostic categories and their impact on behavior.

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

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

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

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)
- As a result of what you learned at this 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.)
See attached.

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

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

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

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

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

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

DATE REVIEWED: November 24, 2014
REVIEWED BY: Executive Committee
APPROVED: YES NO
Credits: AMA/PRA Category 1 Credits: # 4.0
PROFESSIONAL PRACTICE GAP (C2) & EDUCATIONAL OBJECTIVES

Beyond Resilience and Post Traumatic Stress Disorder: Flexibility and Heterogeneity Following Potential Trauma

Learning Objectives:

- Compare post traumatic stress disorder to a broader theoretical approach that takes into account the natural heterogeneity of trauma reactions over time.
- Apply knowledge of divergent response patterns to clinical practice.
- Identify different types of predictors of trauma outcome and assess their role in healthy adjustment to aversive life events.
- Recognize and address prototypical patterns or trajectories of trauma reaction that include chronic dysfunction, but also delayed reactions, recovery, and psychological resilience.

Current Practice Gap: Physicians may not currently consider the limitations of existing trauma theories and may not be familiar with a broader theoretical approach that takes into account the natural heterogeneity of trauma reactions over time.

Optimal Practice: Apply knowledge of divergent response patterns to clinical practice.

Standard D (APA Compliance Standard):

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.

References: The formal acceptance of posttraumatic stress disorder (PTSD) as a legitimate diagnostic category in the 1980 Diagnostic and Statistical Manual of Mental Disorders stimulated a torrent of research on psychological trauma. Not surprisingly, PTSD and its treatment had dominated that research. Another common approach has been to measure the average impact of different potentially traumatic events, as well as the factors that inform that impact. In this article, we consider the limitations of these perspectives and argue for a broader theoretical approach that takes into account the natural heterogeneity of trauma reactions over time. To that end, we review recent attempts to identify prototypical patterns or trajectories of trauma reaction that include chronic dysfunction, but also delayed reactions, recovery, and psychological resilience. We consider the advantages but also the limitations and ongoing controversies associated with this approach. Finally, we introduce promising new research that uses relative sophisticated advances in latent growth mixture modeling as a means of empirically mapping the heterogeneity of trauma responses and consider some of the implications of this approach for existing trauma theories. (Psychological Trauma: Theory, Research, Practice, and Policy. Vol.4(1), Jan 2012, pp. 74-83.)

Trauma and Resilience in Children and Adolescents

Learning Objectives:

- Identify risk factors that contribute to post-disaster posttraumatic stress reactions in children.
- Identify aspects of the post-disaster recovery period that either maintain or help to mitigate children’s distress.
- Identify important areas to include in an assessment of children post-disaster.
- Describe intervention strategies used to enhance resilience factors and reduce risk factors in youth post-disaster.

Current Practice Gap: Physicians may not be aware of how to apply preventive interventions that enhance resilience in children and adolescents exposed to a disaster.

Optimal Practice: Physicians implement preventive interventions to enhance resilience and reduce risk factors for post traumatic stress reaction.

Standard D (APA Compliance Standard):

Criterion 1.2 reflects program content that has been subjected to accepted research practices within psychology and has satisfied broader scientific scrutiny within the field.

Reference: The met allele (BDNF) may play a role in children's disaster reactions. Further research should consider the complex interplay between genes, stressors, support, and psychological outcomes over time. (La Greca AM, Lai BS, Joormann J, Auslander BB, Short MA. J Affect Disord. 2013 Dec;151(3):860-7)

Children with co-morbid symptoms need to be identified early post-disaster. Levels of stressors should be monitored post-disaster, as highly stressed youth have difficulties recovering and may need help. Interventions should be tailored for children with co-morbid symptoms of PTS and depression. (Lai, La Greca, Auslander, & Short, 2013, Journal of Affective Disorders)
Addiction: Resilience & Family

Learning Objectives:
- Examine resilience factors among those with drug and/or alcohol abuse problems.
- Recognize and address factors that contribute to relapse.
- Develop strategies and interventions to enhance resilience and coping in the face of stress and prevent the onset of addiction problems or relapse.

Current Practice Gap: Physicians may not be aware of preventive interventions that can enhance resilience and reduce relapse in addiction.

Optimal Practice: Physicians implement preventive interventions to reduce relapse.

Standard D (APA Compliance Standard):
Criterion 1.2 reflects program content that has been subjected to accepted research practices within psychology and has satisfied broader scientific scrutiny within the field.

Reference:
Acute and chronic stress-related mechanisms play an important role in the development of addiction and its chronic, relapsing nature. Multisystem adaptations in brain, body, behavioral, and social function may contribute to a dysregulated physiological state that is maintained beyond the homeostatic range. In addition, chronic abuse of substances leads to an altered set point across multiple systems. Resilience can be defined as the absence of psychopathology despite exposure to high stress and reflects a person's ability to cope successfully in the face of adversity, demonstrating adaptive psychological and physiological stress responses. The study of resilience can be approached by examining interindividual stress responsibility at multiple phenotypic levels, ranging from psychological differences in the way people cope with stress to differences in neurochemical or neural circuitry function. The ultimate goal of such research is the development of strategies and interventions to enhance resilience and coping in the face of stress and prevent the onset of addiction problems or relapse. (Alcohol Research. 34(4):506-15, 2012.)

SCHEDULE

7:30 a.m.  Registration
7:50 a.m.  Welcome and Introductions
8:00 a.m.  Beyond Resilience and Post Traumatic Stress Disorder: Flexibility and Heterogeneity Following Potential Trauma
George Bonanno, Ph.D.
10:15 a.m.  Trauma and Resilience in Children and Adolescence
Annette M. La Greca, Ph.D., ABPP
11:15 a.m.  Addiction: Resilience & Family
John Eustace, M.D.
12:15 p.m.  Adjourn

FACULTY

Barry M. Crown, Ph.D., J.D.
Symposium Director
Psychologist, Baptist, Doctors, Homestead and South Miami Hospitals
Director of Continuing Education for Psychology, Baptist Health South Florida
Miami, Florida

Richard A. Hamilton, Ph.D.
Symposium Director
Psychologist, Baptist and South Miami Hospitals
Clinical Director, Department of Rehabilitation
Brain Injury and Concussion Rehabilitation Programs,
Baptist Hospital of Miami
Miami, Florida

George Bonanno, Ph.D.
Professor of Clinical Psychology
Department of Counseling and Clinical Psychology
Teachers College, Columbia University
New York, New York

Annette M. La Greca, Ph.D., ABPP
Distinguished Professor of Psychology
Provost Scholar
Director of Clinical Training
University of Miami
Coral Gables, Florida

John C. Eustace, M.D.
Addictionologist
South Miami Hospital
Miami, Florida
CME ACTIVITY TITLE: Spirituality and Medicine: Self-Forgiveness and the Promotion of Better Healthcare

DATE: Wednesday, March 4, 2015
LOCATION: Baptist Hospital Auditorium
TIME: 12:00 noon – 1:00 p.m.
CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTOR: Rev. Guillermo Escalona, MDIV, BCC, CT Chairman/Director, Baptist Health Bioethics Department
CONFERENCE COORDINATOR: Kelly Warwar

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

TARGET AUDIENCE:
Physicians, Psychologists, Nurses and interested members of the healthcare team and other interested healthcare professionals.

EXPECTED NUMBER OF ATTENDEES: 40-50
CHARGE: 0

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)
- Patient: Non-compliance, Lifestyle, Resistance-to-change, Financial/Lack of Insurance
- Physician: Non-compliance, Resistance-to-change, Communication Skills, Financial
- Resources: Institutional Capabilities, Physician Practice Limitations, Community Service Limitations
- National/Regional data

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 THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? Physicians and other healthcare professionals are not always aware of how self-blame increases stress brought on by rumination and self-doubt. They also may not recognize the potential for resulting increased stress levels to negatively impact patient outcomes.

WHAT IS THE OPTIMAL PRACTICE*?
Physicians are aware of how self-forgiveness decreases physical responses related to stress. They manage – or put a stop to – self-blame, because they know self-forgiveness supports better outcomes for their patients.

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

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☐ Competence? -or- ☑ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.) *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)

Physicians will become aware of how self-forgiveness decreases physical responses related to stress. They will manage – or put a stop to – self-blame, because they know self-forgiveness supports better outcomes for their patients.

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

**With the rising popularity of positive psychology, research on forgiveness has flourished. Forgiveness has been found to have application to the field of medicine. We review definitions and describe potential physical and mental benefits of forgiveness. We (1) address potential mechanisms by which forgiveness might affect physical health, (2) evaluate the research on forgiveness and mental health, (3) summarize research on interventions to promote forgiveness, (4) examine issues specifically related to medicine in which forgiveness might play an important role, and (5) discuss forgiveness of self and others and seeking forgiveness in light of those applications. We emphasize the importance of one’s motive in forgiving, noting that altruistic motives hold greater benefits than do self-interested motives. (Abstract-full article not available)**


Doctors are trained to accept responsibility for lives, duty bound to accept responsibility for errors, uncertain about asking for forgiveness, and wary of forgiveness if it is offered. They have earned their guilt the hard way. For some doctors, a mistake is a fall from grace and an unforgivable sin. For others, the problem is more psychological than spiritual. But doctors in crisis—blaming themselves for failing their patients and their profession—are not unique in managing to fail on a tragic scale. [http://muse.jhu.edu/login?auth=0&type=summary&url=/journals/perspectives_in_biology_and_medicine/v055/55.3.becker.html](http://muse.jhu.edu/login?auth=0&type=summary&url=/journals/perspectives_in_biology_and_medicine/v055/55.3.becker.html)


▷ In the aftermath of medical harm, ethically sound practice entails the care of injured patients and their families through truth telling, apology, and fair compensation, actions that are likely to involve the physician responsible for the patient's care at the time of the injury and may involve other professionals and administrators as well. (Fair compensation, for example, will usually require collaboration between the physician and an institution’s risk manager.) A large literature suggests that the emotional impact on physicians of bad outcomes, such as the experience of being “fired” by a patient or family, should be recognized. The physician whose self-confidence has been shaken by one case is still being relied on to provide care to other patients. The ethical dimensions of medical harm therefore include how the involved physician recovers from such incidents.

▷ So what should physicians do in the aftermath of medical harm, with respect to forgiveness? What helps the injured party? And what helps the physician recover from this incident? The physician should not expect to hear the words “I forgive you” from an injured patient or family, even after disclosure, apology, and assistance in securing fair compensation have taken place. Asking for forgiveness may be oppressive to a patient or family still grappling with the fact of the harm, the impact of the harm, and their own emotional response to the harm. Asking them, during a time of crisis and even bereavement, to offer a premature, formulaic response is simply too much to ask. The process of forgiveness may be the work of months or years. At the same time, however, the physician can work toward self-forgiveness, by taking responsibility for his or her past, by working to understand his or her role in an incident that slipped beyond the envelope of safety, and by responding to the needs that have been created as the result of harm. Valuing forgiveness as a desirable and authentically human response to human error in medicine requires physicians and their colleagues to create the conditions that will help those who have been harmed to offer forgiveness, and that will also help those whose actions have caused harm to be restored, as healers.

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

**ORIGINAL**

1. Identify personal and professional consequences of self-blame and not forgiving.
2. Explain how self-blame and grudge-holding affect emotions and stress levels.
3. Examine the potential for increased stress levels to negatively impact patient care and outcomes.
4. Implement strategies that promote self-forgiveness and forgiveness of others.
5. Distinguish between true and false forgiveness.

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

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

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

☑ Baptist Health CME Evaluation Form (post-Conference) ☐ Follow-up Survey
☐ Review of Hospital, Health System or Other Data ☐ Other ____________________________
OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)
► As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?
► If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so:

FACULTY:
Martha Sullivan, LMHC, R.N.
Faith Integrative Counselor
Pastoral Care and Counseling Service
Baptist Health South Florida

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

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

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

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

NON-EDUCATION STRATEGIES: Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.
☐ Process redesign or new protocol ☐ Reminders (Posters, mailings, email blasts) ☐ New order sheets
☒ Other tools or tactics
Explain: ____________________________________________
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 ☒ No Are we partnering with other organizations in a purposeful manner to achieve common interests?
☒ Yes ☐ No Are we collaborating with internal departments in a purposeful manner to achieve common interests?
If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.
The Baptist Health Pastoral Care Department has undertaken an initiative to provide quarterly continuing medical education lectures on current and relevant issues that affect the medical staff.

DATE REVIEWED: January 21, 2015 REVIEWED BY: ☑ Executive Committee ☐ Chairman
APPROVED: ☑ YES ☐ NO ■ Credits: AMA/PRA Category 1 Credits: #
Continuing Psychology Education Credits: # 1 ☐ N/A ■ Continuing Dental Education Credits: # ___ ☐ N/A

Script:
Attention is needed to the emotional impact on healthcare providers in the aftermath of medical harm or poor outcomes. The healthcare provider whose self-confidence has been shaken by one case is still being relied on to provide care to other patients. In order to maintain quality medical care, it is vitally important to address and provide for the wellness and self-care of these healthcare providers. Understanding how clinicians can recover from incidents of medical harm or poor outcomes is essential.
Through an examination of forgiveness, healthcare providers will recognize the extent that unforgiveness and self-blame affects their own personal well-being as well as their patients' and colleagues' -- and emotional forgiveness can release them from physical, spiritual and psychological burdens

Page 64 of 73
CME ACTIVITY TITLE: Homestead Hospital Conference Series: Anticoagulation to Prevent DVT and Stroke

DATE: Wednesday, March 11, 2015

LOCATION: Homestead Hospital Conference Series, Physicians’ Lounge

TIME: 12 noon – 1 p.m.

CREDIT HOURS APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTORS: Andrew Renshaw, M.D.

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


EXPECTED NUMBER OF ATTENDEES: 20-25

CHARGE: 0

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

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

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

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

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

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

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

Other: _____________________________

PROFESSIONAL PRACTICE GAP (C2)

The difference between 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. Given the new medications available for DVT and stroke prevention, physicians may not know how to properly identify ideal candidates for currently available pharmacological interventions.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?) Physicians recognize the benefits of new pharmacological interventions to prevent DVT and stroke and recommend appropriate pharmacological intervention based on patient needs.

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.)

► Physicians will appropriately match patient needs with ideal pharmacological intervention to prevent DVT and stroke.

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

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

(http://www.cdc.gov/ncbddd/dvt/data.html)

The U.S. Food and Drug Administration expanded the approved use of Xarelto (rivaroxaban) to include treating deep vein thrombosis (DVT) or pulmonary embolism (PE), and to reduce the risk of recurrent DVT and PE following initial treatment.

(http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm326654.htm)

Traditional anticoagulants in clinical use for the prevention or treatment of thromboembolic disease are heparin and its analogues and warfarin. However, they have two major limitations: a narrow therapeutic window of adequate anticoagulation without bleeding, and a highly variable dose-response relation among individuals that requires monitoring by laboratory testing. In addition to the lack of effective antidotes for the newer orally active agents (e.g., dabigatran, rivaroxaban, apixaban), there is insufficient evidence at this time for their long-term safety as well as their appropriate use in patients with hepatic or renal impairment, or risk factors for myocardial infarction or acute coronary syndromes. (uptodate.com, Anticoagulants other than heparin and warfarin, November 2012)

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

• Assess the importance of using anticoagulants for DVT and stroke prevention.
• Explain the safety and efficacy of warfarin and newly approved anticoagulants dabigatran, rivaroxaban, and apixaban.
• Identify appropriate candidates who will benefit most from newly approved anticoagulants.

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

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

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

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

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

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

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

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

Steven Fein, M.D.
Hematologist and Oncologist
Baptist Hospital, South Miami, Homestead, Mariners, Doctors, and West Kendall Baptist Hospitals

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

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

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

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

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

Page 66 of 73
OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission?

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

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

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

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

☐ Other tools or tactics

Explain: __________________________________________ _____________________________________

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

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

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

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

DATE REVIEWED: December 19, 2014 REVIEWED BY: ☒ EXECUTIVE COMMITTEE ☐ CHAIRMAN

APPROVED: ☐ YES ☐ NO Category 1 Credits: 1 Continuing Psychology Education Credits: ___ ☐ N/A
CME ACTIVITY TITLE: Ob/Gyn Conference Series: Infectious Diseases

DATE: Thursday, March 12, 2015      TIME: 6-7 p.m.

LOCATION: South Miami Hospital, Classroom E & F

CREDIT HOUR APPLIED FOR: 1 Cat. 1

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

TARGET AUDIENCE: Obstetricians and Gynecologists and Ob/Gyn Nurses.

EXPECTED NUMBER OF ATTENDEES: 30-35      CHARGE: 0

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

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

FACTORS OUTSIDE OUR CONTROL and BARRIERS TO PHYSICIAN CHANGE: - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18) (C19) Patient: ☒ Non-compliance  ☒ Lifestyle  ☒ Resistance-to-change  ☒ Financial/Lack of Insurance
- Physician: ☒ Non-compliance  ☒ Resistance-to-change  ☐ Communication Skills  ☒ Financial
- Resources:  ☒ Institutional Capabilities  ☒ Physician Practice Limitations  ☐ Community Service Limitations
- State of Science:  ☒ Limited or No Treatment Modalities  ☒ Limited or No Diagnostic Modalities
- Other:__________________________________________________ _________________________________________

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
- Physicians may not consistently identify and manage infectious diseases in obstetric and gynecologic patients in a timely manner.

WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
- Physicians implement best practices for identification and management of infectious diseases.

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

- Identify and manage infectious diseases commonly seen by obstetricians and gynecologists including urinary tract infectious, HIV, tuberculosis, endometritis, chorioamnionitis and mastitis.
- Implement current vaccine recommendations

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

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

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

- List the planned method(s) of evaluation:
  - [X] Baptist Health CME Evaluation Form (post-Conference)
  - [X] Follow-up Survey
  - [ ] Review of Hospital, Health System or Other Data
  - [ ] Other

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

Recurrent urinary tract infection (UTI) refers to ≥2 infections in six months or ≥3 infections in one year. Recurrent uncomplicated UTIs are common among young, healthy women even though they generally have anatomically and physiologically normal urinary tracts. Antimicrobial prophylaxis has been demonstrated to be highly effective in reducing the risk of recurrent UTI in women. Prophylaxis has been advocated for women who experience two or more symptomatic UTIs within six months or three or more over 12 months. However, the degree of discomfort experienced by the woman from these infections and concerns about antimicrobial resistance are the most important determinant of whether antimicrobial prophylaxis should be tried. (uptodate.com Recurrent Urinary Tract Infections in Women, Literature review current through: Dec 2014)

Tuberculosis (TB) infection poses substantial challenges for obstetricians and gynecologists globally, as gynecologic involvement may cause infertility, irregular bleeding, and pelvic pain. If TB-infected women are able to conceive, obstetric complications include intrauterine growth restriction and, more rarely, congenital transmission. Appropriate screening for high-risk populations is crucial for diagnosis and treatment of latent and active TB infection, which may prevent reproductive sequelae for individual patients and, eventually, contribute to complete eradication of the disease. (Rev Obstet Gynecol. 2013; 6(3-4): 174–181.)

Treatment of postpartum endometritis is indicated for relief of symptoms and prevention of sequelae. We administer parenteral antibiotics until the patient is clinically improved and afebrile for 24 to 48 hours. In the absence of bacteremia, we recommend not prescribing oral antibiotic therapy after successful parenteral treatment. Improvement in symptoms should be evident within 48 to 72 hours of initiating adequate antibiotic therapy. If the patient has not improved by this time, then the addition of ampicillin or vancomycin, in penicillin allergic patients, to the regimen can improve the response rate. Further evaluation is indicated. For patients undergoing cesarean delivery, we recommend antibiotic prophylaxis and spontaneous, rather than manual, placental extraction to minimize the risk of postpartum endometritis (uptodate.com Postpartum endometritis, Literature review current through: Dec 2014)

In addition to maternal infectious complications (eg, postpartum endometritis), Intraamniotic infection (IAI, also called chorioamnionitis) may impair myometrial contractility, which can result in labor abnormalities, need for cesarean delivery, and postpartum hemorrhage. Cesarean delivery in the presence of IAI increases the risk of wound infection, endomyometritis, and venous thrombosis. Broad spectrum antibiotics should be started at diagnosis to minimize maternal and fetal morbidity. IAI cannot be cured without delivery. We suggest prompt induction or augmentation of labor, as appropriate, with cesarean delivery reserved for standard obstetrical indications. Immediate (cesarean) delivery in the presence of reassuring intrapartum fetal testing, adequate progress of labor, and administration of antibiotics does not improve neonatal or maternal outcome. Adverse neonatal outcomes associated with IAI include perinatal death, asphyxia, early onset neonatal sepsis, septic shock, pneumonia, meningitis, intraventricular hemorrhage (IVH), cerebral white matter damage, long-term neurodevelopmental disability including cerebral palsy, as well as morbidity related to preterm birth. (uptodate.com Intraamniotic infection (chorioamnionitis), Literature review current through: Dec 2014)

Ultrasound is the most effective method of differentiating mastitis from a breast abscess. (See ‘Clinical manifestations and diagnostic evaluation’ above.)

Most lactation associated breast infections are caused by staphylococcus aureus. Methicillin-resistant Staphylococcus aureus (MRSA) is becoming an increasingly important pathogen in cases of lactational mastitis. (uptodate.com Lactational mastitis, Literature review current through: Dec 2014)
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.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty and/or Title(s)</th>
<th>Institution(s)</th>
<th>City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jorge Murillo</td>
<td>M.D.</td>
<td>South Florida Infectious Disease &amp; Tropical Medicine Center</td>
<td>Baptist, South Miami, Doctors and West Kendall Hospitals</td>
</tr>
</tbody>
</table>

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.

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? (C15)

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

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

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

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

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

If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. This meeting was planned in collaboration with the Ob/Gyn Department at South Miami Hospital.

DATE REVIEWED: January 9, 2015
REVIEWED BY: □ Executive Committee □ Chairman
APPROVED: □ YES □ NO □
- Credits: AMA/PRA Category 1 Credits: # _1
- Continuing Psychology Education Credits: # □ N/A
- Continuing Dental Education Credits: # □ N/A
CME ACTIVITY TITLE: Homestead Hospital Conference Series: Anemia

DATE: April 8, 2015  TIME: 12 noon-1 p.m.

LOCATION: Homestead Hospital, Physicians’ Dining Room  CREDIT HOUR(S) APPLIED FOR: 1 Category 1

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

CONFERENCE DIRECTOR: Andrew Renshaw, M.D.

TARGET AUDIENCE: Pediatricians, Emergency Medicine Physicians, Hospitalists, House Physicians, Nurse Practitioners, Physician Assistants and all interested healthcare providers.

EXPECTED NUMBER OF ATTENDEES: 35-40  CHARGE: 0

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

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
- [ ] Best practice parameters
- [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
- [ ] Resources: Institutional Capabilities  [ ] Physician Practice Limitations  [ ] Community Service Limitations
- [ ] State of Science: Limited or No Treatment Modalities  [ ] Limited or No Diagnostic Modalities
- [ ] Other: __________________________________________

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? Physicians are not identifying the early symptoms of anemia in newborn, children and adolescent patients which has led to delays in initiating appropriate treatment.

WHAT IS THE OPTIMAL PRACTICE*? Physicians identify the early signs and symptoms of anemia in newborn, children and adolescent patients and implement treatment accordingly.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to physician:
- [x] Knowledge (They do not know that they need to be doing something.)
- [x] 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 [x] Competence? -or- [x] Performance? -or- [ ] Patient Outcomes**? (Check all that apply.) *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)*
► Physicians implement timely anemia interventions.
**REFERENCES** supporting the current practice and/or the optimal practice and/or practice gap:

Preterm infants are at particular risk for impaired oxygen delivery with anemia because of the increased likelihood of concomitant respiratory disease, high levels of hemoglobin F, and the need to avoid hyperoxia, which increases the risk of bronchopulmonary dysplasia (BPD) and retinopathy of prematurity (ROP). (See 'Oxygen delivery' above.)

Many infants remain asymptomatic despite having hemoglobin levels below 7 g/dL. However, other infants may be symptomatic at similar or even higher hemoglobin levels. Symptoms include tachycardia, poor weight gain, increased requirement of supplemental oxygen, or increased frequency of apnea or bradycardia. (uptodate.com Anemia of prematurity Literature review current through: Nov 2014)

The laboratory examination should begin with a complete blood count, including red blood cell indices, and a reticulocyte count. The MCV and reticulocyte count often provide a preliminary categorization of the anemia, which guides additional testing (algorithm 1). However, multiple factors may contribute to the anemia, and not all patients can be neatly categorized. (See 'Physiologic classification' above and 'Mean corpuscular volume' above.)

Review of the peripheral blood smear is essential. The findings may support or refute the conclusions suggested by the RBC indices, or reveal features that suggest a specific cause of anemia, and helps to evaluate the possibility of a hematologic malignancy. The clinician must critically examine all blood cells and not just the red cells. (uptodate.com Approach to the child with anemia, Literature review current through: Nov 2014)

Recommendations for screening for anemia in adolescents vary. We suggest routine laboratory screening at least every five years for girls starting at age 13, and at least once during the peak growth period for boys. More frequent screening should be performed for patients with additional risk factors. Risk factors include a diet low in iron rich foods (meat, eggs, iron-fortified cereals, or beans – eg, some vegetarian or vegan diets), a history of iron deficiency anemia, high levels of physical activity, malnutrition or underweight, chronic illness, obesity, or excessive menstrual bleeding in females (>80 mL/month). (uptodate.com Iron requirements and iron deficiency in adolescents, Literature review current through: Nov 2014)

**EDUCATIONAL OBJECTIVES:**

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

- Explain the pathophysiology of anemia in newborn, children and adolescent patients.
- Diagnose and treat anemia in newborn, children and adolescent patients.

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

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

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

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

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

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

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

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

Doured Daghistani, M.D.  
Pediatric Hematologist Oncologist  
Baptist Hospital of Miami

**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:** January 12, 2015 REVIEWED BY: EXECUTIVE COMMITTEE CHAIRMAN

**APPROVED:** □ YES □ NO Category 1 Credits: ___ Continuing Psychology Education Credits: ___ N/A