Enduring Surgery Conference Series: Robotic Gastric Bypass (1 Cat. 1) - RENEWAL

RSS Baptist Hospital of Miami - Building Collaborative Leadership (twelve sessions 1 Cat. 1/ ea and ten sessions 2 Cat. 1 /ea)

RSS Nextgen Ambulatory EHR Training (12 Cat. 1 - 3 Sessions of 4 hrs/ ea)

RSS Simulation Training: Crisis Resource Management Instructor Course (15 Cat. 1)

10.21.14 MCVI Research Lecture Series: Renal Denervation - Updates, Advances, Research and Current Trends (2 Cat. 1)

10.21.14 Inpatient Neuromuscular Disorders and the role of EMG/NCS (1 Cat. 1)

10.27.14 Emergency Medicine Conference: Orthopedic Emergencies - The Top Ten Red Flags (1 Cat. 1)

10.28.14 WKBH Grand Rounds: Management of Upper GI Bleeding in a Hospital Setting (1 Cat. 1)

10.29.14 Inpatient Glycemic Management - Standards and Strategies (2 Cat. 1)

11.11.14 Pediatric Emergency Department Conference Series: Orthopedic Updates (1 Cat.1)

11.12.14 Homestead Hospital Conference Series: Hepatitis C & The New Era of Antivirals: Is The Cure Finally At Hand? (1 Cat. 1)

11.12.14 Conversations in Ethics: Child Health Policy & Social Determinants of Healthcare (1 Cat. 1)


11.14.14 Ob/Gyn Conference Series: Gynecologic Oncology- Update for the Generalists Ob/Gyn (1 Cat. 1)

11.15.14 12th Annual Sleep Center Symposium (4.5 Cat. 1)

11.18.14 Dentistry & Medicine Conference Series: Practical Management of Common Medical Emergencies in the Dental Office (1 Cat.1 and 1 dental CE)

12.04.14 Miami Neuro Symposium and Miami Neuro Nursing Symposium (22 Cat. 1)

12.13.14 Inaugural Venous Thromboembolism Symposium: Advances in the Treatment of VTE (3.5 Cat. 1)
CME ACTIVITY TITLE: Surgery Conference Series: Robotic Gastric Bypass

CREDIT HOUR(S) APPLIED FOR: 0.5 Cat. 1

CONFERENCE DIRECTOR: Arturo Fridman, M.D.

Original Approval: June 2012 Expiration: September 2015

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

TARGET AUDIENCE: Bariatric Surgeons, General Surgeons, Family Medicine Physicians and other interest healthcare professionals.
This activity addresses professional practice gaps relevant to physicians in the practice of family medicine and hospitalists. In addition, physicians that identify conditions and refer patients to a bariatric surgeon, and those specialists to whom a bariatric surgeon might refer for follow-up care or treatment, are also included in the target audience, as are members of the hospital care team, i.e.: nurses.

EXPECTED NUMBER OF ATTENDEES: 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 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 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 have thorough knowledge about all available surgical interventions for the treatment of obesity and do not typically know how to effectively communicate possible complications of these procedures to patients.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
► Physicians formulate treatment strategies to include appropriate surgical intervention for morbidly obese patients and they effectively communicate potential complications associated with these procedures to 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.)
► When evaluating available options surgeons consider minimally invasive robotic surgery that will allow patients to have a shorter hospital stay, less risk of infection, less pain, less scarring, faster recovery and a quicker return to normal activities without affecting their surgical risk or outcome.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Bariatric laparoscopic surgery has been shown to lead to sustainable weight-loss in obese individuals. Robotic-assisted laparoscopic surgery is proposed as the next major evolution in minimally invasive surgery. Robotic-assisted bariatric surgery is both a safe and feasible option for severely obese patients. http://www.ncbi.nlm.nih.gov/pubmed/21678542

The goal of gastric bypass surgery is to reduce the morbidity and mortality associated with obesity and to improve metabolic and organ function. Several studies have demonstrated that bariatric surgery is effective in reducing obesity-related comorbidities, while having additional benefits such as reducing monthly medication costs and the number of sick days and improving quality of life (http://www.uptodate.com/patients/content/topic.do?topicKey=~TAwTFg.bOGcqV)

Surgery has traditionally been a specialty within the medical profession that has revolved around invasive procedures to treat various maladies. Minimally invasive surgery has caused a change in the route of access and has significantly and irrevocably changed the surgical treatment of most disease processes. Patients still undergo interventions to treat disease, but minimally invasive surgery makes possible a reduction or complete elimination of the “collateral damage” required to gain access to the organ requiring surgery. While the benefits of this approach were numerous for the patient, early technology limited the application of minimally invasive surgery to some procedures. Specifically, surgeons using standard minimally invasive techniques lost the value of a natural three dimensional image, depth perception, and articulated movements. Magnification of small structures was often difficult and instruments were rigid and without joints. Robotic surgery has provided the technology to address these limitations and allow the application of minimally invasive surgery to a broader spectrum of patients and their diseases. Surgical robots relieve some of these limitations by providing fine motor control, magnified three dimensional imaging and articulated instruments. http://www.springer.com/medicine/surgery/journal/11701

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
• Review the co-morbid medical conditions associated with obesity to include diabetes, hypertension, heart disease and metabolic syndrome, and examine the mortality rate of the morbidly obese patient.
• Demonstrate emerging robotic surgical techniques in the field of bariatric surgery.
• Describe standard robotic port placement and variations for extenuating patient circumstances to include prior abdominal surgery and obesity.
• Acquire a greater knowledge of the detailed surgical steps and philosophies to improve function of varied general and bariatric procedures accomplished with robotic assistance.

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:

- [x] 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.)

**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)

- [x] 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?

- [x] 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
- [x] 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)

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

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

This course has been planned in collaboration with the South Miami Center for Bariatric Surgery. This course has been made available online for the benefit of local, national and international physicians who will be better able to identify patients that may benefit from gastric bypass surgery.

**DATE REVIEWED:** September 25, 2014

**REVIEWED BY:** [ ] Executive Committee [ ] Chairman

**APPROVED:** [ ] YES [ ] NO

- Credits: AMA/PRA Category 1 Credits: # 0.5
- Continuing Psychology Education Credits: # N/A
- Continuing Dental Education Credits: # N/A
CME ACTIVITY TITLE: Baptist Hospital of Miami - Building Collaborative Leadership

DATE: October 17, 2013 – May 22, 2014; Ten (10) Group Meetings, 1 hour each (specific dates listed below) Except 10/17 (2Hours)

TIME: 12-1 p.m. (10 meetings) LOCATION: Baptist Hospital of Miami (classroom listed And one meeting (11:30-1:30 p.m.) below)

CONFERENCE DIRECTOR: Mark Hauser, M.D.- VP-MA

CREDIT HOUR(S) APPLIED FOR: 12 (1 Cat 1 ea. For 10 sessions and 2 Cat. 1 each for 10/17 Session )

TARGET AUDIENCE: Nominated participants who are established or emerging Medical Staff leaders practicing in different specialties as well as nursing managers and administrative executives with oversight of the health care service lines.

EXPECTED NUMBER OF ATTENDEES: 15 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)_________

Integrated format of: a) presenting a concept or practice, b) engaging in group discussion and c) engaging in interactive exercises to apply the educational module presented

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): Needs of newly developed service lines and existing service lines in need of physician leadership development

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. (C2)

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/PRACTICE GAP? (C2) (What are doctors not doing or doing that needs to change?)
Physicians are not communicating and collaborating with each other and with associated disciplines in an effective and timely manner to provide optimum care delivery and time-sensitive information that can benefit their patient, interdisciplinary collaboration, their department or the hospital.
Physicians do not utilize optimal communication and collaborative skills with each other, between different specialties and/or departments, and with other disciplines. Exchange of important administrative and other information is not distributed in a reasonable time, resulting in unnecessary delays in project implementation and ineffective conflict management. Collaboration is not optimized.

This initiative was generated by the CEO of Baptist Hospital of Miami (BHM), Bo Boulenger, and Dr. Mark Hauser, VP-MA, and Dr Tomas Villanueva, Vice President Hospitalist Group, to engage a group of physician leaders with related nursing and administrative executives in building sound collaborative leadership skills to strengthen performance, leadership
WHAT IS THE OPTIMAL PRACTICE? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)

Physicians, healthcare professionals, leaders and administrators utilize sound communication and leadership skills to sustain success in working through critical moments of patient-physician interaction. They employ strong interdisciplinary teamwork, productive communication processes all of which contributes to increased and sustained physician and patient satisfaction.

Concurrent leadership development for medical staff, nursing professionals and hospital executives optimizes their collective efforts for a successful integration of the health care service lines. In addition, it provides a shared experience and team-oriented practices that can inform future efforts. The program uses an “Action Learning” methodology, meaning that new skills are practiced by applying them to advance actual objectives established by the group. The program provides tools to develop high performing leaders with strong communication, relationship, meeting facilitation and systemic thinking skills.

Physician engagement with hospital leadership and strategic planning results in improved physician satisfaction, which in turn positively impacts the goals mentioned below.

In recent years, The Joint Commission’s Board of Commissioners has identified enhancing physician engagement in accreditation and other quality improvement initiatives as one of its top strategic priorities. They also include “improve the effectiveness of communication among caregivers” as part of their National Patient Safety Goals.

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?

► Physician leaders will engage with nursing and administration executives to build sound communication and leadership skills needed to sustain success in working through critical moments of patient-physician interaction, as well as strengthen interdisciplinary teamwork, develop productive communication processes and ultimately boost physician and patient satisfaction.

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:

• Build and expand leadership and communication skills needed to effectively communicate with patients during challenging interactions (‘critical moments’).
• Strengthen resilience, accountability and collaboration between hospitalist leaders and hospital executives to enhance process improvement and patient satisfaction.
• Effectively implement the ten ‘critical moments’ in communication in healthcare institutions, between physician and patient or their family members.
• Review results and feedback obtained by patients when using ‘critical moments’ skills and script between meetings; revise scripting where needed.
• Engage in 360° strategic thinking when working on a project and gauge intended and unintended results.
• Put into practice expanded skills and choices in communication.
• Apply new leadership skills on projects of tangible value to the group and the hospital (action learning).

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: (See below)
1. Feedback charts shared with BHM CEO and VP-MA; quarterly executive reviews
2. BHM Administration assessment based on level of participation (attendance) and group report of project results
3. Coaches’ assessments.

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...
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:
Theodosia Southern, MA, and Patricia (Tricia) Webster
Center for Executive Leadership (CEL)
Boulder, Colorado

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.) Administrative Assistant: Shirley Acle (Dr. Hauser’s assistant; VP –MA at BHM)

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.

Barriers are opportunities in communication skills, agreements for collegial collaboration, feedback approaches, following through on planned activates, organizing projects toward completion, and engaging stakeholders

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? List collaborative efforts related to this CME activity that support achievement of our CME Mission. Yes

DATE REVIEWED: October 29, 2013
REVIEWED BY: ☐ COMMITTEE  ☒ CHAIRMAN-CME Committee  ☒ CHAIRMAN-Executive Committee

APPROVED: ☒ YES  ☐ NO Category 1 Credits: 12 total (10 sessions / 1 each) and (1 session/ 2each)
Group Meeting dates, 10 meetings 12-1 PM and 1 Meeting 11:30-1:30 PM (2 Hours)

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<thead>
<tr>
<th>Date (Tuesday 12-1pm)</th>
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<tr>
<td>1. October 30th</td>
<td>BHM Board Room</td>
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<td>2. November 14th</td>
<td>Neuroscience Conference Room – 2 Clarke</td>
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<td>3. December 12th</td>
<td>Neuroscience Conference Room – 2 Clarke</td>
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<td>4. January 9th</td>
<td>BHM Board Room</td>
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<td>10. May 8th</td>
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<td>11. May 22nd</td>
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BCL 2012-2013 PARTICIPANT LIST

1. Damian Chaupin, M.D.  Cardiovascular Disease/Internal Medicine
2. Lorna Colls           Supervisor, Emergency Team Staff
3. Jorge Coronel, M.D.   Medical Director, Hospitalist Dept.
4. Melissa Epstein, MD   Internal Medicine/ Hospitalist
5. Ivan Espaillat, M.D.  Internal Medicine/ Hospitalist
6. Karel Fuentes, M.D.   Critical Care ICU
7. Michael Harris, M.D.  Supervisor, Care Management
8. Alina Hernandez, R.N. Performance Improvement Nurse
9. Sergio Jaramillo, M.D. Neurology
10. David Mishkin, M.D.  Emergency Medicine
11. Merly Palma, R.N.    Asst. Manager Patient Care, Emergency Department
13. Maday Rafuls, R.N.   Director, Emergency Department
14. Sergio Segarra, M.D. Vice-Chief, Emergency Medicine
15. Jerry Yobin          AVP Patient Access
1 - Group Meeting Objectives - Tues 10/30/13
• Agree on mutual expectations and create agreements: facilitators and group
• Determine when a conversation is crucial
• Identify metrics to accurately evaluate performance
• Strengthen your rapport and perceptual acuity skills to connect with the patient instantly
• Discuss and practice scripting for meeting patient and family

2 - Group Meeting Objectives - Tues 11/14/13
• Clarify process for patient and family members
• Develop pacing and leading skills to ensure the patient feels heard and understands the process

3 - Group Meeting Objectives - Tues 12/12/13
• Establish real time communication practices with discharge team
• Develop and expand your perceptual positions (360 thinking) to best collaborate with patient and discharge team

4 - Group Meeting Objectives - Tues 1/9/14
• Learn how to connect with diverse personalities for more effective communication (HBDI)
• Clarify the values and beliefs that drive your actions
• Develop understanding of the patient’s emotional state
• Expand your comfort zone to relay news in a manner that is well received by the other party

5 - Group Meeting Objectives - Tues 1/23/14
• Learn to communicate clearly, concisely, compassionately to ensure understanding, engagement and consent by the other party
• Resolve conflicting issues effectively
• Help and guide patient and family members reach the best decision

6 - Group Meeting Objectives - Tues 2/13/14
• Strengthen pacing and rapport skills to empathize with patient or family member
• Use multiple perspectives to enhance communication effectiveness & make the patient feel acknowledged and understood
• Be aware of tension escalating and learn to remain calm and diffuse it before it reaches ‘boiling point’; work with the patient to develop solutions

7 - Group Meeting Objectives - Tues 3/13/14
• Develop script to sign out a patient: EDP to Hospitalist, Hospitalist to Hospitalist, Hospitalist to PCP
• Learn to be cohesive, clear and not send ‘mixed messages’ in providing or receiving feedback

8 - Group Meeting Objectives - Tues 3/27/14
• Clarify the facts and assumptions that led to the question and comments
• Acknowledge patient concerns
• Respond with integrity and review your bedside manner, communication skills and attitude of other staff

9 - Group Meeting Objectives - Tues 4/17/14
• Clarify and communicate your priorities
• Create a ‘level playing’ field where you can seek or offer help maintaining respect and boundaries
• Learn to say no in a graceful way that keeps the relationship intact
10 - Group Meeting Objectives- Tues 5/8/14

- Review program themes and practice corresponding scripts for final feedback
- Report on results and impact on patient satisfaction
- Share success stories

11 - Group Meeting Objectives- Tues 5/22/14

- Clarify the facts and assumptions that led to the question and comments
- Acknowledge patient concerns
- Respond with integrity and review your bedside manner, communication skills and attitude of other staff
CME ACTIVITY TITLE: Nextgen Ambulatory EHR Training

DATES: 9/19/14, 9/23/14, 9/26/14, 9/29/14, 10/1/14, 10/3/14, 10/6/14, 10/7/14, 10/8/14, 10/13/14, 10/14/14, 10/15/14, 10/16/14, 10/17/14, 11/3/14, 11/4/14, 11/5/14, 11/6/14/ 11/7/14

CREDIT HOUR(S) APPLIED FOR: 12 hours (3 Sessions of 4 Credits/ ea)

COURSE DIRECTOR: Jorge A. Coronel M.D

Others involved in the planning or content development: BHSF IT Analyst Team: Fanny Roiz (Lead), IT Instructors: Aileen Perez, Karina Vasquez, Marisol Zeco, and Catherine Blanco.

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: Nextgen EHR Clinical Providers

EXPECTED NUMBER OF PARTICIPANTS: 5/ session

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

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

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

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

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
☒ Non-compliance ☐ Resistance-to-change ☐ Communication Skills ☐ Financial

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

Resources: ☐ Institutional Capabilities ☒ Physician Practice Limitations ☐ Community Service Limitations
☐ Limited or No Treatment Modalities ☐ Limited or No Diagnostic Modalities

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

Other: New Ambulatory EMR technology implementation for the Baptist Health system.

DESERVED OUTCOMES (GOAL): What are the desired or expected outcomes of this activity? 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.)

► Competency in EHR will lead to improved awareness in healthcare workflow and re-design to improve efficiency and outcomes.

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

► The Baptist Health Medical Information Technology Physician Services has undertaken an initiative to coordinate Soarian Clinicals and NextGen Ambulatory EHR education based on mandated requirements by the federal government. Health information technologies (ITs) are at the center of the debate on improving quality and reducing cost in the US healthcare system. Federal incentives linked to the adoption of electronic health record (EHR) systems require organizations to demonstrate “meaningful use” of the technologies. Computerized physician order entry (CPOE) and electronic medication administration records (eMAR) are significant components of an EHR capable of meeting future meaningful use objectives. The Institute of Medicine has estimated that at least 1.5 million preventable adverse drug events occur annually in the USA, excluding errors of omission—failure to prescribe evidence-based medications that are likely to reduce morbidity and mortality. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3341782/
NextGen Ambulatory EHR role-based workflows help improve efficiency, reduce the administrative burden of documentation, all while improving care management and allowing more time for patient care. NextGen is both, IDC-10 and “Meaningful Use” compliant. [https://www.nextgen.com/Products-and-Services/Ambulatory/Electronic-Health-Records-EHR](https://www.nextgen.com/Products-and-Services/Ambulatory/Electronic-Health-Records-EHR)

**Educational Objectives**

Upon completion of this two-part training course, participants should be able to effectively navigate and efficiently utilize the NextGen system in day to day practice of inpatient 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)

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

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

**Jorge A. Coronel, M.D.**
Medical Director, Baptist Hospital Medicine Program

**Fanny Roiz (IT Lead)**
Manager, IT Business Systems
Baptist Health South Florida

**Instructors:**

- **Aileen Perez**
  Clinical Business Technology Consultant
  Baptist Health South Florida

- **Karina Vasquez**
  Clinical Business Technology Consultant
  Baptist Health South Florida

- **Marisol Zeno**
  Clinical Business Technology Consultant
  Baptist Health South Florida

- **Catherine Blanco**
  Clinical Business Technology Consultant
  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:** None

**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
- Bibliography or References must be provided to the learner

**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 Baptist Health Medical Group.*
Training will be conducted in three sessions:

- Session 1: NextGen Overview and EHR – 4 hours
- Session 2: Patient Workflow – 4 hours
- Session 3 Provider: Odds and ends, Patient Portal, Dragon – 4 hours

**Agenda:**

Session 1: NextGen Overview – EHR, EPM, ICS, PAQ

- Application
  - Layout / Taskbar / Top Toolbar / Menus / Buttons – 0.25 hour
  - Preferences – 0.25 hour
  - Inbox/Tasking – 0.5 hour
  - Allergy Module – 0.25 hour
  - Medication Module – 0.5 hour
  - Problem Module / Diagnosis Module – 0.5 hour
  - Patient Tracking – 0.25 hour

- Telephone Call Template – 0.5 hour
- PAQ / Provider Test Action Template – 1 hour

**Agenda:**

Session 2: Patient Visit Workflow
Office Visit Workflow (new patient comprehensive)

- Intake – 1 hour
- Histories – 0.5 hour
- Home Page – 0.25 hour
- SOAP – 0.5 hour
- Finalize – 0.5 hour
- Checkout – 0.25 hour
- Practice/Lab – 1 hour

**Agenda:**

Session 3: Provider

- Odds and Ends – 1.25 hours
  - Clinical Reconciliation
  - Patient Demographic Template
  - PHI Log
  - Document Library
  - Review MU Checklist
  - Practice Template / closing the loop on orders

- Patient Portal – 0.75 hours
- Dragon – 2 hours
  - General – 30 min
  - DragonPad – 35 min
  - Vocabulary Editor – 10 min
  - Command Browser – 15 min
  - Accuracy Center – 10 min
  - NextGen – 15 min
CME ACTIVITY TITLE: Simulation Training: Crisis Resource Management Instructor Course

LOCATION/DATE/TIME: Monday 10/13/2014, 4 PM - 8 PM BH-Classroom 5
Wednesday 10/15/2014, 4 PM - 8 PM, BH-Classroom 5
Saturday 10/18/2014, 8 AM - 5 PM SIM Instructor Course BH- Pineapple Room- Cafeteria

CREDIT HOURS APPLIED FOR: 15.0 Cat. 1

CONFERENCE DIRECTOR: Victoria Lopez Beecham, 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: Ob/Gyns, Anesthesiologists, Neonatologists and Nurses.

EXPECTED NUMBER OF ATTENDEES: 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
- Panel
- ARS
- Question & Answer
- Enduring Material
- Internet-Home Study
- Case Studies
- Other: Simulation-based

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, 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 value of successful team behavior and effective communication techniques and their impact on patient outcomes. Physicians may not be familiar with Crisis Resource Management (CRM) principles and how to apply them to develop and prepare case scenarios and conduct a debriefing.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like’?)
- Participants will operate within a system framework to develop, prepare and conduct simulation-based education (SBE) advancing crisis resource management (CRM) strategies within Baptist Health. The multidisciplinary, multiprofessional healthcare team appreciates the importance of communication during a crisis, implements appropriate treatment protocols

effectively and uses their experience in the simulation laboratory to identify and correct systems problems and ultimately improve patient outcomes.

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

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? (Check all that apply.)
- Performance? (Check all that apply.)
- Patient Outcomes*? *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)

Instructors participate in the simulation laboratory to improve function and communication during a crisis situation to enhance teamwork and ultimately to identify and correct systems problems and improve patient outcomes. The trained simulation instructors will be able to develop a SBE program for their departments that improve function and communication.

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

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

Based on Sentinel Event #30 and Sentinel Event #40 TJC recommends team training in perinatal areas to teach staff to work together and communicate. In addition, clinical drills are recommended to help staff prepare for when such events occur. TJC recommends conducting debriefings to evaluate team performance and identify areas of improvement. The drills should be used to train staff in the protocols for responding to change such as hemorrhage and pre-eclampsia, to refine local protocols, and to identify and fix systems problems that would prevent optimal care.

(http://www.jointcommission.org/assets/1/18/SEA_44.PDF; http://www.jointcommission.org/assets/1/18/SEA_30.PDF)

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
- Implement crisis resource management (CRM) principles and explain why they are important in advancing patient safety.
- Create a challenging and safe learning environment.
- Prepare, build, conduct and debrief high fidelity CRM scenarios.
- Utilize effective debriefing techniques.

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

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

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

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

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

Maria Victoria Lopez-Beecham, M.D.
Medical Director, Baptist Health Patient Safety Simulation Lab

Karen P. Baez, BS-HSA, R.N., CEN
Manager, Patient Safety Simulation Lab

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

William Smalling, M.D.
Faculty, Baptist Health Patient Safety Simulation Lab
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 course was planned in collaboration with the Baptist Health Patient Safety Simulation.

DATE REVIEWED: September 22, 2014 REVIEWED BY: ☒ Executive Committee ☐ Chairman
APPROVED: ☐ YES ☒ NO ☐ Credits: AMA/PRA Category 1 Credits: 15.0
Continuing Psychology Education Credits: ☒ N/A ☐ Continuing Dental Education Credits: 15 ☐ N/A

SCHEDULE
Monday, October 13th, 2014 4-8pm Classroom 5
4:00 p.m. Welcome & Introductions
4:30 p.m. Introduction to Simulation-based Education - Victoria Lopez- Beecham, M.D.
5 p.m. Simulation Exercise
5:45 p.m. Debriefing (Part 1) - Victoria Lopez- Beecham, M.D. & Karen Baez
   ○ Debriefing styles
   ○ CMS style
   ○ Plus/Delta
   ○ A/I practice
8 p.m. Adjourn
Total CME/CEs offered: 3.5

Wednesday, October 15th, 2014 4-8pm Classroom 5
4 p.m. Debriefing Part 2- Victoria Lopez- Beecham, M.D. & Karen Baez
   ○ Recap/Questions
   ○ Frames-Actions-Results
   ○ Exercises
   ○ Debriefing phases
   ○ Practice exercises

6:30 p.m. TEAM TRAINING- Victoria Lopez- Beecham, M.D. & Karen Baez
   ○ Building Effective Teams LB
   ○ The ME in Team Karen
   ○ Team Steps/Crisis Resource Management
   ○ Video reviews for CRM debriefing
8 p.m. Adjourn
Total CME/CEs offered: 4.0

Saturday, October 18, 2014 8am-4pm The Pineapple Room, PSSL
8 a.m. Recap and Questions
8:20 a.m. Drills- Karen Baez
8:35 a.m. Patient Safety – Geri Schimmel
9 a.m. Scenario design- Victoria Lopez- Beecham, M.D. & Karen Baez
10 a.m. Course Design
11 a.m. Simulations and Debriefings
12 noon Lunch
12:30 p.m. Simulations and Debriefings
3:30 p.m. Recap, Questions, Course Evaluations
4 p.m. Adjourn

Total CME/CEs offered: 7.5

DATE: Monday, October 27, 2014
TIME: 8-9 a.m.

LOCATION: SMH Classroom E & F

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

CONFERENCE DIRECTOR: John Baldino, M.D.

AMA/PRA LEARNING FORMAT:
- Live activity
- Enduring material
- Journal-based CME activity

TARGET AUDIENCE:
Emergency Medicine Physicians, Urgent Care Physicians, Nurses and other interested healthcare professionals.

In addition, describe how the content of the activity is aligned with the target learners’ current or potential scope of practice (C4). This activity addresses professional practice gaps relevant to physicians in the practice of emergency medicine and those specialists to whom an emergency medicine 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: 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.

► Emergency Medicine Physicians do not consistently assess and treat orthopedic issues or open fractures appropriately in the emergency department.

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

► Emergency Medicine Physicians accurately assess and initiate best practice treatment of orthopedic patients in the emergency department and refer to appropriate specialists for follow up care.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
- Knowledge (Doctors do not know that they need to be doing something.)
- Competence (Doctors do not know how to do it)
**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 ☐ Competence -or- ☐ Performance -or- ☐ Patient Outcomes*? *(Check all that apply.)*

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

► Emergency Medicine Physicians will accurately diagnose and provide best practice initial treatment on patients presenting with orthopedic emergencies.

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

Orthopedic injuries are among the most likely conditions to be missed in the emergency departments. Fractures and other orthopedic injuries may go unnoticed on x-rays if emergency department physicians aren’t familiar with non-obvious signs of trauma. To reduce the number of missed orthopedic injuries, emergency physicians should learn about the types of injuries that are missed most often, and be sure to check for them. In fact, having a number of formal checks in place would be a good practice in emergency departments.

Reducing missed orthopedic injuries in the ER. CMAJ Canadian Medical Association Journal Issue: Volume 186(1), 7 January 2014, p E18

http://ovidsp.tx.ovid.com/sp-3.13.0b/ovidweb.cgi?WebLinkFrameset=1&S=AAODFPFMMDIOGENCLKNAJCMKOC0AA00&returnUrl=ovidweb.cgi%3f%26Full%2bText%3dL%257cS.sh.52.55%257c0%257c00002792-20140107-00031%26S%3dAAODFPFMMDIOGENCLKNAJCMKOC0AA00&direct_link=http%3a%2f%2fgraphics.tx.ovid.com%2fovftpdfs%2fFPDDNCJCJCNAGEM00%2ffs046%2fovt%2flive%2fgv023%2f000002792%2f000002792-20140107-00031.pdf&filename=Reducing+missed+orthopedic+injuries+in+the+ER.&pdf_key=FPDDNCJCNAGEM00&pdf_index=/fs046/ovft/live/gv023/00002792/00002792-20140107-00031&D=medf

The management of open fractures continues to provide challenges for the orthopedic surgeon. Despite the improvements in technology and surgical techniques, rates of infection and nonunion are still troublesome. Early antibiotic administration is of paramount importance in these cases, and when coupled with early and meticulous irrigation and debridement, the rates of infection can be dramatically decreased. When possible, early closure of open fracture wounds, either by primary means or by flaps, can also decrease the rate of infection, especially from nosocomial organisms. Early skeletal stabilization is necessary, which can be accomplished easily with temporary external fixation. Adhering to these principles can help surgeons provide optimal care to their patients and assist them in an early return to function.


http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2740354/

**EDUCATIONAL OBJECTIVES:**

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

- Identify the orthopedic injuries that are most commonly missed in the emergency department setting.
- Implement appropriate initial treatment of orthopedic injuries and accurately describe findings to a referring physician.

**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: ____________________________

☑ Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)
FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

Cornell V. Calinescu, M.D.
Emergency Medicine Physician
South Miami 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. ☒ Yes ☐ No

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 conference is planned in collaboration with the South Miami Emergency Department.

DATE REVIEWED: __09-22-2014____ 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: Management of Upper GI Bleeding in a Hospital Setting

DATE: October 28, 2014    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
☐ Enduring material
☐ Journal-based CME activity
☐ Test-item writing activity
☐ Manuscript review activity
☐ PI CME activity
☐ Internet point-of-care activity


EXPECTED NUMBER OF ATTENDEES: 15-20    CHARGE: 0

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

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

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

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

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

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

PROFESSIONAL PRACTICE GAP (C2)

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

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

► Physicians may not be aware of updated guidelines for the management of patients with upper gastrointestinal bleeding in an inpatient setting.

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

► Physicians effectively identify and manage the care of patients with GI bleeding in an inpatient setting.

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

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

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

► Physician will implement updated guidelines when treating patients with upper GI bleeding.

### REFERENCES
- Supporting the current practice and/or the optimal practice and/or practice gap:
  - Upper gastrointestinal (GI) endoscopy is the most basic part of endoscopy field. Although old and basic procedures are still in use, a line of innovative techniques and devices are being introduced to allow much complex and difficult procedures in endoscopy unit. High quality upper endoscopic procedures can replace or obviate surgical treatment.
- Endoscopic treatment for the upper GI tract is evolving continuously with new techniques and innovative devices. Better quality upper GI endoscopy and subsequent improved patient care is our uppermost goal.


http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3429739/

### EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
- Examine and identify the pathophysiology and risk factors of upper gastrointestinal (GI) bleeding.
- Implement the most recent guidelines to manage and prevent upper GI bleeding.
- Explain the medical and endoscopic management of upper GI bleeding.

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

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

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

### FACULTY:
- **George Sanchez, M.D.**
  - Gastroenterologist
  - Baptist, Doctors, South Miami 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.
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: 09-22-2014 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: Homestead Hospital Conference Series: Hepatitis C & The New Era of Antivirals: Is The Cure Finally At Hand?

DATE: Wednesday, November 12, 2014

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
☑ Test-item writing activity
☐ Internet point-of-care activity
☐ Enduring material
☐ Manuscript review activity
☐ PI CME activity
☐ Journal-based CME activity
☐ Internet-Home Study
☐ Other (specify)

HOMESTEAD TARGET AUDIENCE: Hospitalists, House Physicians, Surgeons, Emergency Medicine Physicians, Physicians

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
☐ 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) BARRIERS TO PHYSICIAN CHANGE:

(C19) Patient: ☐ Non-compliance ☐ Lifestyle ☐ Resistance-to-change ☑ Financial/Lack of Insurance
☐ Communication Skills ☐ Financial

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 recent 2014 studies that detail the use of antivirals for the treatment of Hepatitis C.

WHAT IS THE OPTIMAL PRACTICE***? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like'? ) Physicians should treat chronic HCV genotype 1 in patients without cirrhosis with a combination of antivirals to achieve high rates of cure.

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? *(Check all that apply.)* *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)*
- Physicians will appropriately utilize antivirals to improve patient outcomes.

*REFERENCES* supporting the current practice and/or the optimal practice and/or practice gap:
- Recent study showed that 12 weeks of the single-tablet regimen of ledipasvir–sofosbuvir was a highly effective treatment for a broad range of patients with HCV genotype 1 infection who had not been treated previously. No additional benefit appeared to be associated with the addition of ribavirin or with extension of the duration of treatment to 24 weeks. (Ledipasvir and Sofosbuvir for Untreated HCV Genotype 1 Infection, Nezam Afdhal, M.D., et. Al N Engl J Med 2014; 370:1889-98. DOI: 10.1056/NEJMoa1402454.)

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
- Explain recent study findings, limitations and their impact on treatment of Hepatitis C patients.
- Implement antiviral combination therapies to 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)* 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.)*
Miguel Rodriguez, M.D.
Nephrologist
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.

<table>
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<td>If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.</td>
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</table>

**DATE REVIEWED:** September 19, 2014  **REVIEWED BY:** ☒ EXECUTIVE COMMITTEE ☐ CHAIRMAN  **APPROVED:** ☐ YES ☐ NO  **Category 1 Credits:** 1  **Continuing Psychology Education Credits:** ☐ ☑ N/A
CME ACTIVITY TITLE: Cardiovascular Conference Series: New Lipid Guidelines: What Does it Mean for Your Practice?

DATE: Friday, November 14, 2014  TIME: 12:30 – 1:30 p.m.

LOCATION: SMH, CL C  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

And Live Webcast

CONFERENCE DIRECTOR: Harry Aldrich, 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


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
- 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.

Current physician practice does not include appropriate/consistent use of cardiovascular disease prevention strategies that can serve to reduce cardiovascular disease.
WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)

► Physicians apply the principles of cardiovascular disease prevention with lifestyle intervention and medical therapy to prevent cardiovascular morbidity and mortality.

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

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

► The American College of Cardiology (ACC) and American Heart Association (AHA), in collaboration with the National Heart, Lung and Blood Institute (NHLBI), have recently released a set of four important guideline documents that provide recommendations for blood cholesterol management in adults, management of overweight and obesity, life-style modifications to reduce cardiovascular (CV) risk and the approach to CV risk stratification. Of these, the cholesterol guidelines were perhaps the most awaited, given the significant improvements that have taken place in our understanding of lipid management over the past decade, since the previous NHLBI guidelines (adult treatment panel III) were last updated. However, the new recommendations depart heavily from the prevailing concepts in lipid management and in this process have sparked off an intense debate about their rationale and practicality.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3946473/

LDL cholesterol as the primary target of therapy […] the robust relationship between total cholesterol and CHD found in epidemiological studies strongly implies that an elevated LDL is a powerful risk factor. Subsequent studies have shown that LDL is the most abundant and clearly evident atherogenic lipoprotein. The role of LDL in atherogenesis is confirmed by genetic disorders in which serum LDL cholesterol is markedly increased in the absence of other CHD risk factors. Notable examples of such genetic disorders are homozygous and heterozygous forms of familial hypercholesterolemia; in both, atherogenesis is markedly accelerated. Finally, a causal role for LDL has been corroborated by controlled clinical trials of LDL lowering; recent trials especially have revealed a striking reduction in incidence of CHD. Evidence for LDL being both a major cause of CHD and a primary target of therapy will be examined in some detail. Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3full.pdf

EDUCATIONAL OBJECTIVES

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

• Summarize the 2013 ACC/AHA Cholesterol Management Guidelines, and analyze their limitations.
• Implement lipid management recommendations for various groups of patients to improve 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) 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.)

Francisco Lopez-Jimenez, M.D.
Professor of Medicine
Mayo College of Medicine
Director, Preventive Cardiology
Cardiovascular Division, Department of Medicine
Director of Research, Dan Abraham Healthy Living Center
Mayo Clinic, Rochester

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 SMHC.

DATE REVIEWED: September 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

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

CME ACTIVITY TITLE: Inaugural Venous Thromboembolism Symposium: Advances in the Treatment of VTE

Page 29 of 94
DATE: Saturday, December 13, 2014
TIME: 7:15 a.m.– 12:00 p.m.
TIME: LOCATION: Baptist Hospital Auditorium
CREDIT HOUR(S) APPLIED FOR: 3.5 Cat. 1
Miami, Florida

SYMPOSIUM DIRECTORS: Ian del Conde Pozzi, M.D., Barry T. Katzen, M.D., Constantino S. Peña, M.D.

AMA/PRA LEARNING FORMAT:

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


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 vascular and interventional medicine. In addition, physicians who identify conditions and refer patients to a vascular surgeon are also included in the target audience, as are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 75-100

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 do not consistently use proper work-up of patients who presents with venous thromboembolism (VTE) or pulmonary embolism (PE). Additionally, they are not always aware of the various available interventional treatments, their risk and complications and the type of patients who would benefit from them.
WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
► Physicians perform proper work-up for patients presenting with VTE or PE. They determine the most appropriate interventional treatments for the patients who would most benefit from them.

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 symposium? 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 provide optimal care and achieve best outcomes when they consistently perform proper work-up for patients presenting with VTE or PE. They will determine the most appropriate interventional treatments for the patients who would most benefit from them.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Venous thromboembolism occurs in the Western World in 100–180 individuals per 100,000 annually. The most important demographic risk factor is age, logarithmic increment in incidence from less than 5 per 100,000 in children to 450–600 per 100,000 in octogenarians. Another demographic risk factor is age with an increasing incidence from Asians, via Hispanics, Whites and to the highest incidence in African-Americans. In large observational studies the provoked venous thromboembolic events have a slight dominance over the unprovoked. One third of the patients are diagnosed with pulmonary embolism and the remaining two thirds with deep vein thrombosis. Despite efforts during the past two decades to improve and generalize prophylaxis, an increasing prevalence of venous thromboembolism by 33% from 2002 to 2006 was recently reported. It is therefore critical to improve efforts to reduce the provoked events in order to minimize the preventable proportion of fatal pulmonary emboli as well as to decrease the prevalence of the long-term consequences – post-thrombotic syndrome and pulmonary hypertension. Likewise, early and accurate diagnosis of deep vein thrombosis or pulmonary embolism is paramount to avoid progression of the disease with more widespread destruction of venous valves or fatal pulmonary embolism. [https://www.clinicalkey.com/#!/ContentPlayerCtrl/doPlayContent/1-s2.0-S1521692612000539/](https://www.clinicalkey.com/#!/ContentPlayerCtrl/doPlayContent/1-s2.0-S1521692612000539/)

Pulmonary embolism? Deep vein thrombosis?
Clinical assessment
History, symptoms, signs
Low probability (unlikely)
D-dimer
Negative
Do not anticoagulate
Intermediate/high probability (likely)
Imaging diagnostics
Negative
Positive
Anticoagulate

FACULTY, SCHEDULE and EDUCATIONAL OBJECTIVES WITH REFERENCES
Please see below

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

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

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

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

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

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

- □ 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)

- □ 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 Venous Thromboembolism Symposium is a collaborative project between the Miami Cardiac and Vascular Institute and the Department of CME to improve patient care via implementation of evidenced-based approaches to care for patients with Venous Thromboembolism or Pulmonary Embolism.

DATE REVIEWED: September 16, 2014  REVIEWED BY: □ Executive Committee  □ Chairman

APPROVED: □ YES □ NO  Credits: AMA/PRA Category 3.5

Continuing Psychology Education Credits: # 3.5  □ Continuing Dental Education Credits: # ___ □ N/A

FACULTY

GUEST FACULTY
Adam Cuker, M.D., M.S.
Assistant Professor of Medicine
Assistant Professor of Pathology & Laboratory Medicine
Perelman School of Medicine
Penn Comprehensive Hemophilia and Thrombosis Program
University of Pennsylvania
Philadelphia, Pennsylvania

BAPTIST HEALTH SOUTH FLORIDA AFFILIATED FACULTY

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Medical Director, Peripheral Vascular Laboratory
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Clinical Professor of Radiology
Florida International University Herbert Wertheim College of Medicine
Miami, Florida

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Cardiovascular Disease and Vascular Medicine Specialist
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Alex Powell, M.D.
Diagnostic, Vascular & Interventional Radiologist
Miami Cardiac & Vascular Institute, Baptist, Doctors, Homestead, South Miami and West Kendall Baptist Hospitals and Baptist Outpatient Services
Miami, Florida

Shaun Samuels, M.D.
Diagnostic, Vascular & Interventional Radiologist
Miami Cardiac & Vascular Institute
Miami, Florida

SCHEDULE
7:30 a.m.  Registration and Continental Breakfast
7:55 a.m.  Welcome and Introductions
SESSION 1  (1.5 Credits) MEDICAL ASPECTS OF VENOUS THROMBOSIS
8:00 a.m.  Clinical Use of the New Oral Anticoagulants
Ian del Conde Pozzi, M.D.
8:15 a.m.  Thrombophilia Testing: What, When and Who to Test?
Adam Cuker, M.D.
8:30 a.m.  What to do with Line-Associated Deep Vein Thrombosis (DVT), Calf Vein DVT, and Superficial Vein Thrombosis?
Ian del Conde Pozzi, M.D.
8:45 a.m.  Diagnosis, Management, and Disposition of Patients with DVT in the ER
Adam Cuker, M.D.
9:00 a.m.  Overview of Endovascular Therapies for VTE: Available Devices and Techniques
Shaun Samuels, M.D.
9:15 a.m.  Roundtable/Question-and-Answer Session
Panelists:
James Benenati, M.D., Adam Cuker, M.D., Jose Poleo, M.D., and Shaun Samuels, M.D.
Moderator:
Ian del Conde Pozzi, M.D.

9:30 a.m.  Break and Visit Exhibits

SESSION 2  (1 Credit) INTERVENTIONAL THERAPIES FOR DVT
9:45 a.m.  Which Patients with Lower Extremity DVT Benefit From Endovascular Therapy?
Alex Powell, M.D.
10:00 a.m.  IVC Filters: Expected Outcomes, Controversies and Indications
Constantino Peña, M.D.
10:15 a.m.  Evaluation and Management of Upper Extremity DVT
James Benenati, M.D.
10:30 a.m.  Roundtable Discussions and Question-and-Answer Session
Panelists:
Adam Cuker, M.D., Ian del Conde Pozzi, M.D., Jose R. Poleo, M.D., and Alex Powell, M.D.
Moderator:
Constantino Peña, M.D.

10:45 a.m.  Break and Visit Exhibits
SESSION 3  (1 Credit) RATIONALE FOR THROMBOLYSIS IN PULMONARY EMBOLISM AND PATIENT RISK STRATIFICATION
11:00 a.m.  Rationale for Thrombolysis in Pulmonary Embolism
Ian del Conde Pozzi, M.D.
11:15 a.m.  New Interventional Therapies for Pulmonary Embolism
Ripal Gandhi, M.D.
11:30 a.m.  Cases from the MCVI Archives
Constantino Peña, M.D., and James Benenati, M.D.
11:50 a.m.  Roundtable Discussions and Question-and-Answer Session
Panelists:
James Benenati, M.D., Adam Cuker, M.D., Ripal Gandhi, M.D., Constantino Peña, M.D.
Moderator:
Ian del Conde Pozzi, M.D.
12:00 Noon  Closing Remarks and Adjourn

EDUCATIONAL OBJECTIVES AND REFERENCES
EDUCATIONAL OBJECTIVES
Assume these are overall objectives for the web page/post-card. Bold objectives are what I recommend.

- Implement clinical evaluation strategies that promote early identification of VTE.
- Advance early detection of VTE by implementing recommended clinical evaluation strategies.
- Apply evidence-based strategies to improve outcomes for the VTE patient.
- Improve outcomes for VTE patients by applying evidence-based treatment strategies.
- Examine and assess the use of new anticoagulants and
- Explore the value of endovascular therapies for VTE.

**Ian del Conde Pozzi, M.D.**

**Clinical Uses of the New Oral Anticoagulants**

Educational Objectives

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

- Identify new oral anticoagulants approved by the FDA for the treatment and prevention of VTE, including their indications, contra-indications, approved doses, and necessary dose adjustments.
- Discuss the basic pharmacokinetics and pharmacodynamics of approved new oral anticoagulants and analyze the clinical evidence behind the use of these agents in VTE.

**Adam Cuker, M.D.**

**Thrombophilia Testing: What, When and Who to Test**

Educational Objectives

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

- Determine when testing for underlying thrombophilia is indicated.
- Discuss the specific thrombophilia tests that can be ordered, their correct interpretation and limitations.
- Recognize when results of a thrombophilia evaluation change the clinical management of VTE patients.

**Ian del Conde Pozzi, M.D.**

**What to do with Line-Associated DVT, Calf Vein DVT and Superficial Vein Thrombosis**

Educational Objective

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

- Discuss the indications for anticoagulation surveillance using duplex ultrasound.

**James Benenati, M.D.**

**Upper Extremity DVT Evaluation and Management**

Educational Objectives

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

- Recognize the diverse nature of pathologies that can present as upper extremity DVT.
- Implement a basic evaluation strategy for patients with upper extremity DVT, including appropriate use of imaging modalities, specifically duplex ultrasound and MR/CT venography.
- Examine the management of various VTE etiologies.

**Shaun Samuels, M.D.**

**Overview of Endovascular Therapies for VTE: Available Devices and Techniques**

Educational Objectives

Upon completion of this conference, participants should:

- Discuss the evolution and development of interventional therapies for VTE.
- Examine the basic components of interventional therapies for VTE, including access, general description of the main procedures used, basic procedural risks and complications.
- Examine the basic components of interventional therapies for VTE including access, procedural overview and potential risks and complications.
- Discuss endovascular therapeutic approaches to VTE management including specific devices and techniques employed.

**Alex Powell, M.D.**

**Which Patients with Lower Extremity DVT Benefit from Endovascular Intervention?**

Educational Objectives

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

- Identify signs and symptoms of severe venous outflow obstruction.
- Perform a basic evaluation on a patient with iliofemoral DVT, including appropriate use of different imaging and diagnostic modalities.
- Examine the basic clinical aspects of post-thrombotic syndrome, including risk factors, clinical presentation and management.
• Identify patients with acute lower extremity DVT who may benefit from endovascular therapy.
• Discuss the basic clinical aspects of the May-Thurner syndrome and other syndromes caused by extrinsic venous compression.

**Constantino Peña, M.D.**  
**IVC Filters: Expected Outcomes, Controversies and Indications**

Educational Objectives
Upon completion of this conference, participants should be better able to:
• Discuss the indications and contraindications for the use of IVC filters.  
• Recognize the expected benefits and risks of IVC filter use.  
• Distinguish the official recommendations of the different multidisciplinary guidelines on the use of IVC filters.  
• Describe the IVC filter placement procedure.

**Adam Cuker, M.D.**  
**Diagnosis, Management, and Disposition of Patients with VTE in the ER**

Educational Objectives
Upon completion of this conference, participants should be better able to:
• Discuss pretest probability for diagnosis of DVT.  
• Determine when patients should be evaluated with duplex ultrasound.  
• Identify patients with DVT who can be safely discharged from ER.

**Ian del Conde Pozzi, M.D.**
**Rationale for Thrombolysis in PE**

Educational Objectives
Upon completion of this conference, participants should be better able to:
• Describe the rationale and clinical evidence behind thrombolysis (systemic and catheter-directed) for the treatment of acute PE.  
• Implement appropriate strategies to risk-stratify patients with PE including use of chest CT angiography, biomarkers, and echocardiography.  
• Identify which patients are at increased risk of poor outcomes.

**Ripal Gandhi, M.D.**
**New Interventional Therapies for PE**

Educational Objectives
Upon completion of this conference, participants should be better able to:
• Discuss the current status of the field of interventional therapies for PE, including results of the most recent clinical trials.  
• Analyze the indications and contraindications for implementation of interventional therapies for PE.  
• Examine various types of interventions for PE, including thrombolysis, mechanical thrombolysis, and suction embolectomy.
CME ACTIVITY TITLE: Preventing Aggression and Bullying in School and Community: Multi-Systemic Approaches

DATE: Friday, October 3, 2014  TIME: 8:30-12 noon.

LOCATION:  Newman Alumni Center, University of Miami, 6200 San Amaro Drive | Coral Gables, FL 33146

CREDIT HOUR(S) APPLIED FOR: 3 CEUs for Psychologists

CONFERENCE DIRECTOR: Lynn Aptman, M.E.d.

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

TARGET AUDIENCE: Educators, guidance counselors, psychologists, social workers, family mediators, mental health workers, marriage and family therapists, social agency personnel, judges, law enforcement personnel, clergy, pediatricians, primary care physicians and psychiatrists.

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 psychology and psychiatrists that treat children and adolescents.

EXPECTED NUMBER OF ATTENDEES: 50-100  CHARGE: 0

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

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

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.
- [ ] This conference will critically examine the roles and responsibilities of adults in their relationships with children in school and the community.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
- [ ] Psychologists and psychiatrists effectively conduct screening, identification and progress monitoring of children with aggressive behavior.
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.)
- Psychologists and psychiatrists will effectively conduct outcome-driven assessments, taking under consideration ways to improve community-based, psychotherapeutic and educational interventions, to improve treatment options for children with aggression.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
Physical aggression in children is a major public health problem. Not only is childhood physical aggression a precursor of the physical and mental health problems that will be visited on victims, but also aggressive children themselves are at higher risk of alcohol and drug abuse, accidents, violent crimes, depression, suicide attempts, spouse abuse, and neglectful and abusive parenting. Furthermore, violence commonly results in serious injuries to the perpetrators themselves. Although it is unusual for young children to harm seriously the targets of their physical aggression, studies of physical aggression during infancy indicate that by 17 months of age, the large majority of children are physically aggressive toward siblings, peers, and adults. This study aimed, first, to identify the trajectories of physical aggression during early childhood and, second, to identify antecedents of high levels of physical aggression early in life. Such antecedents could help to understand better the developmental origins of violence later in life and to identify targets for preventive interventions. [http://www.ncbi.nlm.nih.gov/pubmed/15231972](http://www.ncbi.nlm.nih.gov/pubmed/15231972)

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
1. Consider the rights, roles and responsibilities of adults in their relationships with children in school and the community.
2. Recognize the cognitive and behavioral developmental problems associated with aggression in children and their families.
3. Develop awareness of the procedures for screening, identification, and progress monitoring in the school setting and community;
4. Discuss the essential elements for the group and individual treatment of children and adolescents experiencing behavior problems associated with aggression.
5. Formulate ways to engage parents and community partners in prevention strategies that benefit the school environment and neighborhood.

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: (See below)

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
- ☑ Yes
- ☐ No
- ☐ CME Dept. Leadership and Staff
- ☐ CME Committee
- ☐ Conference Director (see above)
- ☑ Others (i.e.: Conference Coordinator, Planning Group etc.) Trish Ramsay (Coordinator)
COMMERCIAL SUPPORT: The Baptist Health Continuing Medical Education Department will not solicit or accept grants from commercial interests to support CME activities, thereby strengthening the CME Program's commitment to be independent and free of the influence of commercial interests. 

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

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? If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission. ►The Melissa Institute for Violence Prevention and Treatment

DATE REVIEWED: September 22, 2014 REVIEWED BY: □ Executive Committee ❌ Accelerated Approval

APPROVED: □ YES  □ NO  □ Credits: AMA/PRA Category 1 Credits: # 0
Continuing Psychology Education Credits: # 3  □ N/A  □ Continuing Dental Education Credits: # 0  □ N/A

SCHEDULE

Friday, October 3, 2014

8:00 a.m.  Registration and Continental Breakfast
8:30 a.m.  Opening Remarks – Social Responsibility In and Out of School
Isaac Prilleltensky, Ph.D., Dean, School of Education & Human Development, University of Miami
8:45 a.m.  Childhood Aggression and the Developing Brain
Debra J. Pepler, Ph.D.
9:30 a.m.  Family-Centered Screening for Violence and Weapon Injury Risk
Judy Schaechter, M.D., MBA
10:15 a.m.  Break
10:30 a.m.  Intervention Strategies and Prevention Resources for Family Aggression
Daniel Santisteban, Ph.D.
11:30 a.m.  Panel of Experts will respond to topics and questions - Moderator: Etiony Aldarondo, Ph.D.
Drs. Pepler, Santisteban, Schaechter
12:00 noon  Adjourn

CONFERENCE DIRECTOR
Lynn Aptman, M.Ed., is President of The Melissa Institute and a former elementary school teacher. She is one of the founders of the Institute, along with her husband, Michael Aptman, M.D., Suzanne L. Keeley, Ph.D., and Donald Meichenbaum, Ph.D.

PRESENTERS

Etiony Aldarondo, Ph.D., is Associate Dean for Research, Director of Dunspaugh-Dalton Community and Educational Well-Being Research Center and an Associate Professor in the School of Education at the University of Miami. His professional career includes appointments at Boston College, Harvard Medical School’s Cambridge Hospital, and the Philadelphia Child Guidance Center. The recipient of various recognitions for academic excellence, his scholarship focuses on positive development of ethnic minority and immigrant youth, domestic violence, and social justice-oriented clinical practices. His publications include the books Advancing Social Justice Through Clinical Practice (Routledge) and Programs for Men Who Batter: Intervention and Prevention Strategies in a Diverse Society (Civic Research Institute with Fernando Mederos, Ed.D.)

Debra J. Pepler, Ph.D., C. Psych., is Distinguished Research Professor of Psychology at York University, Toronto, Ontario, and co-director of Promoting Relationships and Eliminating Violence Network (PREVNet), Canada’s national initiative for bullying prevention. She is an internationally recognized expert on bullying and childhood aggression and an authority on school-based interventions. She speaks widely to professional and community audiences and publishes extensively. Her major research program examines the antisocial behavior of children and adolescents, particularly in the school and peer contexts. She is an author and co-editor of Understanding and Addressing Bullying: An International Perspective. She was honored with the Contribution to Knowledge award from the Psychology Foundation of Canada.

Isaac Prilleltensky, Ph.D., is Dean of the School of Education and Human Development at the University of Miami. Prior to that he was Director of the Doctoral Program in Community Research and Action at Peabody College of Vanderbilt University. Dr. Prilleltensky is concerned with value-based ways of promoting personal, relational, and collective well-being. He is the author, co-author or co-editor of several books, including Community Psychology: In Pursuit of Liberation and Well-Being, Doing Psychology Critically, Critical Psychology, Promoting Family Wellness and Preventing Child Maltreatment, and The Morals and Politics of Psychology. The book Promoting Well-Being: Linking Personal, Organizational, and Community Change was co-authored with his wife, Dr. Ora Prilleltensky.

Daniel Santisteban, Ph.D., is a Clinical Psychologist and Professor at the University of Miami, School of Education and Human Development. Dr. Santisteban has been the recipient of six NIH grants to develop and test enhancements to family treatments for special populations (Hispanics and drug abusing adolescents with co-occurring disorders), and is the developer of Culturally Informed and Flexible Family Based Treatment for Adolescents (CIFFTA), and empirically derived treatment. Dr. Santisteban has published over 35 book chapters and articles on family therapy outcomes, family processes, cultural competence, adolescent co-occurring disorders, and the blending of research and practice. He has received numerous awards including the 2004 American Family Therapy Academy award for Distinguished Contribution to Family Systems Research and the 2012 University of Miami Civic Engagement Award. He has been a contributor to NIH grant review committees, treatment guidelines panels, editorial boards of journals, and to State agencies focused on bridging research and practice in the public health systems.

Judy Schaechter, M.D., M.B.A., is associate professor and interim chair of the Department of Pediatrics at the University of Miami Miller School of Medicine and chief of service at Holtz Children’s Hospital at Jackson Memorial Medical Center. Dr. Schaechter is a general pediatrician with special interests in adolescence, injury and violence prevention, education, and community health. She currently serves as president of the national Injury Free Coalition for Kids, is the appointed child health policy expert on the Florida Healthy Kids Corporation board, has served on the Florida Children and Youth Cabinet since its inception, is a Senior Advisor to the Florida Children’s Movement, was a founding board member of The Children’s Trust, is an elected member of the AAP’s Council on Injury, Violence, and Poison Prevention, and serves as chair of the Miami-Dade County Immunization Coalition. Dr. Schaechter has a regional and national reputation for advocating child safety, access to care, and health promotion.

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

CME ACTIVITY TITLE: 2014 Baptist Health Medical Group Wellness & Prevention Journal Club

DATE:  10/8/2014 – DATE CHANGED 10/15/14

LOCATION:  South Miami Hospital  Education Center

CREDIT HOUR(S) APPLIED FOR:  1 Cat. 1/ each
CONFERENCE DIRECTOR: Ted Feldman, M.D., Khurram Nasir, MD, Arthur Agatston, MD
Coordinator:

TARGET AUDIENCE: BHMG physicians, nurses and dietitians

EXPECTED NUMBER OF ATTENDEES: 10-15 CHARGE: $0.00

TYPE OF MEETING (FORMAT):
☒ Live ☐ Didactic Lecture ☐ ARS
☐ Question & Answer ☐ Case Studies ☐ Panel
☐ Enduring Material ☐ Internet-Home Study ☐ Other Journal Club

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:

PRACTICE /PERFORMANCE 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?)
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.

OPTIMAL PRACTICE:
Journal clubs are staples of graduate and continuing medical education. 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. They then seek information, including colleagues’ experiences, and think about how to apply it. When subsequently faced with a similar situation, health professions then consider the applicability of the newly learned information (reflection in action). Therefore, journal clubs structured as social learning activities for discussing new knowledge in the context of previous and current experience could lead to new learning that might translate into clinical practice. They allow individuals to share evidence, ideas, tacit (“how to”) knowledge, and practical experience in a safe environment for continuous learning.

Facilitated interactive journal clubs focused on problems shared by attendees can be useful learning formats for translating evidence into practice and documenting barriers to evidence translation. This structure provides continuity between sessions and reinforce previous learning and gathered short term self reported practice change outcomes data. [http://www.jcehp.com/vol28/2803price.asp](http://www.jcehp.com/vol28/2803price.asp)

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.

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: BHMG Group physicians do not participate on a journal club educational activity to keep current with up-to-date information on evidence-based practice and research findings.

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 physicians will formulate new optimal patient care strategies in cardiovascular medicine by translating evidence into practice.

EDUCATIONAL OBJECTIVES

Upon completion of this conference, participants should be better able to implement evidence-based strategies into their clinical practice to improve care of the cardiac patient.

COMPETENCIES (Desirable Physician Attributes as per IOM, ACGM and AGMS):
☒ Patient Care ☐ Interpersonal and Communications Skills ☐ Professionalism
☒ Medical Knowledge ☐ Systems-based Practice
EVALUATION METHOD(S):
☒ Baptist Health CME Evaluation Form (post-Conference) ☐ Follow-up Survey
☐ Review of Hospital, Health System or Other Data ☒ Other: Discuss identified "learnings" from previous meeting at the beginning of each new session; identify factors facilitating and/or barriers to implement changes in practice, short-term self-reported practice change and outcomes data.

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: ___________________________________________

MODERATORS:
Theodore Feldman MD, Khurram Nasir, MD, Arthur Agatston, MD

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: September 23, 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

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

CME ACTIVITY TITLE: Inpatient Glycemic Management – Standards and Strategies

DATE: Wednesday, October 29, 2014 TIME: 6-8 p.m.

LOCATION: Baptist Cardiac and Vascular Institute – 5th Floor Conference Room
CREDIT HOUR(S) APPLIED FOR: 2  Cat. 1

CONFERENCE DIRECTOR: Michael Fili, M.D.

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

TARGET AUDIENCE: Hospitalists, Internists, Family Practitioners, Emergency Medicine Physicians, Surgeons, Cardiologists, Endocrinologists, Podiatrists, nurses, pharmacist, dieticians and other interested healthcare practitioners. 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 Endocrinology, Internal Medicine, Family Medicine and Hospitalist Medicine. In addition, physicians that identify conditions and refer patients to an Endocrinologist and those specialists to whom a Hospitalist, Internist and Family Practitioner 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: 75  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 (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.

► Hyperglycemia in hospitalized patients is associated with increased morbidity and mortality. However, the management of inpatient hyperglycemia is associated with many clinical challenges that contribute to suboptimal patient outcomes. Evidence indicates that uncontrolled hyperglycemia is a common and substantial problem among noncritically ill patients, but recent data on aggressive glycemic control in the inpatient setting has created controversy and confusion, indicating the need for education on treatment guidelines and strategies for achieving optimal glycemic targets in this population.

WHAT IS THE OPTIMAL PRACTICE***? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
► Physicians consistently and effectively follow evidenced-based assessment and treatment plans to evaluate and control blood sugar levels of patients in an inpatient setting.

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 successfully implement evidenced-based assessment and treatment plans targeted at controlling patient’s blood sugar levels.

*REFERENCES* supporting the current practice and/or the optimal practice and/or practice gap:
► Hyperglycemia is a common, serious, and costly health care problem in hospitalized patients. Observational and randomized controlled studies indicate that improvement in glycemic control results in lower rates of hospital complications in general medicine and surgery patients. Implementing a standardized insulin order set promoting the use of scheduled basal and nutritional insulin therapy is a key intervention in the inpatient management of diabetes. We provide recommendations for practical, achievable, and safe glycemic targets and describe protocols, procedures, and system improvements required to facilitate the achievement of glycemic goals in patients with hyperglycemia and diabetes admitted in non-critical care settings.


► The AACE and ADA task force on inpatient glycemic control guidelines recommended for the majority of patients in the ICU setting using insulin infusion and targeting blood glucose levels between 140 and 180 mg/dL (7.8 and 10.0 mmol/L) is recommended. Despite the lack of strong scientific evidence, lower glucose targets between 110 and 140 mg/dL (6.1 and 7.8 mmol/L) may be appropriate in selected ICU patients (i.e., ICUs with extensive experience and appropriate support, CABG surgical patients, stable glycemic control without hypoglycemia, total parenteral nutrition). Blood glucose targets > 180 mg/dL or < 110 mg/dl are not recommended.

An optimal target for glucose control in ICU patients remains unclear. This prospective randomized controlled trial compared the effects on ICU mortality of intensive insulin therapy (IIT) with an intermediate glucose control.
A prospective randomised multi-centre controlled trial on tight glucose control by intensive insulin therapy in adult intensive care units: the Glucontrol study.

EDUCATIONAL OBJECTIVES:
**Rationale and Guidelines for non-critical Inpatient Diabetes Management**
Upon completion of this conference, participants should be better able to:
- Apply clinical practice guidelines and current evidence to improve inpatient management of hyperglycemia.
- Implement treatment options available for safely achieving glycemic targets avoiding hypoglycemia in an inpatient setting.
- Analyze results of different clinical trials in non-ICU settings and determine best practices.

**Glucose Management of the Critically Ill Patient**
Upon completion of this conference, participants should be better able to:
- Determine and implement the best treatment options to safely achieve glycemic targets avoiding hypoglycemia in the ICU.
- Assess results of different clinical trials on glucose management in the ICU and identify areas needing further research.

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:
Guillermo E. Umpierrez, M.D.
Professor of Medicine
Division of Endocrinology and Metabolism
Emory University School of Medicine
Atlanta, Georgia

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

DATE REVIEWED: 09.23-2014 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 ☐

CME ACTIVITY TITLE: Miami Neuro Symposium and Miami Neuro Nursing Symposium

DATE: Thursday, December 4, 2014
Friday, December 5, 2014
Saturday, December 6, 2014

TIME: 8:00 a.m. – 5:00 p.m.
8:00 a.m. – 5:00 p.m.
8:00 a.m. – 5:00 p.m.
TIME: LOCATION:  Biltmore Hotel, Coral Gables, Florida  EXPECTED NUMBER OF ATTENDEES:  130-175

CREDIT HOUR(S) APPLIED FOR:  Friday and Saturday, December 5-6  14 Cat. 1
Thursday, December 4    8 Cat. 1

SYMPOSIUM DIRECTORS:  Stroke: Guilherme Dabus, M.D., Italo Linfante, M.D.
Neurocritical Care: Karel Fuentes, M.D.
Tumor Management: Sergio González-Arias, M.D. Ph.D.
Epilepsy: Alberto Pinzon Ardila, M.D., Ph.D.

Baptist Health Neuroscience Center: “Nursing” Symposium Directors
  ▪ Marguerite Rowell, MSN, MSM/HM, MBA, ONC, Director of Nursing, Baptist Neuroscience Center
  ▪ Cris Alegria-Agurto, MBA, Manager, Neuroscience Research
  ▪ Bridget Gorman, MS, R.N., CCRN, CRN, SCRn, ACNS-BC, Neuro MedSurg, Neuroscience Department
  ▪ Amy K. Starosciak, Ph.D., CRG Outcomes Research

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: Neurologists, neurosurgeons, neuro-oncologists, stroke neurologists, neuroradiologists, diagnostic radiologists, critical care physicians, neurointensivists, emergency medicine physicians, internal medicine physicians, interventional neuroradiologists, psychologists, critical care and neuroscience nurses, neurosurgery nurses, nurse practitioners, physical therapists, respiratory therapists, dietitians, radiology technologists and clinical pharmacists

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 neuroradiology, neurosurgery, neurocritical care and tumor oncology. In addition, physicians that identify conditions and refer patients to a neurointensivist, neuroradiologist, neurosurgeon and/or tumor oncologist are also included in the target audience, as are related members of the hospital care team, i.e.: nurses, etc.

CHARGES:  Physicians  BHSF EMP  Non-BHSF  Fellows
Entire Course  $250  $105  $135  $135
Daily Rates
Thursday all day  $35  $45  $45
Friday all day  $125  $35  $45  $45
Saturday all day  $125  $35  $45  $45

*Group discounts available for three or more physicians who register together as a group by Monday, November 24. No add-ons. Call for details. **Registration must be accompanied by a letter from the Fellowship/Residency Director.

Note: The Miami Neuro Nursing Symposium, for nurses and allied health professional, precedes the Neuro Symposium. CME credits will be available for this session as well. Details are provided below following those of the Miami Neuro symposium.

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

► Epilepsy: The goal of treatment in patients with epileptic seizures is to achieve a seizure-free status without adverse effects. This goal is accomplished in more than 60% of patients who require treatment with anticonvulsants. Many patients experience adverse effects from these drugs, however, and some patients have seizures that are refractory to medical therapy.
Specific references provided along with educational objectives.

► Brain Tumor Oncology: Most of the advanced MRI technologies that have existed for more than a decade are less than ideal for imaging brain tumors. Specific references provided along with educational objectives.

► Stroke: Despite years of research and pioneering clinical work, stroke remains a massive public health concern. Specific references provided along with educational objectives.

► Neurocritical Care: Most neurocritical care patients are cared for in multidisciplinary intensive care units staffed by general Intensivists. However, in most instances physician exposure to Neurocritical Care during general critical care training is limited. Additionally a nihilistic approach to the care of these patients is prevalent throughout the critical care community. Critical care practitioners in the community might not be aware of -- or have not implemented change -- based on recent developments, standards of care, and current practices used in the care of the neurologically-injured patient. Specific references provided along with educational objectives.

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

► Epilepsy: Physicians perform proper evaluation of patients at risk of seizures, seizure recurrence, and risk of toxic effects from anticonvulsant and the benefits of avoiding another seizure. The clinician should also describe seizure precautions.

► Brain Tumor Oncology: Physicians perform proper evaluation of the patient with a suspected brain tumor and provide a detailed history, a comprehensive neurologic examination and appropriate diagnostic neuroimaging studies.

► Stroke: Physicians’ first goal in stroke management is immediate diagnosis and evaluation to determine the most appropriate treatment approach. The physician performs expertly and has advanced technological capabilities to achieve the optimal outcome. Prevention of recurrent stroke should be a priority for patients, caregivers, providers, and health systems.

► Neurocritical Care: Intensive care units with neurologically impaired patients are staffed by a neurointensivist-led neurocritical care team; in-hospital mortality is reduced and hospital discharge disposition for patients is improved.

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 symposium? 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 provide optimal care and achieve best outcomes when they consistently implement evidence-based methods of diagnosis, evaluation and treatment to effectively identify and manage important medical conditions in neurologic patients.

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

**Epilepsy:** For patients who have had more than 1 unprovoked seizure, treatment with an anticonvulsant is recommended. However, the standard of care for a single unprovoked seizure is avoidance of typical precipitants (e.g., alcohol, sleep deprivation); anticonvulsants are not recommended unless the patient has risk factors for recurrence. The risk of recurrence in the 2 years after a first unprovoked seizure is 15-70%. Principal factors that increase the risk of recurrence are an abnormal brain magnetic resonance image (MRI) study, an abnormal electroencephalogram, and a partial-onset seizure. On brain MRI, a focal abnormality in the cortical or limbic regions that indicates a possible substrate for an epileptogenic zone is the finding that most often suggests increased risk for seizure recurrence. Diffuse abnormalities, such as hydrocephalus, may increase the risk by injuring the cerebral cortex. Many physicians underestimate the consequences that an epilepsy diagnosis may have on patients. For example, patients with epilepsy may live in fear of experiencing the next seizure and they may be unable to drive or work at heights. Patients must be told that anticonvulsants can reduce their risk of having another seizure but will not eliminate that risk. [http://emedicine.medscape.com/article/1184846-treatment](http://emedicine.medscape.com/article/1184846-treatment)

**Brain Tumor Oncology:** Brain tumors account for 85% to 90% of all primary central nervous system (CNS) tumors. Whether primary, metastatic, malignant, or benign, brain tumors must be differentiated from other space-occupying lesions such as abscesses, arteriovenous malformations, and infarction, which can have a similar clinical presentation. Over the last years, the limitations of Response Criteria in Solid Tumors have become increasingly evident. Early response predictions by anatomic imaging are not possible. In contrast, glucose metabolic PET/CT imaging with FDG permits reliable response predictions as early as after a single cycle of chemotherapy. Approaches to standardizing response assessments are now underway and FDG-PET imaging is rapidly emerging as the standard of care for treatment response assessments. [http://www.uptodate.com/contents/clinical-presentation-and-diagnosis-of-brain-tumors](http://www.uptodate.com/contents/clinical-presentation-and-diagnosis-of-brain-tumors)

**Stroke:** Numerous studies have documented gaps in the quality of care for myocardial infarction, heart failure, and stroke as well as in primary CVD prevention. These missed opportunities that adversely affect long-term patient outcomes occur despite higher levels of healthcare spending than any other nation. According to a recent survey, total US health expenditures rose 6.7% in 2006 to $2.1 trillion, or $7026 per person, equal to ≈16% of the US gross domestic product. The direct and indirect costs of CVD and stroke for 2007 alone are estimated to exceed $448 billion. Therefore, if the United States intends to improve patient outcomes and, if possible, decrease overall healthcare spending, we must engage in serious and sustained efforts directed to healthcare providers, patients, and individuals at risk. [http://circ.ahajournals.org/content/118/6/687.full?sid=558a4bf0-b926-42eb-ba2d-79e49bac5ea1](http://circ.ahajournals.org/content/118/6/687.full?sid=558a4bf0-b926-42eb-ba2d-79e49bac5ea1)

**Neurocritical Care:** Neurocritical care diseases carry a high morbidity and mortality. Therapeutic and technological advances in neurocritical care have greatly improved the outcome of a variety of life-threatening disorders including traumatic brain injury, acute ischemic stroke, intracerebral and subarachnoid hemorrhage, and anoxic injury following cardiac arrest. These advances have stemmed from a better understanding of the physiology of neurocritical care illnesses, improved neuromonitoring techniques, and the introduction of more efficacious treatments. Despite all the advances in neuromonitoring, diagnostic imaging, and emerging treatments, much research needs to be undertaken in neurocritical care. [http://www.ncbi.nlm.nih.gov/pubmed/21792751](http://www.ncbi.nlm.nih.gov/pubmed/21792751) [http://www.ncbi.nlm.nih.gov/pubmed/21424884](http://www.ncbi.nlm.nih.gov/pubmed/21424884)

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

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

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

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

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

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

**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)
- [ ] Yes
- [ ] No
  If yes, please describe the related CME program change. This symposium will meet the 4-8 hours of stroke education requirement for different medical and clinical staff groups (ED, ICU, eICU, Neuroscience, and Neuro Interventional).
  And describe how the impact of the related program improvement will be measured and documented? (C15)
  BHSF CME Dept. will keep attendance records of physicians, as will the Baptist Hospital Neuroscience Dept.

**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?
  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 Miami Neuro Symposium is a collaborative project between the Baptist Health Neuroscience Center and the Department of CME to improve patient care via implementation of evidenced-based approaches to care of the neurologically impaired patient.
  The Baptist Stroke Program continued to monitor comprehensive stroke metrics in preparation of Comprehensive Stroke Center certification by the Joint Commission. Performance measures were finalized summer 2014 and they are effective as of January 2015. The metrics includes the following: severity scores (NIHSS, Hunt & Hess, ICH Score), modified rankin score (mRS) post discharge, INR reversal achieved, hemorrhagic complications, nimodipine treatment administered, and interventional recanalization.
  BHM is designated as a Comprehensive Stroke Center through the state of Florida (ACHA) and certified by the Joint Commission as of September 2014. SMH and WKBH are considered a Primary Stroke Center through ACHA too. As a requirement, specific stroke education hours are necessary for the staff. The symposium will allow them to acquired the necessary education in a one-stop shop conference and apply lessons learned at the bedside. BHM serves as a liaison for WKBH as they pursue their journey with Primary Stroke Center certification by the Joint Commission too.
The BHSF Stroke Committee continues to collaborate to standardize stroke doctor’s orders set system wide and implement them into Computerized Physician Order Entry (CPOE). System wide stroke orders were approved as of June 2014 and live date for stroke orders CPOE is planned for fall 2014.

In collaboration with WKBH, the Transfer Center, and Neurologists on staff, the Telemedicine Stroke (Tele-Stroke) Care Program went live in April 2014 at WKBH. This service offers a 24/7 clinical stroke consultation. This symposium will incorporate lessons learned and best practice approach as the telemedicine program expands to Homestead Hospital and neurosurgery services for BHSF.

BHM Stroke Committee collaborates with Fire Officers Association of Miami-Dade (FOAM-D) Stroke Consortium to offer the best diagnosis, transport, and treatment of stroke victims. This initiative was created to collaborate with seven fire rescue departments in Miami-Dade and 16 major hospitals in the county. Even though the initiative was agreed as of July 2012, data reporting to EMS is pending through a partnership with Get with the Guidelines (GWTG), a national stroke database and Redcap (an online database). BHM will participate in this initiative and become a centralized GWTG process review for BHSF.

Worked collaboratively with Center for Research & Grants and hired a PhD neuroscience researcher (9/13), a data coordinator (10/13), and a nurse clinical abstractor (2/14) to enhance the Neuroscience Research Infrastructure along with the 2 current stroke data analyst/educators. The researcher will lead tracking comprehensive stroke performance measures and other neuroscience research projects. A multidisciplinary outcomes database is being developed to incorporate all aspects of stroke patient care from acute neurology management to neurosurgery and neuro intervention treatments. A similar database will be created to incorporate other neuro disciplines (i.e. spine, epilepsy, tumor, etc.) as well. This symposium includes many of the topics required for the comprehensive measures and future database development.

The Baptist Health Neuroscience Center recognizes that nurses play a crucial role in the treatment and recovery of neuroscience patients. The Miami Neuro Nursing Symposium offers a broad curriculum focusing on current and emerging state-of-the-art approaches to diagnosis and treatment of the neuroscience patient. From the emergency department to neurocritical care and neurosurgery to rehabilitation – distinguished experts will address complex neurological complications, stroke, epilepsy rehabilitation and pharmacologic management of neuroscience patients. The symposium goal is to share innovative best clinical practices that optimize patient outcomes in all areas of neuroscience.

DATE REVIEWED: September 23, 2014
REVIEWED BY: Executive Committee Chairman
APPROVED: YES NO
Credits: AMA/PRA Category 22
Continuing Psychology Education Credits: # 22
Continuing Dental Education Credits: # ___ N/A

NOTE: The Miami Neuro Nurse Symposium, for nurses and allied health professionals, precedes the Miami Neuro Symposium. CME will be available for this session as well. All details are provided below following those of the Miami Neuro Symposium.

FACULTY

**Epilepsy Management**
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Brain Tumor Oncology
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Knock Out Stroke
Italo Linfante, M.D., FAHA
Symposium Director
Medical Director, Interventional Neuroradiology and Endovascular Neurosurgery
Baptist Health Neuroscience Center and Miami Cardiac & Vascular Institute
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Fundamentals of Neurocritical Care
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SCHEDULE

Friday, December 5
SESSION I: Epilepsy Management (3.5 Cat. 1)
Moderator: Alberto Pinzon Ardila, M.D., Ph.D.
7:15 a.m.  Registration and Continental Breakfast
7:50 a.m.  Welcome and Introductions
Alberto Pinzon-Ardila, M.D., Ph.D.
8:00 a.m. Diagnosis and Treatment of Catastrophic Epilepsy: Multidisciplinary, Multi-modality and Multistage Approach
Ki Hyeong Lee, M.D.

9:00 a.m. Transcranial Magnetic Stimulation for Functional Mapping and Uses in Epilepsy
Malek Adjouadi, PhD

9:30 a.m. Surgical Options in the Management of Intractable Epilepsy: Current Review
Fernando Vale, M.D.

10:00 a.m. Break and Visit Exhibits

10:30 a.m. Minimally Invasive Strategies for Epilepsy Treatment
Prasanna Jayakar, M.D., Ph.D.

11:00 a.m. Management of Malignant Brain Tumors: Clinical Best-practices and Research Update
Henry Friedman, M.D.

12 noon Adjourn

SESSION II: Brain Tumor Oncology (3.5 Cat. 1)
Moderator: Sergio Gonzalez-Arias, M.D., Ph.D.

12:55 p.m. Welcome and Introductions

1:00 p.m. Nanoparticle Based Drug Delivery Systems Can Overcome the Challenge of the Blood Brain Barrier
Anthony McGoron, Ph.D.

1:30 p.m. Evidence–based Management of Brain Metastases
William Friedman, M.D.

2:00 p.m. Radiosurgery Management of Arteriovenous Malformations
L. Dade Lunsford, M.D.

2:30 p.m. Break and Visit Exhibits

3:00 p.m. Radiosurgery for Vestibular Schwannoma
William Friedman, M.D.

3:20 p.m. Functional Radiosurgery: Coming Full Circle
L. Dade Lunsford, M.D.

4:00 p.m. Brain Tumors: When Should Radiosurgery be Adjuvant?
Vitaly Siomin, M.D.

4:30 p.m. Panel Discussion with Questions and Answers
5:00 p.m. Adjourn

Saturday, December 6
SESSION III: Knock Out Stroke (3.5 Cat. 1)
Moderators: Italo Linfante, M.D., Guilherme Dabus, M.D.

7:15 a.m. Registration and Continental Breakfast

7:50 a.m. Welcome and Introductions
Italo Linfante, M.D., Guilherme Dabus, M.D.

8:00 a.m. Update on Neuroimaging: Focus on Perfusion Imaging in Stroke
Kevin Abrams, M.D.

8:20 a.m. Acute Stroke Intervention
Italo Linfante, M.D.

8:40 a.m. Next-generation Devices to Treat Aneurysms and Stroke
David Fiorella, M.D., Ph.D.

9:00 a.m. Spinal Vascular Shunts: Symptoms Classification and Treatment
Ajay Wahkloo, M.D., Ph.D.

9:30 a.m. Break and Visit Exhibits

10:00 a.m. Focus on Unruptured Brain Aneurysms
Guilherme Dabus, M.D.

10:30 a.m. Basic Science of Flow Diverters and Challenging Cases
Ajay Wahkloo, M.D., Ph.D.

New 10:30 a.m. Advanced Imaging in Neurovascular Suite
Ajay Wahkloo, M.D., Ph.D.

10:50 a.m. Review of Clinical Trials: PUFS, INTREPED, SCENT and FRED
Italo Linfante, M.D.

11:10 a.m. Treatment of Craniofacial Arteriovenous Malformation
Guilherme Dabus, M.D.

11:30 a.m. Case Presentations with Panel Discussion
Moderators: Italo Linfante, M.D., Guilherme Dabus, M.D.
Kevin Abrams, M.D., David Fiorella, M.D., Ajay Wahkloo, M.D., Ph.D

12:00 noon Adjourn
SESSION IV: Fundamentals of Neurocritical Care (3.5 Cat. 1)
Moderator: Karel Fuentes, M.D.

12:05 p.m.  Lunch

12:55 p.m.  Welcome and Introductions
            Karel Fuentes, M.D.

1:00 p.m.  Case Studies in Neuroimaging
            Kevin Abrams, M.D.

1:30 p.m.  Sedation and Delirium in the Neurocritical Care Unit
            Javier Proven, M.D.

2:00 p.m.  Approach to the Comatose Patient
            Karel Fuentes, M.D.

2:30 p.m.  Break and Visit Exhibits

3:00 p.m.  Multimodal Monitoring in the Neuro ICU
            Javier Proven, M.D.

3:20 p.m.  Traumatic Brain Injury
            Kristine O’Phelan, M.D.

4:00 p.m.  Acute Spinal Cord Injury
            Kristine O’Phelan, M.D.

4:30 p.m.  Panel Discussion with Questions and Answers

5:00 p.m.  Adjourn

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**OBJECTIVES**

### Epilepsy Management
Upon completion of these lectures, participants should be better able to:
- Examine catastrophic epilepsy and drug-resistant epilepsy with epileptic encephalopathy, and recognize the common causes.
- Determine treatment options based on the causes and severity of catastrophic epilepsy.
- Explain the pathophysiology of epileptic encephalopathy.
- Discuss the limitations of individual localization tools and the need for multimodality approaches to treatment.
- Recognize the functional capabilities of transcranial magnetic stimulation (TMS) for mapping the eloquent cortex of the brain.
- Assess the merits of TMS in developing protocols with safety considerations for potential therapeutic interventions in epilepsy.
- Describe current surgical options for the management of medically-resistant epilepsy.
- Explain the pre-operative work-up and the selection process for surgical intervention.
- Define the epileptogenic target – the area that needs to be ablated to control seizures.
- Explore existing and emerging technologies to enhance safety and efficacy of focal ablation.
- Delineate strategies for making a proper evaluation of the brain tumor patient and determination of clinical manifestations.

### Brain Tumor Oncology
Upon completion of these lectures, participants should be better able to:
- Evaluate the state-of-the-art of nanoparticle drug delivery for brain cancer treatment.
- Recognize the mechanisms for drug transport across the blood brain barrier and examine current methods for overcoming this barrier.
- Examine in vitro models of the blood brain barrier used to screen drugs and drug delivery systems intended to treat neurological diseases.
- Consider the level I and level II evidence for brain metastasis treatment.
- Examine the role of radiosurgery in the treatment of brain metastases.
- Examine the indications for radiosurgery in the management of brain arteriovenous malformations (AVM).
- Review expected outcomes, risks, and benefits of radiosurgery treatment of AVM.
- Examine the role of radiosurgery in the treatment of vestibular schwannoma and assess the risks and benefits compared to open surgery.
- Discuss the application of stereotactic radiosurgery (SRS) as a technique for treatment of trigeminal neuralgia and movement disorders.
- Delineate patient selection criteria, indications for use, benefits and potential drawbacks of SRS for movement disorders and trigeminal neuralgia.
- Examine the role of radiosurgery as an adjuvant treatment strategy, and explore benefits such as avoiding potential toxicity of WBRT and improving local control.
- Assess the effectiveness of radiosurgery adjuvant treatment as a strategy for delaying and even foregoing whole-brain radiotherapy.

### Knock Out Stroke
Upon completion of these lectures, participants should be better able to:
- Determine when perfusion imaging is useful in the assessment and treatment of acute stroke.
• Evaluate the limitations and potential pitfalls of using perfusion imaging in the assessment of acute stroke.
• Review the concept and technical aspects for acute stroke intervention.
• Describe contemporary strategies for the treatment of acute aneurysms and stroke.
• Evaluate potential treatment devices for the minimally invasive evacuation of intracranial hemorrhage.
• Recognize the potential utility of new devices for the treatment of wide necked bifurcation aneurysms.
• Identify the various neurological symptoms associated with spinal arteriovenous (AV) shunts.
• Define the classifications of spinal AV shunts and recognize their distinct treatment strategies.
• Examine the value of various imaging modalities in the diagnosis of spinal AV shunts.
• Recognize indications for use of flow diverters.
• Review a comparison study of flow diversion and standard endovascular approaches for the treatment of intracranial aneurysms.
• Demonstrate the use of newer imaging technologies introduced and added to the neuroangiography suite to treat complex neurovascular lesions including acute ischemic and hemorrhagic stroke and expound technical feasibility and possible applications.
• Evaluate non-surgical treatment methods for unruptured brain aneurysms, and discuss safety and efficacy compared to surgical treatment.
• Analyze recent clinical trials associated for the treatment of intracranial aneurysms.
• Apply optimal treatment strategies in patients with unruptured intracranial aneurysms considering the risks vs. benefits of treatment vs. non-treatment.

Fundamentals of Neurocritical Care
Upon completion of these lectures, participants should be better able to:
• Recognize MR imaging features distinguishing between infection and infarction.
• Review the utility of MR perfusion in differentiating between infection and tumor.
• Recognize unique patient care challenges delirium presents including detection of life-threatening neurological events and pain management.
• Identify reliable screening methods and treatment strategies for managing pain, agitation and delirium in the neurocritical care unit.
• Appropriately evaluate, diagnose and treat the comatose patient.
• Examine new and emerging multimodal monitoring techniques, and identify the benefits of their use in the Neuro ICU.
• Describe the mechanisms of primary and secondary injury following acute traumatic brain injury (TBI).
• Recommend an individualized approach to elevated intracranial pressure in a patient with TBI.
• Identify the mechanisms of primary and secondary injury following acute spinal cord injury.
• Implement strategies to wean acute spinal cord injury patients from mechanical ventilation.

LECTURE-SPECIFIC OBJECTIVES AND REFERENCES

SESSION I: Epilepsy Management
Diagnosis and Treatment of Catastrophic Epilepsy: Multidisciplinary, Multimodality and Multistage Approach
Ki Hyeong Lee, M.D.
Upon completion of this lecture, participants should be better able to:
• Examine catastrophic epilepsy and drug-resistant epilepsy with epileptic encephalopathy, and recognize the common causes.
• Determine treatment options based on the causes and severity of catastrophic epilepsy.
• Explain the pathophysiology of epileptic encephalopathy.
• Discuss the limitations of individual localization tools and the need for multimodality approaches to treatment.

References
Epileptic encephalopathies (EEs) are electroclinical entities with a peculiar course of disease; seizures and electroencephalographic (EEG) epileptiform abnormalities, ictal and interictal; contribute to progressive disturbance of cerebral functions. Frequently EEs are drug resistant, and consequences may be catastrophic. For a correct therapeutic approach it is mandatory to have an as accurate as possible syndromic and etiologic diagnosis. Multispecialist support is recommended in EE. Management should be global from the onset, integrating not only seizure control but also all issues related to comorbidities, particularly neuropsychological and psychiatric. Therapeutic approach to epileptic encephalopathy’s, Vigevano F1, Arzimanoglou A, Plouin P, Specchio N.; Epilepsia. 2013 Nov; 54 Suppl 8:45-50. doi: 10.1111/epi.12423. http://www.ncbi.nlm.nih.gov/pubmed/24571117

Transcranial Magnetic Stimulation for Functional Mapping and Uses in Epilepsy
Malek Adjouadi, Ph.D.
Educational Objectives:
Upon completion of my presentation, participants should be better able to:
• Recognize the functional capabilities of transcranial magnetic stimulation (TMS) for mapping the eloquent cortex of the brain.
• Assess the merits of TMS in developing protocols with safety considerations for potential therapeutic interventions in epilepsy.

References
Surgical Options in the Management of Intractable Epilepsy: Current Review
Fernando Vale, M.D.
Upon completion of this lecture, participants should be better able to:
• Describe current surgical options for the management of medically-resistant epilepsy.
• Explain the pre-operative work-up and the selection process for surgical intervention.

References
Approximately 0.5% to 1% of the population suffers from some type of epilepsy. About 70% are well controlled with medical therapy, leaving 30% who are not. About half of the patients intractable to pharmacological treatment could either be controlled medically or cured with surgical treatment. It has been estimated that 100,000 people in the United States would benefit from epilepsy surgery. In contrast, approximately 2000 procedures are performed annually. The acceptance and availability of this therapy are increasing, but it is still underutilized. Furthermore, surgical treatment tends to be offered only in specialized centers.

Surgery is underutilized for several reasons. First, patients and their families are unaware of the option of surgical treatment. If presented with the option, they are often misinformed about the safety and effectiveness of contemporary procedures. Second, patients are usually unemployed as a result of their epilepsy and have limited access to specialized medical care. Furthermore, payers limit access to specialized centers capable of offering surgical treatment. Third, primary care physicians and general neurologists still tend to have an aversion to referring epilepsy patients for surgical evaluation. This reluctance may also partially reflect socioeconomic-insurance issues and incentives against superspecialty referrals. Unfortunately, much of the reluctance may reflect a lack of knowledge about the available techniques.

Minimally Invasive Strategies for Epilepsy Treatment
Prasanna Jayakar, M.D., Ph.D.
Upon completion of this lecture, participants should be better able to:
• Define the epileptogenic target – the area that needs to be ablated to control seizures.
• Explore existing and emerging technologies to enhance safety and efficacy of focal ablation.

References
For about 30% of epilepsy patients, pharmaceutical therapy fails to control their seizures. MR-guided laser interstitial thermal therapy (MRgLITT) allows for real-time thermal monitoring of the ablation process and feedback control over the laser energy delivery. We report on minimally invasive surgical techniques of MRgLITT and short-term follow-up results from the first five pediatric cases in which this system was used to ablate focal epileptic lesions. MR-guided laser interstitial thermal therapy has a significant potential to be a minimally invasive alternative to more conventional techniques to surgically treat medically refractory epilepsy in children.

Management of Malignant Brain Tumors: Clinical Best-practices and Research Update
Henry Friedman, M.D.
Upon completion of this lecture, participants should be better able to:
• Delineate strategies for making a proper evaluation of the brain tumor patient and determination of clinical manifestations.

References
Brain tumors rank second as the cause of cancer-related deaths in children and adults younger than 34 years old, and they are seen in adults of all ages. Primary malignant brain tumors are associated with the third highest cancer-related mortality rate and a disproportionate level of disability and morbidity. Brain tumors can produce symptoms and signs by local brain invasion, compression of adjacent structures, and increased intracranial pressure (ICP). In addition to the histology of the tumor, the clinical manifestations are determined by the function of the involved areas of the brain. The proper evaluation of the patient with a suspected brain tumor requires a detailed history, comprehensive neurologic examination, and appropriate diagnostic neuroimaging studies. Brain tumors can produce symptoms and signs by local brain invasion, compression of adjacent structures, and increased intracranial pressure (ICP). In addition to the histology of the tumor, the clinical manifestations are determined by the function of the involved areas of brain. The proper evaluation of the patient with a suspected brain tumor requires a detailed history, a comprehensive neurologic examination, and appropriate diagnostic neuroimaging studies. Although newer imaging techniques often provide information suggesting a specific histology, an adequate tissue sample should generally be obtained, either at the time of neurosurgical resection or by stereotactic biopsy, to optimize treatment.
SESSION II: Brain Tumor Oncology
Nanoparticle Based Drug Delivery Systems can Overcome the Challenge of the Blood Brain Barrier
Anthony McGoron, Ph.D.

Upon completion of this lecture, participants should be better able to:
• Evaluate the state-of-the-art of nanoparticle drug delivery for brain cancer treatment.
• Recognize the mechanisms for drug transport across the blood brain barrier and examine current methods for overcoming those barriers.
• Examine in vitro models of the blood brain barrier used to screen drugs and drug delivery systems intended to treat neurological diseases.

References
The development of blood-brain barrier (BBB)-targeting technologies is a very active field of research: targeting therapeutic actives to the central nervous system by means of systemic administration means crossing the BBB, and this is now one of the most challenging problems in drug development. The BBB is a unique regulatory system that protects the brain environment by separating it from direct contact with the circulating blood. In doing so, it impedes at the same time the access of a large number of diagnostic and therapeutic agents into the brain parenchyma. One of the possibilities of bypassing this barrier relies on specific properties of nanoparticulate vectors designed to interact with BBB-forming cells at a molecular level, as a result of which the transport of drugs or other molecules (such as nucleic acids, proteins or imaging agents) could be achieved without interfering with the normal function of the brain.

HTTP://WWW.NCBI.NLM.NIH.GOV/PUBMED/19435406

Evidence–based Management of Brain Metastases
William Friedman, M.D.

Upon completion of my presentation, participants should be better able to:
• Consider the level I and level II evidence for brain metastasis treatment.
• Examine the role of radiosurgery in the treatment of brain metastases.

References
Recent progresses in treatment of brain metastases have improved survival and quality of life in cancer patients. Surgery and stereotactic radiosurgery are two validated techniques for brain metastases treatment. Actually, these two modalities of treatment could be used separately or in combination depending on the clinical situation (age, primitive disease status, type of primitive cancer, Karnofsky performance status) and radiological situation (number of brain metastases, localization). http://www.ncbi.nlm.nih.gov/pubmed/24923058

Radiosurgery Management of Brain Arteriovenous Malformations
L. Dade Lunsford, M.D.

Upon completion of this lecture, participants should be better able to:
• Examine the indications for radiosurgery in the management of brain Arteriovenous Malformations (AVM).
• Review expected outcomes, risks, and benefits of radiosurgery treatment of AVM.

References
Radiosurgery is an option that is generally used to treat AVMs that are approximately 3 cm in diameter or less. Proton beam, linear accelerator, or gamma knife methods are used to deliver a high dose of radiation to the AVM, while minimizing the effects to surrounding brain tissue; a single dose generally is given. However, staged radiosurgery procedures are being used more frequently to treat symptomatic large AVMs in conjunction with embolization. Radiotherapy is thought to work by inducing thrombosis. This approach is appealing because of its apparent noninvasiveness.
The current (Mar14) American Heart Association multidisciplinary management guidelines for the treatment of brain AVMs recommend the following approach: ....2.Radiation therapy alone is recommended for Spetzler-Martin grade I or II if the AVM is less than 3 cm in size and surgery has an increased surgical risk based on location and vascular anatomy. ...

Radiosurgery for Vestibular Schwannoma
William Friedman, M.D.

Upon completion of this lecture, participants should be better able to:
• Examine the role of radiosurgery in the treatment of vestibular Schwannoma and assess the risks and benefits of compared to open surgery.

References
Radiosurgery has become an established alternative or complement to microsurgery of vestibular Schwannoma. Ever further progress in radiosurgery for vestibular Schwannoma has been achieved in the past few years, and the requirements essential to performing a successful radiosurgical treatment have become available with several platforms. Advances in MRI have enabled not only the detection of smaller tumors, but also an outstanding resolution of the structural anatomy of the
cerebello-pontine angle. Consequently, dosimetry and treatment planning software have become more refined.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3379795/

Radiosurgery has become an accepted treatment option for vestibular Schwannoma. Nevertheless, predictors of tumor control and treatment toxicity in current radiosurgery of vestibular Schwannoma are not well understood.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3379795/

Specific recommendations are made regarding target population, treatment alternatives, interventions and practices and additional research needs. Appropriate use of radiosurgery for patients with vestibular Schwannoma is recommended. This guideline is intended to provide the scientific foundation and initial framework for the person who has been diagnosed with a vestibular Schwannoma. The assessment and recommendations provided herein represent the best professional judgment of the working group at this time, based on research data and expertise currently available.

http://www.irsa.org/AN%20Guideline.pdf

Functional Radiosurgery: Coming Full Circle
Dade Lunsford, M.D.
Upon completion of this lecture, participants should be better able to:
• Discuss the application of stereotactic radiosurgery (SRS) as a technique for treatment of trigeminal neuralgia and movement disorders.
• Delineate patient selection criteria, indications for use, benefits and potential drawbacks of SRS for movement disorders and trigeminal neuralgia.

References
Advances in stereotactic radiosurgery (SRS) techniques associated with improvements in MRI targeting, planning software, and a better knowledge of SRS parameters brought the technique to a precision capable of performing focal and precise lesions in the basal ganglia for the treatment of movement disorders. SRS might be the only treatment option for selected patients' movement disorder surgery. Stereotactic radiosurgery for movement disorders; Surg Neurol Int. 2012; 3(Suppl 1): S10–S16; Published online Jan 14, 2012. doi: 10.4103/2152-7806.91605;
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3400484/

Brain Tumors: When Radiosurgery Should be Adjuvant?
Vitaly Siomin, M.D.
Upon completion of this lecture, participants should be better able to:
• Examine the role of radiosurgery as an adjuvant treatment strategy, and explore potential benefits such as avoiding potential toxicity of WBRT and improving local control.
• Assess the effectiveness of radiosurgery adjuvant treatment as a strategy for delaying and even foregoing whole-brain radiotherapy.

References
Cavity-directed radiosurgery combined with high-resolution MR imaging detection and radiosurgical treatment of synchronous brain metastases is an effective strategy for delaying and even foregoing whole-brain radiotherapy (WBRT) in most patients. This technique provides acceptable local disease control, although distant treatment failure remains significant.


Saturday, December 6
SESSION III: Knock Out Stroke
Update on Neuroimaging Focus on Perfusion Imaging in Stroke
Kevin Abrams, M.D.
Upon completion of this lecture, participants should be better able to:
• Determine when perfusion imaging is useful in assessment and treatment of acute stroke.
• Evaluate the limitations and potential pitfalls of using perfusion imaging in assessment of acute stroke.

References
Therapy for acute stroke depends on ensuring the diagnosis and excluding diseases that mimic cerebral ischemia, such as hypoglycemia, hyponatremia, a seizure, or a mass lesion such as a tumor or subdural hematoma. The exclusion of a hemorrhagic rather than ischemic stroke can be determined rapidly and accurately with CT or MR imaging. The differentiation of a transient ischemic attack (TIA) from ischemia potentially producing infarction often can be made clinically, with the former lasting only a matter of minutes. It is more difficult to clinically differentiate those neurological deficits due to ischemia that are likely to improve or reverse spontaneously from those that are likely to persist or worsen, and this is a significant value of perfusion imaging. http://stroke.ahajournals.org/content/34/4/1084.full

Acute Stroke Intervention
Italo Linfante, M.D.
Upon completion of this lecture, participants should be better able to:
• Review the concept and technical aspects for acute stroke intervention.
The main goals in the initial phase of acute stroke management are to ensure medical stability, to quickly reverse conditions that are contributing to the patient's problem, to determine if patients with acute ischemic stroke are candidates for thrombolytic therapy, and to begin to uncover the pathophysiologic basis of the neurologic symptoms.


References

Next Generation Devices to Treat Aneurysms and Stroke
David Fiorella, M.D., Ph.D.
Upon completion of my presentation, participants should be better able to:
• Describe contemporary strategies for the treatment of acute ischemic stroke.
• Evaluate potential treatment devices for the minimally invasive evacuation of intracranial hemorrhage.
• Recognize potential utility of new devices for the treatment of wide necked bifurcation aneurysms.

References

Decisions regarding the timing and choice of therapy for a ruptured intracranial aneurysms are ideally made by a team of experienced clinicians who consider the neurologic grade and clinical status of the patient, the availability of expertise in surgical and endovascular techniques, as well as the anatomic characteristics of the aneurysm.


Spinal Vascular Shunts: Symptoms Classification and Treatment
Ajay Wahkloo, M.D., Ph.D.
Upon completion of this lecture, participants should be better able to:
• Identify the various neurological symptoms associated with spinal arteriovenous (AV) shunts.
• Define the classifications of spinal AV shunts and recognize their distinct treatment strategies.
• Examine the value of various imaging modalities in the diagnosis of spinal AV shunts.

References

Spinal cord AV malformations are (like their cerebral counterpart) shunts, which are fed by arteries normally supplying the neural tissue (ie, the intrinsic arteries of the spinal cord), whereas SDAVFs (like their cranial counterparts, the dural AV fistulas [DAVFs]) are fed by radiculomeningeal arteries (which are, in fact, similar to meningeal arteries). The previously called “epidural,” “osteodural,” or “paravertebral” AV shunts can be categorized into this group. Because the draining veins of these shunts do not drain the spine but the bone, these shunts will not become symptomatic due to venous congestion of the cord. Instead they may become symptomatic due to compression of the spinal cord or nerve roots by the enlarged epidural venous pouches. There have been only a few case reports describing associated perimedullary reflux causing congestive myelopathy. A hypothesis about a possible defective valve-like mechanism normally impeding retrograde flow from the epidural plexus to perimedullary veins has been put forward to explain this finding. However, it may also be argued, that the reflux is due to an extensive thrombosis of the normal epidural outlets that leads to secondary retrograde drainage into the perimedullary veins. http://www.ajnr.org/content/30/4/639.full

Focus on Unruptured Brain Aneurysms
Guilherme Dabus, M.D.
Upon completion of this lecture, participants should be better able to:
• Evaluate non-surgical treatment methods for unruptured brain aneurysms, and discuss safety and efficacy compared to surgical treatment.

References

The management of unruptured intracranial aneurysms is controversial. There are no randomized trials on which to base recommendations. Decisions about therapy need to weigh the natural history of the aneurysm, the risks of intervention, and patient preferences. Risk factors for poor outcomes include advanced age, larger aneurysm size, and location in the posterior circulation; these are more consistently observed in surgically rather than endovascularly treated patients. Age is a crucial element in deciding whether to treat an unruptured aneurysm.

http://www.uptodate.com/contents/unruptured-intracranial-

Basic Science of Flow Diverters and Challenging Cases
Speaker is on the Strikers speakers bureau maker of flow diverters. We resolved this COI by changing the topic
Ajay Wahkloo, M.D., Ph.D.
Upon completion of this lecture, participants should be better able to:
• Recognize indications for use of flow diverters.
• Review a comparison study of flow diversion and standard endovascular approaches for the treatment of intracranial aneurysms.
Validated through in vitro and in vivo experimental studies, the concept of flow diversion is finding its way into the clinical realm of intracranial aneurysm treatment. Preliminary data demonstrate acceptable safety and high efficacy of FDs for a wide range of intracranial aneurysms of the anterior and posterior circulation without the need for coiling and with the use of a single implant. Durability and high rate of progressive occlusion and a cure of aneurysms observed are promising but require long-term follow-up studies. Monitoring antplatelet treatment needs special attention to prevent periprocedural and delayed thromboembolic events and parenchymal hemorrhage. The treatment of a subset of fusiform aneurysms affecting the entire basilar artery remains difficult owing to the risk of perforator occlusion. http://ovidsp.tx.ovid.com/sp-3.12.0b/ovidweb.cgi?neurosurgery-online.com

New Advanced Imaging in Neurovascular Suite
Ajay Wahkloo, M.D., Ph.D.

Upon completion of this lecture, participants should be better able to:
• Demonstrate the use of newer imaging technologies introduced and added to the neuroangiography suite to treat complex neurovascular lesions including acute ischemic and hemorrhagic stroke and expound technical feasibility and possible applications.

References
Transportation of patients requiring multiple diagnostic and imaging-guided therapeutic modalities is unavoidable in current radiological practice. This clinical scenario causes time delays and increased risk in the management of stroke and other neurovascular emergencies. Since the emergence of flat-detector technology in imaging practice in recent decades, studies have proven that flat-detector X-ray angiography in conjunction with contrast medium injection and specialized reconstruction algorithms can provide not only high-quality and high-resolution CT-like images but also functional information. This improvement in imaging technology allows quantitative assessment of intracranial hemodynamics and, subsequently in the same imaging session, provides treatment guidance for patients with neurovascular disorders by using only a flat-detector angiographic suite—a so-called one-stop quantitative imaging service (OSIS). In this paper, we review the recent developments in the field of flat-detector imaging and share our experience of applying this technology in neurovascular disorders such as acute ischemic stroke, cerebral aneurysm, and stenoocclusive carotid diseases.
http://www.hindawi.com/journals/bmri/2013/873614/

Review of Clinical Trials: PUFS, INTREPED, SCENT and FRED
Italo Linfante, M.D.

Upon completion of this lecture, participants should be better able to:
• Analyze recent clinical trials for the treatment of intracranial aneurysms.

References
The goal of future, well-controlled acute stroke trials is to expeditiously bring patients the most effective stroke therapy.
http://stroke.ahajournals.org/content/28/7/1518.full

Treatment of Craniofacial Arteriovenous Malformation
Guilherme Dabus, M.D.

Upon completion of this lecture, participants should be better able to:
• Apply optimal treatment strategies in patients with unruptured intracranial aneurysms considering the risks vs. benefits of treatment vs. non-treatment.

References
Treatment of arteriovenous malformation AVMs can be difficult, as frequently, following an apparently successful extirpation, there is regrowth of the tumor to a size larger than its original size, often with supply by surgically inaccessible vessels. Furthermore, the high flow rates and hyper vascularity of these lesions can lead to life-threatening complications, such as hemorrhage and/or cardiovascular instability. With the advent of super-selective angiography and new embolic agents, Embolization has become an integral part of treatment. The pre-operative Embolization diminishes blood loss and facilitates complete surgical extirpation. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2740518/

SESSION IV: Fundamentals of Neurocritical Care
Case Studies in Neuroimaging
Kevin Abrams, M.D.

Upon completion of my presentation, participants should be better able to:
• Recognize MR imaging features distinguishing between infection and infarction.
• Review utility of MR perfusion in differentiating between infection and tumor.

References
Magnetic resonance (MR) imaging with intravenous contrast agent is the test of choice to diagnose and monitor brain tumors before, during, and after therapy. Recent advances in imaging methods such as diffusion-weighted imaging, perfusion imaging, and spectroscopic imaging all have in common the ability to provide quantitative cellular, hemodynamic, and
metabolic information that may enhance our understanding of brain tumor biology, help us to better assess treatment response, more accurately determine tumor activity during therapy, and differentiate recurrent tumor and treatment related complications.  http://www.ncbi.nlm.nih.gov/pubmed/15627003

Sedation and Delirium in the Neurocritical Care Unit

Javier Provencio, M.D.

Upon completion of this lecture, participants should be better able to:
• Recognize unique patient care challenges delirium presents including detection of life-threatening neurological events and pain management.
• Identify reliable screening methods and treatment strategies for managing pain, agitation and delirium in the neurocritical care unit.

References

Symptoms of pain, agitation and delirium are common among critically ill patients. In the last ten years, an explosion of studies has addressed the management of agitation among patients in medical and surgical intensive care units (ICUs), yet little evidence supports reliable management of pain, agitation and delirium in a neurological ICU (NICU). Critically ill patients with a primary neurological injury (PNI) and those without are similar; however, those with brain injury pose unique challenges in the prevalence of delirium, risk to the brain, and monitoring for progression of the primary insult. The lack of investigation into the etiology of delirium for patients with PNI can lead to life-threatening neurological events going unnoticed. In addition, greater understanding of the level of pain in patients with PNI is important as pain can complicate management of the neurological injury and precipitate agitation and delirium.

Although many characteristics are shared between patients with and without PNI, several unique attributes of acute neurological injury must be considered when treating pain, agitation – and particularly delirium – in this population. Pain and agitation can be very disruptive in the management of and recovery from brain injury. Delirium, a symptom with a plethora of causes, is a unique and important early marker for a serious neurological event requiring prompt intervention. Identifying reliable screening methods and treatment strategies for managing pain, agitation and delirium in the NICU are urgently needed. The use of functional tests, such as continuous EEG monitoring, near-infrared scanning and microdialysis, are promising avenues for future research.


Approach to the Comatose Patient

Karel Fuentes, M.D.

Upon completion of this lecture, participants should be better able to:
• Appropriately evaluate, diagnose and treat the comatose patient.

References

Coma and other states of impaired consciousness are signs of extensive dysfunction or injury involving the brainstem, diencephalon, or cerebral cortex and are associated with a substantial risk of death and disability. Management of impaired consciousness includes prompt stabilization of vital physiologic functions to prevent secondary neurologic injury, etiological diagnosis, and the institution of brain-directed therapeutic or preventive measures. Neurologic prognosis is determined by the underlying etiology and may be predicted by the combination of clinical signs and electrophysiological tests.


Multimodal Monitoring in the Neuro ICU

Javier Provencio, M.D.

Upon completion of my presentation, participants should be better able to:
• Examine new and emerging multimodal monitoring techniques, and identify the benefits of their use in the Neuro ICU.

References

New monitoring techniques can provide the neurointensivist with crucial information about brain physiology and metabolism. Combining these techniques (“multimodal monitoring”) can produce a more accurate overall picture. This approach, along with new computer systems for integrating data at the bedside, may change the way patients with brain injury are monitored and treated in the future.


Traumatic Brain Injury

Kristine O’Phelan, M.D.

Upon completion of this lecture, participants should be better able to:
• Describe the mechanisms of primary and secondary injury following acute traumatic brain injury (TBI).
• Recommend an individualized approach to elevated intracranial pressure in a patient with TBI.

References

A decision-analytical model was created to compare costs, outcomes, and cost-effectiveness of 3 strategies for treating a patient with severe traumatic brain injury (TBI). The aggressive-care approach is compared with “routine care,” in which the Brain Trauma Foundation guidelines are not followed. A “comfort care” category, in which a single day in the ICU is followed by routine floor care. When all the costs of severe TBI are considered, aggressive treatment is a cost-effective option, even for older patients. Comfort care for severe TBI is associated with poor outcomes and high costs, and should be
reserved for situations in which aggressive approaches have failed or testing suggests such treatment is futile.  
http://thejns.org/doi/abs/10.3171/2012.1.JNS11962

Lavinio A, Menon D. Intracranial pressure: why we monitor it, how to monitor it, what to do with the number and what’s the future? Curr Opinion in Anesthesiology 2011;24:117-123.


Acute Spinal Cord Injury
Kristine O’Phelan, M.D.

Upon completion of this lecture, participants should be better able to:
• Identify the mechanisms of primary and secondary injury following acute spinal cord injury.
• Implement strategies to wean acute spinal cord injury patients from mechanical ventilation.

References
Spinal cord injury has become epidemic in modern society. Despite advances made in the understanding of the pathogenesis and improvements in early recognition and treatment, it remains a devastating event, often producing severe and permanent disability. A neurologic examination should be completed as soon as possible to determine the level and severity of the injury, both of which impact prognosis and treatment.  


Miami Neuro Nursing Symposium
Thursday, December 4, 2014
Biltmore Hotel, Coral Gables, Florida

Target Audience ■ Nurses, nurse practitioners, clinical pharmacists, respiratory therapists, emergency first responders and other interested healthcare professionals who treat and care for patients and families in all areas of neuroscience, including physicians in the neuro-specialties, who are part of the care team.

Overview ■ Nurses are a crucial part of the treatment and recovery of neuroscience patients. The Neuro Nursing Symposium offers a broad curriculum focusing on current and state-of-the-art evidence-based practices for nursing and other healthcare professionals who treat and care for neuroscience patients and their families. The symposium will address the treatment and nursing care of the neuroscience patient from the emergency department through rehabilitation. The Neuro Nursing Symposium’s expert faculty will educate the audience about patient care issues related to neurological complications, traumatic brain injury, stroke, tumors, rehabilitation and groundbreaking technology used to improve the care of neuroscience patients. The goal of the symposium is to optimize patient outcomes throughout all areas of neuroscience by implementing the most innovative and evidence-based clinical practices.

Baptist Health Neuroscience Center: “Nursing” Symposium Directors
■ Marguerite Rowell, MSN, MSM/HM, MBA, ONC, Director of Nursing, Baptist Neuroscience Center
■ Cris Alegria-Aguerto, MBA, Manager, Neuroscience Research
■ Bridget Gorman, MS, R.N., CCRN, CNRN, SCRN, ACNS-BC, Neuro MedSurg, Neuroscience Department
■ Amy K. Starosciak, Ph.D., CRG Outcomes Research

FACULTY
Mary Kay Bader RN, MSN, CCNS, CNRN, CCRN, FAHA
Neuro/Critical Care Clinical Nurse Specialist, Mission Hospital
Mission Viejo, California

Danette Birkhimer, RN, MS, CNS, AOCNS
Clinical Nurse Specialist
Ohio State University Comprehensive Cancer Center
Arthur G. James Cancer Hospital
SCHEDULE

Thursday, December 4 (8.0)

7:00 a.m. Registration, Continental Breakfast and Visit Exhibits

7:45 a.m. Welcome and Introductions

8:00 a.m. Overview of Clinical Evaluation and Management of Central and Peripheral Nervous System Tumors
  Sergio González-Arias, M.D., Ph.D.

9:00 a.m. Traumatic Brain Injury
  Mary Kay Bader, R.N.

10:00 a.m. Break and Visit Exhibits

10:30 a.m. Tumor-treating Fields: A Novel Treatment for Glioblastoma Multiforme
  Danette Birkhimer, R.N.

11:30 a.m. Inside the Black Box: ICP and Multi-modality Monitoring in the Neuro Critical Care Patient
  Mary Kay Bader, R.N.

12:30 p.m. Lunch and Visit Exhibits

1:30 p.m. Cardioembolic Strokes
  Kendra Menzies Kent, R.N.

2:30 p.m. Telesstroke Care: Instant Evidence Based Expertise
  Brett C. Meyer, M.D.

3:30 p.m. Break and Visit Exhibits

4:00 p.m. Thrombotic Ischemic Strokes: Care Through Rehabilitation
  Kendra Menzies Kent, R.N.

5:00 p.m. Adjourn

OBJECTIVES

Upon completion of these presentations, participants should be better able to:

- Differentiate between benign and malignant brain and spinal tumors.
- Examine current surgical treatment modalities for brain and spinal tumors.
- Review ongoing research of novel treatment methods.
- Identify the pathophysiological changes following severe brain injury, and correlate these changes to secondary brain injury.
- Prioritize the interventions used to manage intracranial pressure (ICP) and brain oxygen.
- Apply the Brain Trauma Injury Foundation guidelines to clinical practice.
- Demonstrate how to use the Bedside Shivering Assessment Score and maintain normothermia.
- Apply interventions to maximize the patient’s emergence through coma.
- Examine the mechanism of actions of tumor-treating fields (TTFs) for the management of glioblastoma multiforme.
- Review current applications and approved uses of TTFs and describe the nursing role in therapy.
- Identify the resource shortage regarding acute stroke management.
- Describe techniques, systems and workflows regarding acute telestroke care.
- Review the evidence for reliability of performing neurologic examinations using telestroke care.
- Evaluate the data related to rt-PA administration and telestroke care.
• Recognize the evidence for efficacy for acute stroke decision making using telestroke care.
• Identify risk factors for cardioembolic stroke.
• Manage atrial fibrillation issues including rate-control and rhythm control.
• Identify common territory for a cardioembolic stroke and discuss the pathophysiology.
• Implement appropriate initial management of cardioembolic strokes in the emergency department including use of thrombolytics.
• Discuss the current recommendations for primary and secondary prevention of cardioembolic strokes.
• Identify the causes of increased ICP, and define the normal/abnormal values.
• Relate the pathophysiological changes in elevated ICP to their clinical manifestations.
• Differentiate between the types of ICP monitoring and Cerebrospinal Fluid drainage systems. Identify the interventions for reducing ICP in stroke patients with malignant cerebral edema as well as TBI patients.
• Utilize a pupillometer – a noninvasive device for ICP monitoring – in stroke patients to measure cerebral swelling and potential increases in ICP.
• Discuss the pre-hospital guidelines for timing and assessment of patients with neurological changes.
• Determine the initial management of a patient presenting with an ischemic thrombotic stroke in the emergency department, including appropriate radiological studies.
• Delineate the indications for administering thrombolytics including the extension to 4.5 hours with new exceptions.
• Describe the interventional options for a thrombotic ischemic stroke patient.
• Identify primary goals and management of a thrombotic stroke patient within the ICU and acute care settings.

LECTURE-SPECIFIC OBJECTIVES AND REFERENCES
Clinical Evaluation and Surgical Management of Central and Peripheral Nervous System Tumors
Sergio Gonzalez-Arias, M.D., Ph.D.
Educational Objectives: Upon completion of this lecture, participants should be better able to:
• Differentiate benign and malignant brain and spinal tumors.
• Examine current surgical treatment modalities for brain and spinal tumors.
• Review ongoing research of novel treatment methods.

References
Peripheral nerve tumors are uncommon and many neurologists will see only a handful in their careers, unless they have a practice enriched in patients with neurofibromatosis. A careful family history is important in the assessment of an underlying neurogenetic disorder, such as neurofibromatosis. For patients with tumors that do require treatment, surgery is the primary tool. For benign tumors, removal of the tumor with minimization of residual neurologic deficit is the goal, though that can be impossible given the location of the tumor and intertwining with nerve fascicles, especially if the tumor is non-encapsulated. Metastatic cancer to peripheral nerve is not common but in that scenario, CT, MRI, and PET scanning take on the additional importance of determining the primary tumor and staging the cancer.
http://www.uptodate.com/contents/peripheral-nerve-tumors#H30352918

Traumatic Brain Injury
Mary Kay Bader RN, MSN, CCNS, CNRN, CCRN, FAHA
Educational Objectives: Upon completion of this lecture, participants should be better able to:
• Identify the pathophysiological changes following severe brain injury, and correlate these changes to secondary brain injury.
• Prioritize the interventions used to manage intracranial pressure (ICP) and brain oxygen.
• Apply the Brain Trauma Injury Foundation guidelines to clinical practice.
• Demonstrate how to use the Bedside Shivering Assessment Score and maintain normothermia.
• Apply interventions to maximize the patient’s emergence through coma.

References
Traumatic brain injury is a serious public health problem in the United States. Each year, traumatic brain injuries contribute to a substantial number of deaths and cases of permanent disability.
http://www.cdc.gov/traumaticbraininjury/

Tumor-treating Fields: A Novel Treatment for Glioblastoma Multiforme
Danette Birkhimer, MS, RN, CNS, OCN
Educational Objectives: Upon completion of this lecture, participants should be better able to:
• Examine the mechanism of actions of tumor-treating fields (TTFs) for the management of glioblastoma multiforme.
• Review current applications and approved uses of TTFs and describe the nursing role in therapy.

References
Tumor treating fields (TTFs) are an evolving new anticancer modality. The U.S. Food and Drug Administration have approved the first device, the NovoTTF-100A™, that uses this technology and is indicated for use in progressive glioblastoma multiforme after standard therapies have failed. Promising clinical trial results will likely lead to expanded uses in primary brain tumors and other cancer types. This article will review the concept of TTFs and their mechanism of action, and overview the TTF device and its approved usage.
Inside the Black Box: ICP and Multimodality Monitoring in the Neurocritical Care Patient
Mary Kay Bader RN, MSN, CCNS, CNRN, CCRN, FAHA

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

- Identify the causes of increased ICP, and define the normal/abnormal values.
- Relate the pathophysiological changes in elevated ICP to their clinical manifestations.
- Differentiate between the types of ICP monitoring and Cerebrospinal Fluid drainage systems. Identify the interventions for reducing ICP in stroke patients with malignant cerebral edema as well as TBI patients.
- Utilize a pupillometer – a noninvasive device for ICP monitoring – in stroke patients to measure cerebral swelling and potential increases in ICP.

References
An important goal of neurocritical care is the management of secondary brain injury (SBI), that is pathological events occurring after primary insult that add further burden to outcome. Brain oedema, cerebral ischemia, energy dysfunction, seizures and systemic insults are the main components of SBI.

Cardioembolic Strokes
Kendra Menzies Kent, MS, RN-BC, CCRN, CNRN, SCRN

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

- Identify risk factors for cardioembolic stroke.
- Manage atrial fibrillation issues including rate-control and rhythm control.
- Identify common territory for a cardioembolic stroke and discuss the pathophysiology,
- Implement appropriate initial management of cardioembolic strokes in the emergency department including use of thrombolytics.
- Discuss the current recommendations for primary and secondary prevention of cardioembolic strokes.

References
Cardioembolic stroke is largely preventable, warranting efforts at primary prevention for major-risk cardioembolic sources. Once stroke due to cardiac embolism has occurred, the likelihood of recurrence is relatively high for most cardioembolic sources; consequently, secondary prevention is also important.
http://emedicine.medscape.com/article/1160370-overview

Telestroke Care: Instant Evidence-based Expertise
Brett C. Meyer, M.D.

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

- Identify the resource shortage regarding acute stroke management.
- Describe techniques, systems and workflows regarding acute telestroke care.
- Review the evidence for reliability of performing neurologic examinations using telestroke care.
- Evaluate the data related to rt-PA administration and telestroke care.
- Recognize the evidence for efficacy for acute stroke decision making using telestroke care.

References
The most important factor in successful thrombolytic therapy of acute ischemic stroke is early treatment. Nonetheless, selection of appropriate candidates for thrombolysis demands a neurologic evaluation and a neuroimaging study. In addition, the use of thrombolytics for acute stroke requires a system that coordinates emergency services, stroke neurology, intensive care services, neuroimaging, and neurosurgery to provide optimal treatment.

"Time is brain": the sooner intravenous treatment is initiated after ischemic stroke, the more likely it is to be beneficial. Eligible patients should be treated as quickly as possible within the appropriate 3 or 4.5 hour time limit. To achieve the earliest treatment, current guidelines recommend that the elapsed time to the start of infusion should be ≤60 minutes from the time of patient arrival in the emergency department.


Telestroke is the use of telemedicine specifically for stroke care. Telemedicine is the use of electronic communication methods, such as telephone, Internet, and videoconferencing, to exchange medical information from one geographic site to another. Another organization, the American Heart Association/American Stroke Association (AHA/ASA) recommends the use of telemedicine, or telestroke, to improve stroke care in rural, remote, or underserved areas by providing acute care on a timely basis for patients at outlying hospitals during the critical period following onset of stroke symptoms.

Thrombotic Ischemic Strokes: Care Through Rehabilitation
Kendra Menzies Kent, MS, RN-BC, CCRN, CNRN, SCRN

Educational Objectives: Upon completion of this lecture, participants should be better able to:
• Discuss the pre-hospital guidelines for timing and assessment of patients with neurological changes.
• Determine the initial management of a patient presenting with an ischemic thrombotic stroke in the emergency department, including appropriate radiological studies.
• Delineate the indications for administering thrombolytics including the extension to 4.5 hours with new exceptions.
• Describe the interventional options for a thrombotic ischemic stroke patient.
• Identify primary goals and management of a thrombotic stroke patient within the ICU and acute care settings.

References
Thrombotic strokes are those in which the pathologic process giving rise to thrombus formation in an artery produces a stroke either by reduced blood flow distally (low flow) or by an embolic fragment that breaks off and travels to a more distant vessel (artery-to-artery embolism). All thrombotic strokes can be divided into either large or small vessel disease.

http://www.uptodate.com/contents/overview-of-the-evaluation-of-stroke?source=machineLearning&search=Thrombotic+Ischemic+Strokes&selectedTitle=1%7E150&sectionRank=1&anchor=H18#H7
TARGET AUDIENCE: Bariatric Surgeons, General Surgeons, Family Medicine Physicians and other interest healthcare professionals. This activity addresses professional practice gaps relevant to physicians in the practice of family medicine and hospitalists. In addition, physicians that identify conditions and refer patients to a bariatric surgeon, and those specialists to whom a bariatric surgeon might refer for follow-up care or treatment, are also included in the target audience, as are members of the hospital care team, i.e.: nurses.

EXPECTED NUMBER OF ATTENDEES: CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5).
- Live activity
- Test-item writing activity
- Enduring material
- Manuscript review activity
- Internet point-of-care activity
- Journal-based CME activity
- PI CME activity
- Didactic Lecture
- Question & Answer
- Case Studies
- Internet-Home Study
- ARS
- Panel
- Other (specify)_________

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 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 have thorough knowledge about all available surgical interventions for the treatment of obesity and do know typically know how to effectively communicate possible complications of these procedures to patients.

WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’)?
- Physicians formulate treatment strategies to include appropriate surgical intervention for morbidly obese patients and they effectively communicate potential complications associated with these procedures to 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.)
- When evaluating available options surgeons consider minimally invasive robotic surgery that will allow patients to have a shorter hospital stay, less risk of infection, less pain, less scarring, faster recovery and a quicker return to normal activities without affecting their surgical risk or outcome.
**REFERENCES** supporting the current practice and/or the optimal practice and/or practice gap:

► Bariatric laparoscopic surgery has been shown to lead to sustainable weight-loss in obese individuals. Robotic-assisted laparoscopic surgery is proposed as the next major evolution in minimally invasive surgery. Robotic-assisted bariatric surgery is both a safe and feasible option for severely obese patients. [http://www.ncbi.nlm.nih.gov/pubmed/21678542](http://www.ncbi.nlm.nih.gov/pubmed/21678542)

The goal of gastric bypass surgery is to reduce the morbidity and mortality associated with obesity and to improve metabolic and organ function. Several studies have demonstrated that bariatric surgery is effective in reducing obesity-related comorbidities, while having additional benefits such as reducing monthly medication costs and the number of sick days and improving quality of life ([http://www.uptodate.com/patients/content/topic.do?topicKey=~TAwTFg.bOGcqV](http://www.uptodate.com/patients/content/topic.do?topicKey=~TAwTFg.bOGcqV))

Surgery has traditionally been a specialty within the medical profession that has revolved around invasive procedures to treat various maladies. Minimally invasive surgery has caused a change in the route of access and has significantly and irrevocably changed the surgical treatment of most disease processes.

Patients still undergo interventions to treat disease, but minimally invasive surgery makes possible a reduction or complete elimination of the "collateral damage" required to gain access to the organ requiring surgery. While the benefits of this approach were numerous for the patient, early technology limited the application of minimally invasive surgery to some procedures. Specifically, surgeons using standard minimally invasive techniques lost the value of a natural three dimensional image, depth perception, and articulated movements. Magnification of small structures was often difficult and instruments were rigid and without joints. Robotic surgery has provided the technology to address these limitations and allow the application of minimally invasive surgery to a broader spectrum of patients and their diseases. Surgical robots relieve some of these limitations by providing fine motor control, magnified three dimensional imaging and articulated instruments. [http://www.springer.com/medicine/surgery/journal/11701](http://www.springer.com/medicine/surgery/journal/11701)

**EDUCATIONAL OBJECTIVES:**

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

- Review the co-morbid medical conditions associated with obesity to include diabetes, hypertension, heart disease and metabolic syndrome, and examine the mortality rate of the morbidly obese patient.
- Demonstrate emerging robotic surgical techniques in the field of bariatric surgery.
- Describe standard robotic port placement and variations for extenuating patient circumstances to include prior abdominal surgery and obesity.
- Acquire a greater knowledge of the detailed surgical steps and philosophies to improve function of varied general and bariatric procedures accomplished with robotic assistance.

**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)

- [x] Patient Care
- [x] Medical Knowledge
- [x] Interpersonal and Communications Skills
- [ ] Professionalism
- [x] Systems-based Practice
- [x] 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)
- [ ] 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.)

**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)

- [x] 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: __________________________________________

Since its inception in August of 2006, the South Miami Hospital Center for Robotic Surgery program is ranked within the top five Centers in the world. The uniqueness of the program is that it encompasses many surgical specialties – GYN, general, bariatric, urology, thoracic and ENT.

The South Miami Hospital Center for Robotic Surgery program has conducted several webcasts to educate the public about the Robotic program and the different specialties available. The webcasts also allowed the community to learn more about robotic surgery and its many benefits. The webcasts include GYN, bariatric, thoracic, and urology surgical specialties.

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

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

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

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

This course has been planned in collaboration with the South Miami Center for Bariatric Surgery. This course has been made available online for the benefit of local, national and international physicians who will be better able to identify patients that may benefit from gastric bypass surgery.

DATE REVIEWED: September 25, 2014 REVIEWED BY: ☑ Executive Committee ☐ Chairman

APPROVED: ☑ YES ☐ NO □ Credits: AMA/PRA Category 1 Credits: # 0.5

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

CME ACTIVITY TITLE: Conversations in Ethics: Child Health Policy & Social Determinants of Healthcare

DATE: Wednesday, November 12, 2014 TIME: 12:00 noon - 1:00 p.m.

LOCATION: Baptist Cardiac & Vascular Lab, 5th Fl Conf Room CREDIT HOUR(S) APPLIED FOR: 1.0

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

CONFERENCE COORDINATOR: Rose Allen, R.N., M.S.M. /H.M., CHPN, Director, Bioethics & Palliative Care
AMA/PRA LEARNING FORMAT:
- Live activity
- Enduring material
- Journal-based CME activity
- Test-item writing activity
- Manuscript review activity
- Internet point-of-care activity

TARGET AUDIENCE:
Physicians, Psychologists, Nurses, Social Workers, Respiratory Therapists, Clergy, Pharmacist, Registered Dietitians and other interested healthcare professionals. (C4)
This activity addresses professional practice gaps relevant to physicians who may seek ethics consultations as well as related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 40-50  CHARGE: 0

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

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

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.

The Baptist Health Bioethics Committee has undertaken an initiative to provide monthly continuing medical education lectures on current medical ethical issues. Topics selected by the Bioethics Committee are influenced by recent confidential ethics consultations.

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**?
- The United States excels at treating the most complex medical conditions, but our low-ranking health statistics (relative to other countries) do not match our high-end health care spending. One way to understand this paradox is to examine the history of federal children’s health programs. In the 1800s, children’s health advocates confronted social determinants of health to reduce infant mortality. Over the past 100 years, however, physicians have increasingly focused on individual doctor–patient encounters; public health professionals, meanwhile, have maintained a population health perspective but struggled with the politics of addressing root causes of disease. Political history and historical demography help explain some salient differences with European nations that date to the founding of federal children’s health programs in the early 20th century. More recently, federal programs for children with intellectual disability illustrate technical advances in medicine, shifting children’s health epidemiology, and the politics of public health policy. (Am J Public Health. 2012;102:1848–1857. doi:10.2105/AJPH.2012.300714)

WHAT IS THE OPTIMAL PRACTICE*?
- Healthcare professionals will recognize the split between clinical medicine and public health and implement changes in clinical medicine to address population health.
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)
- [x] 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:
► Caring for the health of children is as ancient as our species; federal children’s health programs are modern phenomena that reflect specific historical circumstances and are shaped by broader trends in demography, science, medicine, politics, and culture. Over the past century, succeeding generations of federal children’s health leaders have addressed the pressing health issues of their time and have used the most advanced medicine and technology available, within the funding and priorities set by Congress and the president. Federal children’s health programs are but one factor in determining children’s health in the United States, of course, but all efforts to improve children’s health over the past century have faced the same enduring set of historical circumstances. This history helps explain the paradoxes of children’s health in the United States: despite remarkable progress over the past century, significant disparities among racial/ethnic groups remain, and overall, the United States does poorly compared with other nations of similar wealth. One current response to persistent health disparities is a return to the 19th-century focus on social determinants of health. Although poverty and other social factors have never disappeared from our understanding of children’s health, over the past century our medical system was increasingly dominated by individual doctor–patient encounters, and many in our nation see a relatively limited role for government in maintaining and promoting health. Our choices today are not determined by previous ones, but the legacy of previous decisions is all around us: we have inherited institutions, attitudes, professional training, expectations, tax codes, laws, and regulations that all reflect a particular approach to improving the health of children. One key to navigating toward a brighter future is to recognize how past generations’ decisions are embedded in our present. The legacy of children’s health programs in the United States presents a challenge for those who seek to address the social determinants of health from a life course perspective. (Am J Public Health. 2012;102:1848–1857. doi:10.2105/AJPH.2012.300714)

EDUCATIONAL OBJECTIVES
Upon completion of this conference, participants should be better able to:
- Explain the causes of the mortality transition in Western populations.
- Recognize how the split between clinical medicine and public health affects population health.
- Describe at least one change in clinical medicine or medical education to address population health.

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)
- [x] Patient Care
- [x] Medical Knowledge
- [x] Interpersonal and Communications Skills
- [ ] Professionalism
- [ ] Systems-based Practice
- [x] 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)
- [ ] Follow-up Survey
- [ ] Review of Hospital, Health System or Other Data
- [ ] Other ________________________________

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

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

Speaker:
Jeffrey P. Brosco, M.D., Ph.D.
Professor of Clinical Pediatrics, University of Miami Miller School of Medicine
Associate Director, Mailman Center for Child Development
Chair, Pediatric Bioethics Committee, Jackson Memorial 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.
The Baptist Health Bioethics Committee has undertaken an initiative to provide monthly continuing medical education lectures on current medical ethical issues. Topics selected by the Bioethics Committee are influenced by recent confidential ethics consultations.

DATE REVIEWED: October 2, 2013 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

Script:
Over the last 100 years, Western medicine has increasingly focused on technical interventions delivered to individual patients. This has led to remarkable improvements in the health of some patients, yet there is evidence that broader social determinants have had a greater impact on population health. This presentation will review the evidence regarding child (and adult) health, and explore the roles and responsibilities of clinicians in the 21st century to address social determinants of health.

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


DATE: Tuesday, October 21, 2014 TIME: 5-7 p.m.

LOCATION: Baptist Hospital, 5MCVI Conference 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 ☐ PI CME activity
Internet point-of-care 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:** 30-50  **CHARGE:** $0

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

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

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

- [ ] Best practice parameters
- [x] Consensus of experts
- [ ] Joint Commission initiatives
- [ ] Mortality/morbidity statistics
- [ ] National Pt Safety Goals
- [ ] National/regional data
- [x] Other (Explain): New BCVI vision and strategic plan has created interest on the part of physicians regarding the use of clinical research to advance evidence-based practices. Preliminary meetings with physicians have resulted in a strong interest in learning more about best practices and fundamental conduct of research.

**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
  - [x] Resistance-to-change
  - [ ] Financial/Lack of Insurance

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

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

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

- **Other:**
  - Access to quality research programs

**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 may not be aware of all factors that may influence the best available renal denervation therapies for their patients.

**WHAT IS THE OPTIMAL PRACTICE***? Physicians consider all factors that may influence the best available renal denervation therapies for the hypertensive patient.

**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 [ ] 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 will consider all renal denervation treatments available and current research when making treatment options for the hypertensive patient.

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

► Renal sympathetic nerve activation contributes to the pathogenesis of hypertension. Symplicity HTN-2, a multicenter, randomized trial, demonstrated that catheter-based renal denervation produced significant blood pressure lowering in treatment-resistant patients at 6 months after the procedure compared with control, medication-only patients.
The prevalence of hypertension is increasing worldwide, with an estimated 972 million adults with hypertension in 2000 that is predicted to grow to 1.56 billion by 2025. Despite the availability of numerous effective antihypertensive medications, many hypertensive adults remain uncontrolled for various reasons, including inadequate treatment. Among hypertensive patients receiving treatment, the estimated proportion of patients with blood pressure uncontrolled to <140/90 mm Hg ranges from 47% to 84% in Europe and North America. Furthermore, a subset of patients who adhere to a prescribed pharmacological regimen of ≥3 drugs, including a diuretic, continue to have uncontrolled or resistant hypertension. The proportion of patients with resistant hypertension is uncertain. In the United States, estimates of resistant hypertension prevalence range from 13% to 30% of adults receiving drug treatment for hypertension. These numbers reflect a serious global health challenge given the observation that with every 20/10-mm Hg increase in blood pressure, cardiovascular mortality doubles.

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

- Evaluate current renal denervation clinical research.
- Assess some of the new therapies poised to impact immediate future of renal denervation treatment.
- Implement new renal denervation 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) 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)
Barry T. Katzen, M.D., FACC, FACR, FSIR
Founder and Chief Medical Executive, Miami Cardiac & Vascular Institute
Miami Health Associate Dean of Clinical Affairs
Clinical Professor of Radiology and Surgery
Florida International University Herbert Wertheim College of Medicine
Miami, Florida

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

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

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

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

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

OVERALL PROGRAM CHANGES: Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission? Yes No If yes, please describe the related CME program change. And describe how the impact of the related program improvement will be measured and documented? (C15)
**NON-EDUCATION STRATEGIES:** Explain what we are doing (CME or BHSF) -- or what we could do -- to enhance change as an adjunct (in addition to) to this CME activity? (C17) These would be tactics and tools to facilitate change that go beyond this CME activity.

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

Explain: Additional education on basics of conducting research in all fields of study

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

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

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

Partnering with BCVI Research Department and FIU Herbert Wertheim College of Medicine clinical faculty as part of Baptist Hospital’s mission to support this affiliation.

**DATE REVIEWED:** Thursday, October 2, 2014  
**REVIEWED BY:** [X] Executive Committee  [ ] Chairman

**APPROVED:**  [ ] YES  [ ] NO  
**Credits:** AMA/PRA Category 1 Credits: # _2
- Continuing Psychology Education Credits: # _ N/A
- Continuing Dental Education Credits: # _ N/A

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**CME ACTIVITY TITLE:** 12th Annual Sleep Center Symposium

**DATE:** Saturday, November 15, 2014  
**TIME:** 8:00 a.m. – 12:50 p.m.

**LOCATION:** Baptist Hospital of Miami – Auditorium  
**CREDIT HOUR(S) APPLIED FOR:** 4.50 Cat. 1

**CONFERENCE DIRECTORS:** Timothy L. Grant, M.D. and Jeremy I. Tabak, M.D.

**AMA/PRA LEARNING FORMAT:**

- [X] 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: Sleep medicine specialists, neurologists, pulmonologists, primary care physicians, general internists, general surgeons, cardiologists, ENT physicians, psychiatrists, psychologists, nurses, social workers, pharmacists, respiratory specialists, and sleep technicians.

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 sleep medicine. In addition, physicians that identify conditions and refer patients to a sleep medicine specialist, neurologist, pulmonologist, ENT physician, general surgeon or a psychologist, and those specialists to whom a family physician or a pediatrician 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: 150-175 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): The Director of Continuing Education for Psychology has determined that this conference addresses aspects of ICD-10 and DSM-V which describes mental disorders due to general medical conditions. This conference addresses ICD-10 and DSM-V diagnostic categories and their impact on behavior.

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.
► Physician diagnosis of sleep apnea syndromes has increased, current physician practices does not include consistent evaluation of sleep symptomatology in the majority of patients.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
► Physicians screen all patients for symptomatology in order to appropriately diagnose and treat disorders. This reduces risks of co-morbidities such as hypertension, obesity, diabetes and chronic obstructive lung disease.

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

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

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
- Please see below.

EDUCATIONAL OBJECTIVES:

Please see below.

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)
- ☐ Review of Hospital, Health System or Other Data
- ☐ Follow-up Survey
- ☐ 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:

Please see below.

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

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

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

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

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. ______________

As a part of the education programming of the Sleep Centers with Baptist Health, and in order to comply with educational requirements, the Center is offering an educational series on sleep disorders to all interested medical staff. Sleep Center reading physicians are required to have 10 hours CE credit on sleep medicine a year. Continuing Medical Education helps the Sleep Diagnostic Centers within the Baptist Health System meet their department and system-wide goals by providing educational opportunities to hospital staff and physicians concerning sleep disorders.

DATE REVIEWED: __10-02-2014____________________ REVIEWED BY: ☐ Executive Committee ☒ Chairman

APPROVED: ☒ YES ☐ NO □ Credits: AMA/PRA Category 1 Credits: # ___4.5____
Continuing Psychology Education Credits: # ___4.5___ □ N/A □ Continuing Dental Education Credits: # ____ N/A

Schedule

7:30 a.m.  Registration and Continental Breakfast
7:50 a.m.  Welcome and Introductions
Timothy L. Grant, M.D. and Jeremy I. Tabak, M.D.
8:00 a.m.  Can We Truly Control Our Dreams?
Timothy L. Grant, M.D.
8:30 a.m.  Hypoglossal Nerve Stimulator – New Technique for Sleep Apnea Patients
Rolando Molina, M.D.
9:00 a.m.  Sleep Apnea, Arrhythmias and Sudden Death
Virend K. Somers, M.D. Ph.D.
9:45 a.m.  Cognitive Behavior Therapy and CPAP Compliance
Marcy Wasman, Ph.D.
10:15 a.m. Break and Visit Exhibits
10:35 a.m. Update on Sleep Apnea
Jeremy I. Tabak, M.D.
11:05 a.m. Sleep Deprivation and Cardiometabolic Dysregulation – Does Sleeping less make you fat?
Virend K. Somers, M.D., Ph.D.
11:50 a.m. Sleep and Neuro-degenerative Disorders
David Seiden, M.D.
12:20 p.m. Panel Discussion with Case Presentations
12:50 p.m. Adjourn

Faculty

Timothy L. Grant, M.D., FAASM
Symposium Co-director
Medical Director, Baptist Health Sleep Center at Sunset
Neurologist, Baptist and South Miami Hospitals
Diplomate, American Board of Sleep Medicine
Miami, Florida

Jeremy I. Tabak, M.D. FCCP, FAASM
Symposium Co-director
Medical Director, Baptist Hospital Sleep Laboratory and Baptist Sleep Center at Galloway
Pulmonologist, Critical Care and Sleep Medicine
Baptist, Doctors, Mariners and South Miami Hospitals
Diplomate, American Board of Sleep Medicine and American Board of Internal Medicine in Sleep Medicine
Miami, Florida

Rolando Molina, M.D.
Otolaryngologist
Baptist, Doctors, Homestead, South Miami and West Kendall Baptist Hospitals
Miami, Florida

David Seiden, M.D., FAASM
Medical Director Baptist Sleep Centers at Miami Lakes and Pembroke Pines
Miami, Florida

Virend K. Somers, M.D., Ph.D.
Professor of Medicine Consultant in Cardiovascular Diseases
Director, Sleep and Cardiovascular Clinical Research Units Mayo Clinic
and Mayo Foundation
Rochester, Minnesota

Marcy I. Wasman, Ph.D., CBSM
Psychologist
Baptist, South Miami and Doctors Hospitals
Miami, Florida

Educational Objectives

Timothy L. Grant, M.D., FAASM
Can We Truly Control Our Dreams?
Educational Objectives:
• Explain sleep architecture and the electrophysiology of dreams.
• Identify different types of dreams and how they relate to sleep disorders.
• Implement appropriate treatment options for dream related sleep disorders.

Reference:
Under the assumption that dream recall is a peculiar form of declarative memory, we have hypothesized that (1) the encoding of dream contents during sleep should share some electrophysiological mechanisms with the encoding of episodic memories of the awake brain and (2) recalling a dream(s) after awakening from non-rapid eye movement (NREM) and rapid eye movement (REM) sleep should be associated with different brain oscillations.

http://ovidsp.tx.ovid.com/sp-3.13.0b/ovidweb.cgi?&S=BECJFPELHPDDCNFDNCLKLG0BDPLAA00&Complete+Reference=S.sh.47%7c11%7c1

Rolando Molina, M.D.
Hypoglossal Nerve Stimulator – A New Technique for Patients with Sleep Apnea
Educational Objectives:
• Identify the anatomical levels involved in the management of obstructive sleep apnea (OSA).
• Define the role of surgery in the management of OSA patients.
• Explain the role of neurostimulation of the tongue to treat OSA.

Reference:
Upper airway occlusion in obstructive sleep apnea has been attributed to a decline in pharyngeal neuromuscular activity occurring in a structurally narrowed airway. Surgical treatment focuses on the correction of anatomic abnormalities, but there is a potential role for activation of the upper airway musculature, especially with stimulation of the hypoglossal nerve and genioglossus muscle.

Electrical stimulation of the hypoglossal nerve in the treatment of obstructive sleep apnea, 2010-10-01Z, Volume 14, Issue 5, Pages 299-305
https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S1087079209001221

Virend K. Somers, M.D., Ph.D.
Sleep Apnea, Arrhythmias and Sudden Death
Educational Objectives:
• Identify cardiovascular disease mechanisms activated by sleep apnea.
• Discuss the role of the diving reflex in bradyarrhythmias triggered by sleep apnea.
• Describe the association between sleep apnea, myocardial ischemia and cardiac arrhythmias.
• Examine the interaction and mechanisms linking sleep apnea and sudden death.

Reference:
In patients with hypertrophic cardiomyopathy, sleep apnea and its severity correlate positively both with left atrial size and with the presence of atrial fibrillation (AF). Because AF constitutes the most important determinant of death in patients with hypertrophic cardiomyopathy, screening for sleep disordered breathing (SDB) and treatment of SDB in this population might improve survival; however, further studies are necessary to confirm this hypothesis. Recent data show that hypertrophic cardiomyopathy patients who have SDB suffer from significantly decreased exercise tolerance, as measured by cardiopulmonary exercise testing.

Ondrej Ludka, MUDr, PhD, Tomas Konecny, MD, MUDr, and Virend Somers, MD, DPhil
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3147220/?report=classic

Marcy I. Wasman, Ph.D., CBSM
Cognitive Behavior Therapy and CPAP Compliance
Educational Objectives:
• Identify behavior patterns associated with CPAP compliance issues.
• Implement cognitive behavior therapy to optimize CPAP adherence.

Reference:
Recent efforts have focused on applying theory-driven psychological interventions to the problem of PAP adherence. One study, for example, found that a group intervention that used a cognitive behavioral approach improved PAP use by 2.9 h compared to standard care.

Motivational Enhancement to Improve Adherence to Positive Airway Pressure in Patients with Obstructive Sleep Apnea: A Randomized Controlled Trial
Mark S. Aloia, PhD, J. Todd Arnedt, PhD, Matthew Strand, PhD, Richard P. Millman, MD, and Belinda Borrelli, PhD
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3792382/

Jeremy I. Tabak, M.D. FCCP, FAASM
Update on Sleep Apnea
Educational Objectives:
• Evaluate patients with sleep apnea and provide appropriate treatment recommendations incorporating new treatment modalities.
• Describe the role of polysomnography in a patient with suspected sleep apnea.

Reference:
Sleep disorders are prevalent in the general population and can significantly affect physical and mental health and emotional well-being. There is a broad range of sleep disorders with varied clinical presentations. Physicians of all specialties should screen for the presence of disturbed sleep and consider referral to a sleep specialist when indicated.


Virend K. Somers, M.D., Ph.D.
Sleep Deprivation and Cardiometabolic Dysregulation – Does Sleeping Less Make You Fat?
Educational Objectives:
• Connect epidemiologic evidence linking sleep deprivation to weight gain and cardiovascular risks.
• Identify effects of sleep deprivation on energy intake and expenditure.
• Explain mechanisms linking sleep deprivation with weight gain and cardio-metabolic dysfunction.

Reference:
During the past 30 years, rates of partial sleep deprivation and obesity have increased in the United States. Evidence linking partial sleep deprivation, defined as sleeping <6 hours per night, to energy imbalance is relevant to weight gain prevention and weight loss promotion. With a majority of Americans overweight or obese, weight loss is a recommended strategy for reducing comorbid conditions.

David Seiden, M.D.
Sleep and Neuro-degenerative Disorders
Educational Objectives:
  • Identify common sleep disturbances occurring in various neurodegenerative states.

Reference:
Many neurochemical systems interact to generate wakefulness and sleep. Wakefulness is promoted by neurons in the pons, midbrain, and posterior hypothalamus that produce acetylcholine, norepinephrine, dopamine, serotonin, histamine, and orexin/hypocretin. Most of these ascending arousal systems diffusely activate the cortex and other forebrain targets. NREM sleep is mainly driven by neurons in the preoptic area that inhibit the ascending arousal systems, while REM sleep is regulated primarily by neurons in the pons, with additional influence arising in the hypothalamus. Mutual inhibition between these wake- and sleep-regulating regions likely helps generate full wakefulness and sleep with rapid transitions between states.

Sleep Neurobiology from a Clinical Perspective Rodrigo A. España, PhD1; Thomas E. Scammell, MD2
Department of Physiology and Pharmacology, Wake Forest University Health Sciences, Winston Salem, NC; Department of Neurology, Beth Israel Deaconess Medical Center, Boston, MA
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3119826/pdf/aasm.34.7.845.pdf

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

CME ACTIVITY TITLE: Ob/Gyn Conference Series: Gynecologic Oncology- Update for the Generalists Ob/Gyn
DATE: Friday, November 14, 2014
TIME: 8-9 a.m.
LOCATION: Baptist Hospital of Miami, Auditorium
CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1
CONFERENCE DIRECTOR: Jason James, M.D.
AMA/PRA LEARNING FORMAT:
☒ Live activity  ☐ Test-item writing activity  ☐ Internet point-of-care activity
☐ Enduring material  ☐ Manuscript review activity
☐ Journal-based CME activity  ☐ PI CME activity
TARGET AUDIENCE: Ob/Gyns and Nurses.

EXPECTED NUMBER OF ATTENDEES: 30-35

CHARGE: 0

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

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- 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.
- The generalist Ob/Gyn may not be familiar with current gynecologic cancer evaluation, diagnosis and treatment guidelines.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like'?)
- The generalist Ob/Gyn identifies pre-malignant conditions and gynecologic cancers and provides timely referrals as indicated to a specialist. The generalist Ob/Gyn provides patients with a basic overview of available treatment interventions for gynecologic cancers.

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.)

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 ☑ Competence? -or- ☑ Performance? -or- ☑ Patient Outcomes*? (Check all that apply.) *(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)
- The generalist Ob/Gyn becomes familiar with latest gynecologic cancer evaluation, diagnosis and treatment and provides timely referral. The generalist Ob/Gyn explains available treatment interventions to their gynecologic cancer patients.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
- Most OB/GYNs are generalists and see a variety of medical conditions in the office, perform surgery, and manage labor and delivery. Office practice consists of providing women with preventive examinations and other primary care and identifying gynecologic problems. OB/GYNs typically evaluate infertility, abnormal uterine bleeding, leiomyomatos pelvic masses, pelvic organ prolapse, abnormal Pap smears, pelvic pain, endometriosis, breast disorders, and urinary incontinence. Examples of
minor office procedures are colposcopy, endometrial biopsy, Pap smears, and vulvar biopsy. (ACOG, https://www.facs.org/education/resources/residency-search/specialties/obgyn)

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

- Assess pre-malignant conditions and follow appropriate referral indications.
- Explain recent changes in gynecologic cancer evaluation, diagnosis and treatment advances.

**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.)

Troy A. Gatcliffe, M.D., F.A.C.O.G., F.A.C.S.
Ob/Gyn and Gynecologic Oncologist
Baptist Hospital
Clinical Assistant Professor
Department of Obstetrics and Gynecology
Herbert Wertheim College of Medicine
Florida International University

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

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

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

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

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

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

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

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

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

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

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

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

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

This meeting is planned in collaboration with the Baptist Hospital Ob/Gyn Department.

DATE REVIEWED: October 8, 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 ☐

CME ACTIVITY TITLE: Inpatient Neuromuscular Disorders and the role of EMG/NCS

DATE:  October 21, 2014  TIME: 7:30-8:30 am

LOCATION:  5 BCVI Conference Room - Side B  CREDIT HOUR(S) APPLIED FOR:  _1_  Cat. 1

CONFERENCE DIRECTOR:  Sergio Gonzalez-Arias, M.D.

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

TARGET AUDIENCE:
Neurologists, neurosurgeons, neuroradiologists, diagnostic radiologists, critical care physicians, neurointensivist, emergency medicine physicians, internal medicine physicians, interventional Neuroradiologists, critical care and neuroscience nurses, neurosurgery nurses, nurse practitioners, and clinical pharmacists.

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
- 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.
► Neuromuscular disorders is a general term that refers to diseases that affect any part of the nerve and muscle systems. These disorders vary according to characteristics such as a pattern of inheritance, origin in of the genetic mutation, incidence, symptoms, age of onset, rate of progression, and prognosis. Current physician practice gap is lacking expertise and available resources to diagnose a neuromuscular patients whose symptoms resolved and patients are discharged from the Emergency Department without additional assessment from a neuroscience specialist.

WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like')?
► Physicians will perform proper evaluation of the patient with a suspected neuromuscular disorder, a detailed history, a comprehensive neurologic examination and appropriate diagnostic studies to determine treatment plan. Physicians will be able to treat neuromuscular emergencies and consult with a neuroscience specialist for further admission to an inpatient setting for medication therapy, electromyography (EMG) and/or nerve conduction studies (NCS). Common indications for EMG include radiculopathy, neuropathy, muscle diseases, and motor neuron diseases. Common indications for NCS include carpal tunnel syndrome, ulnar neuropathy, brachial plexopathy, radiculopathy, myasthenia gravis, and muscle disease.

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

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

- Physicians will perform proper evaluation of the patient with a suspected neuromuscular disorder, a detailed history, a comprehensive neurologic examination and appropriate diagnostic studies to determine treatment plan.

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

- Varela, H, Gooch C. Neuromuscular disorders. Geriatric Neurology; 2011
- Katirji, B, Clinical Assessment in Neuromuscular Disorders. Neuromuscular Disorders in Clinical Practice; 26 Apr 2013

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
- Describe common inpatient neuromuscular disorders.
- Explain the electrophysiological studies of the nerve and muscle.
- Define the utility of EMG/NCS in the inpatient setting.
- Identify and implement appropriate treatment plans for patients with neuromuscular emergencies.

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.)
Heber Varela, M.D.
Neurologist
Baptist Health Neuroscience Center
Baptist, South Miami and West Kendall Baptist Hospitals
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  [x] No  Are we partnering with other organizations in a purposeful manner to achieve common interests?
- [ ] Yes  [x] 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 series is planned in collaboration with the Baptist Hospital Neuroscience Center, a Stroke-accredited Center, and which also includes the Neuro-critical care and Spine Surgery departments.

### DATE REVIEWED:

10-16-2014

### REVIEWED BY:

- [ ] Executive Committee
- [x] Chairman

### APPROVED:

- [x] YES  [ ] NO  Credits: AMA/PRA Category 1 Credits: # 1

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

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**Applicable Credits: AMA Category 1  [x] Continuing Psychology Education  [x] Continuing Dental Education [ ]**

**CME ACTIVITY TITLE:** Pediatric Emergency Department Conference Series: Orthopedic Updates

**DATE:** Tuesday, November 11, 2014  **TIME:** 6:00 – 7:00 p.m.

**LOCATION:** Baptist Hospital, Auditorium  **VC to Homestead Hospital Boardroom**

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

**CONFERENCE DIRECTOR:** Pooya Hosseinzadeh, M.D.

**AMA/PRA LEARNING FORMAT:**

- [x] 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:**
EXPECTED NUMBER OF ATTENDEES: 40-45

CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- Live
- Question & Answer
- Enduring Material
- Didactic Lecture
- Case Studies
- Internet-Home Study
- ARS
- Panel
- 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.
- Pediatricians do not always appropriately diagnose and treat orthopedic fractures in children. Undiagnosed and untreated fractures may lead to considerable morbidity later in life.

WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
- Pediatricians accurately diagnose fractures and know when to refer their patients to a specialist for appropriate treatment avoiding potential morbidities later in life.

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.)*
- Pediatricians accurately diagnose fractures in children and know when to refer them to a specialist for appropriate treatment avoiding potential morbidities later in life.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
- Supracondylar fractures of the humerus are widely considered to be the most common fracture of the elbow in children. Approximately 3 percent of all fractures in children are supracondylar fractures. They often result from trauma to the elbow, most often due to a fall from a height or related to sports or leisure activities. Even though these fractures are so common, high-quality scientific data regarding their treatment are lacking.
In most patients with displaced fractures and vascular compromise, limb perfusion improves after reduction. In the absence of improvement, surgical exploration of the antecubital fossa is indicated for patients with absent wrist pulses and a cold, pale hand. The orthopaedic surgeon will need to use clinical judgment and may want a consult regarding vascular injury.


The timing of treatment for displaced pediatric supracondylar humerus fractures is an important practical concern addressed in the fifth recommendation. The advisability of urgent/emergent treatment is often weighed against the availability of a surgeon, access to an operating room, and the relative safety of anesthesia.


The United States Preventive Services Task Force concluded that evidence is insufficient to recommend routine screening of infants for DDH as a means to prevent adverse outcomes and that newborn screening leads to overdiagnosis of hips that do not benefit and may be harmed by treatment. The Pediatric Orthopaedic Society of North America (POSNA) has responded to this recommendation by acknowledging a lack of data to support screening, but pointing to the value of early diagnosis in preventing long-term complications. POSNA recommends following the AAP Clinical Practice Guideline with assessment for DDH at birth and every well-child visit until the child is walking normally. This approach is supported by a decision analysis that recommends screening of all infants with physical examination combined with selective use of ultrasound in infants that are high risk. This is especially relevant given reports that missed diagnosis of DDH is a common cause for malpractice suits against pediatricians. http://www.uptodate.com/contents/developmental-dysplasia-of-the-hip-clinical-features-and-diagnosis?source=see_link&anchor=H23#H23

Estimates of the incidence of developmental dysplasia of the hip (DDH) are quite variable and depend upon the means of detection, the age of the child, and the diagnostic criteria. It is estimated that dislocatable hips and hips with severe or persistent dysplasia occur in 3 to 5 per 1000 children. Historically, the incidence of DDH with dislocation is 1 to 2 per 1000 children. Mild hip instability is more common in newborns, with reported incidence as high as 40 percent. However, mild instability and/or mild dysplasia in the newborn period often resolve without treatment. Infants with mild instability and/or mild dysplasia in the newborn period should not be included in estimates of incidence; their inclusion results in overestimation.


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

Update on Supracondylar Humerus Fractures in Children
- Examine the benefits of lateral entry only pin constructs
- Describe the optimal pin configuration.
- Define criteria for an acceptable reduction.
- Describe treatment regimen for perfused, pulseless supracondylar humerus fracture.

- Identify the risk factors for developmental dysplasia of the hip.
- Explain the physical examination maneuvers for assessing newborn hip stability.
- Recognize indications for ultrasonography of the neonatal hip.
- Describe the treatment modalities for newborn hip dysplasia.

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  [X] Medical Knowledge  [X] Interpersonal and Communications Skills
- [ ] Professionalism  [X] Systems-based Practice  [X] 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)
- [ ] 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.)

Steven L. Frick, M.D.
Surgeon-in-Chief
Chair, Department of Surgery
Chair, Department of Orthopaedic Surgery
Nemours Children's Hospital
Orlando, 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 ☐ MRE Dept. Leadership and Staff ☑ CME Committee
☐ Conference Director (see above) ☐ Others (i.e.: Conference Coordinator, Planning Group etc.)

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

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

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

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

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

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

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

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

DATE REVIEWED: October 10, 2014 REVIEWED BY: ☑ Executive Committee ☐ Chairman

APPROVED: ☑YES ☐ NO Credits: AMA/PRA Category 1 Credits: #_1
Continuing Psychology Education Credits: #_1 ☐ N/A ☑ Continuing Dental Education Credits: # ☐ N/A

Schedule

5:30 p.m. Department meeting
Dinner and Registration

6:00 p.m. Update on Supracondylar Humerus Fractures in children

6:25 p.m. Q&A
6:30 p.m. Developmental Dysplasia of the Hip: What's old, What's New
6:55 p.m. Q&A
7:00 p.m. Adjourn
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 dentistry. In addition, physicians that identify conditions and refer patients to an otolaryngologists (ENT) and those specialists to whom a dentist 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: 20-25 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
- 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 and dentists are sometimes the first professionals to identify medical emergencies. Physicians and dentists do not consistently know how to manage or prevent medical emergencies in their practice.

WHAT IS THE OPTIMAL PRACTICE***? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)
- Physicians and dentists utilize the appropriate skills to prevent and manage medical emergencies seen in their practice.

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

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

Dentists and physicians consistently utilize the appropriate skills to prevent and manage medical emergencies seen in their practice.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
Dentists must be prepared to manage medical emergencies which may arise in practice. Most of these complications, approximately 90%, are mild, but 8% are considered to be serious. It was found that 35% of the patients are known to have some underlying disease. Cardiovascular disease was found in 33% of those patients. Medical emergencies are most likely to occur during and after local anesthesia, primarily during tooth extraction and endodontics. Over 60% of the emergencies are syncope, with hyperventilation the next most frequent at 7%. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1586863/

In the United States and Canada, studies have also shown that syncope is the most common medical emergency seen by dentists. Syncope represented approximately 50% of all emergencies reported in one particular study, with the next most common event, mild allergy, represented only 8% of all emergencies. In addition to syncope, other emergencies reported to have occurred include allergic reactions, angina pectoris/myocardial infarction, cardiac arrest, postural hypotension, seizures, bronchospasm and diabetic emergencies. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1586863/

The extent of treatment by the dentist requires preparation, prevention and then management, as necessary. Prevention is accomplished by conducting a thorough medical history with appropriate alterations to dental treatment as required. The most important aspect of nearly all medical emergencies in the dental office is to prevent, or correct, insufficient oxygenation of the brain and heart. Therefore, the management of all medical emergencies should include ensuring that oxygenated blood is being delivered to these critical organs. This is consistent with basic cardiopulmonary resuscitation, with which the dentist must be competent. This provides the skills to manage most medical emergencies, which begin with the assessment, and if necessary the treatment of airway, breathing and circulation (the ABCs of CPR). Usually, only after these ABCs are addressed should the dentist consider the use of emergency drugs. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1586863/

Drugs that should be promptly available to the dentist can be divided into two categories. The first category represents those which may be considered essential. The second category contains drugs which are also very helpful and should be considered as part of the emergency kit. The precise composition of the drug kit can vary as the presence of the drugs in this latter group may depend on the nature of the dental practice. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1586863/

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

- Manage common medical emergencies seen in the dental practice setting.
- Discuss concepts and implement required skill sets for basic airway management, intravenous access and office preparedness.
- Discuss treatment for specific emergencies and where appropriate the drugs used.
- Recognize signs and symptoms of relevant medical emergencies.
- Outline routes of drug administration appropriate to dental practitioners.

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

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

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

List the planned method(s) of evaluation:

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

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

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

FACULTY:
Charles H. Kates, DDS
Dentist North 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.)
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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.

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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: October 10, 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