CME Applications
For Executive Committee Review & Approval
July 1 - September 25, 2013

RSS
TAVR Patient Care Team – Cases Review (1 Cat. 1/ ea.)

RSS
Primary Care and Basic Science Sports Medicine Series (1 Cat. 1/ ea.)

Enduring
Renewal: Surgery Conference Series: Robotic Gastric Bypass (0.5 Cat. 1)

Ongoing
Renewal: Neonatology Crisis Resource Management

Ongoing
Renewal: Reducing Transfusions and Phlebotomy

Ongoing

Ongoing
Neonatology Crisis Resource Management – Team Training (3.0 Cat. 1 each)

Ongoing
Multidisciplinary Approach to Development of a Maternal Hemorrhage Management Plan (1 Cat. 1)

Ongoing
Internet Point of Care Learning (0.5 Cat. 1 per submission)

Ongoing
Renewal: Peripartum Hemorrhage and Disseminated Intravascular Coagulation- Diagnosis and Treatment (1.25 Cat. 1)

09.12.13
Cardiovascular Conference Series: Diabetes and Cardiovascular Disease – New Strategies to Reduce CVD Risk (1 Cat. 1) (REVISED DATE)

09.13.13
Cardiovascular Conference Series: Hot Topics in Endovascular Medicine: An Overview of Renal Denervation (1 Cat. 1)

09.21.13
Inaugural SIM WARS Competition

09.25.13
Risk Management and Patient Safety: Diversity and Simulation Training (2 Cat. 1)

10.01.13
Pediatric Multispecialty Conference Series: A Practical Approach to the Diagnosis of Common Genetic Disorders in Infancy and Childhood (1.25 Cat. 1 each)

10.04.13
2013 Baptist Health South Florida Research Summit: Managing Change in Clinical Research (5.25 Cat 1)

10.05.13
Sleep Center Symposium (4.25 Cat 1)

10.09.13
Homestead Hospital Conference Series: Sickle Cell Anemia Crisis Management (1 Cat. 1)

10.11.13
Ob/Gyn Conference Series: Prenatal Genetic Testing in the 21st Century (1 Cat. 1)

10.19.13
Second Annual Diabetes Symposium: Inpatient and Outpatient Treatment Principles and Guidelines. (5 Cat. 1)

10.28.13
Radiology Grand Rounds: Critical Findings In OB Imaging (1.5 Cat 1)

11.05.13
Mariners Hospital Conference Series: Incontinence – Current Practice Recommendations (1 Cat. 1)

11.13.13
Homestead Hospital Conference Series: Diagnostic Radiology: CT in the Emergency Department (1 Cat. 1)

11.18.13
Radiology Grand Rounds: Pitfalls & Errors in Body CT – What Are They and How to A Avoid Them (1 Cat. 1)

11.19.13
Dentistry & Medicine Conference Series: Oral Manifestations of Human Papillomavirus (HPV) (1 Cat. 1 and 1 Dental CE)

12.06-7.13
Miami Neuro Symposium (18.25 Cat. 1)
CME ACTIVITY TITLE: TAVR Patient Care Team – Cases Review

DATE/TIME: August 2013-August 2014   LOCATIONS: 5 BCVI (Alison McLaughlin)
Every Tuesday, 7:30-8:30 a.m.

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

CONFERENCE DIRECTOR: Niberto Moreno, M.D.
CONFERENCE COORDINATOR: Alison McLaughlin

TARGET AUDIENCE: TAVR Patient Care Team Members.
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 the TAVR patient care team. In addition, physicians that identify conditions and refer patients to a cardiovascular surgeon and those specialists to whom a cardiologist might refer for further evaluation or treatment.

EXPECTED NUMBER OF ATTENDEES: 10-15   CHARGE: 0

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

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
☐ Best practice parameters  ☐ 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): New TAVR program at BCVI

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: New TAVR program at BCVI

PROFESSIONAL PRACTICE GAP (C2)

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

WHAT IS/ARE THE CURRENT PRACTICE* and/or THE PRACTICE GAP*? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
Physicians are currently not involved in a “community of practice” activity to discuss new knowledge in the context of previous and current experiences and translate the "new learnings" into clinical practice in the care of the cardiac patient who may benefit from a transcatheter aortic valve (TAVR) implantation for the treatment of severe symptomatic aortic stenosis (AS).

WHAT IS THE OPTIMAL PRACTICE**? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
Baptist Health TAVR patient care team participates regularly in a clinical review educational activity to remain current with up-to-date information on evidence-based practice and research findings.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is in physician:
☐ Knowledge? (They do not know that they need to be doing something.)
☒ Competence? (They do not know how to do it)
☐ Performance? (They know how to do it but are non-compliant - or are not doing it properly)
EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:

- Review results from various transcatheter aortic-valve replacement (TAVR) surgery cases.
- Assess indications for proper patient selection for TAVR.
- Implement evidence-based strategies into clinical practice to improve care of the TAVR patient.

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

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

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

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

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)
As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?

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

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State) (If necessary, attach a list.)
Moderator
Niberto L. Moreno, M.D., FACS
Cardiothoracic Surgeon
Chief of Cardiothoracic Surgery
Baptist Health Cardiac & Thoracic Surgical Group
Baptist Cardiac & Vascular Institute
Miami, Florida

Coordinator:
Alison McLaughlin
Interventional Services
Baptist Cardiac & Vascular Institute

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

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

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

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

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

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

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

DATE REVIEWED: August 23, 2013 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: Primary Care and Basic Science Sports Medicine Series

DATE: September 2013 to June 2014  TIME: 7-8 a.m.

LOCATION: Doctors Hospital – UHZ Conference Room  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 each

CONFERENCE DIRECTOR: John Uribe, 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
- Case Studies
- Panel
- Internet-Home Study
- Other (specify)

TARGET AUDIENCE: Orthopedists, Team Physicians, Primary Care Physicians, Pediatricians, Physicians in Training, Physician Assistants, Athletic Trainers, Physical Therapists, Exercise Physiologists, Nurses and other interested healthcare providers. 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 Orthopedic Sports Medicine. In addition, physicians who identify conditions and refer patients to an Orthopedic Sports Medicine specialist, and those specialists to whom an Orthopedic Sports Medicine might refer for further evaluation or treatment, are also included in the target audience, as are related members of the sports medicine and hospital care teams, i.e.: exercise physiologist, athletic trainer, nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 15-20 each  CHARGE: 0

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

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- Other (Explain): ACGME Program Requirements for Graduate Medical Education in Orthopedic Sports Medicine.

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare ‘quality gap’ being addressed. (C18)
Patient:  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
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.
► In order to meet ACGME Competencies and requirements of a Sports Medicine fellowship program:
► Orthopedic sports medicine fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.
► Fellows must demonstrate competence in their knowledge of:
  - Non-orthopaedic problems that occur in sports medicine and how to deal with those problems or how to refer them appropriately;
  - sports equipment, particularly protective devices intended to allow the athlete to continue to compete, including helmets, protective pads, knee braces, foot orthotics, and others not specifically named.
WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?)

► Physicians accurately screen patients with a variety of health conditions and follow up with necessary specialists.

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 who have completed the sports medicine fellowship program will competently 1) identify non-orthopaedic "primary care" health conditions that occur in sports medicine and either treat or refer them appropriately; and 2) apply components of ACGME Competencies into the practice of orthopedic sports medicine including the basic sciences, quality improvement and patient safety initiatives and recognition/mitigation of fatigue and sleep deprivation.

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

► ACGME Competencies - The program must integrate the following ACGME competencies

1. Curriculum/Basic Science
[Program Requirement IV.A.3.b)]
All fellows must participate in didactic sessions devoted to the basic sciences, including anatomy, biomechanics, and biology of healing.

2. Curriculum/Primary Care
[Program Requirement IV.A.3.c)]
Instruction should also be provided in sports medicine issues in the areas of cardiology, dermatology, pulmonology, preventive medicine, pediatric and adolescent medicine, exercise physiology, environmental exposure, athletic populations, team physicians, and protective equipment (including braces).

3. Fellow Participation in Quality Improvement and Patient Safety Program
[Common Program Requirement VI.A.3]
The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

4. Faculty and Resident Education to Recognize Signs of Fatigue and Sleep Deprivation
[Common Program Requirement VI.C.1.a)]
The program must educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation.


EDUCATIONAL OBJECTIVES:

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

- Identify non-orthopedic "primary care" issues that occur in sports medicine specifically in the areas of cardiology, dermatology, pulmonology, preventive medicine, pediatric and adolescent medicine, exercise physiology, environmental exposure, athletic populations, team physicians, and protective equipment (including braces).
- Critically review and discuss treatment indications, clinical outcomes, evidence-based guidelines, complications, morbidity, and mortality.
- Link the pathophysiologic process and findings of clinical disorders to the appropriate diagnosis, treatment and management.
- Determine when to refer to a specialist for follow-up care.
- Explain principles of biomechanics as well as terminology and application to orthopedic sports medicine.
- Apply specific required components of basic sciences to the practice of orthopedic sports medicine, including biochemistry, biomechanics, embryology, immunology, microbiology, pathology, pharmacology, and physiology.
- Integrate interdisciplinary clinical quality improvement and patient safety principles into practice.
- Recognize the signs of fatigue and sleep deprivation and implement fatigue mitigation processes to manage the potential negative effects on patient care.

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:
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.)
TO BE DETERMINED

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 Primary Care Sports Medicine Series supports the Sports Medicine Fellowship Program. The series provides valuable education to the fellows as well as to physicians who see athletes in their offices and must provide follow up to address any medical conditions.

DATE REVIEWED: 09-13-13 REVIEWED BY: ☐ Executive Committee ☒ Chairman
APPROVED: ☒ YES ☐ NO  Credits: AMA/PRA Category 1 Credits: # 1 each
Continuing Psychology Education Credits: # __ ☒ N/A  Continuing Dental Education Credits: # __ ☒ N/A

CME ACTIVITY TOPICS

Topics for the series from September – June will include but are not limited to the following:
- Cardiology
- Dermatology
- Pulmonology
- Preventive Medicine
- Pediatric and Adolescent Medicine
- Exercise Physiology
- Environmental Exposure
- Athletic Populations
- Team Physicians
- Protective Equipment
- Pathology
- Biomechanics
- Basic Sciences – biochemistry, biomechanics, embryology, immunology, microbiology, pathology, pharmacology and physiology
- Anatomy
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: August 2014

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

TARGET AUDIENCE: 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: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5).
- Live activity
- 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
- 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.)
Surgical robots relieve some of these limitations by providing fine motor control, magnified three-dimensional imaging, 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. 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

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.

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:

☐ 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)
  ☑ 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 it’s 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 4, 2013  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: Neonatology Crisis Resource Management

DATE: June 2012 to June 2013. Original approval: June 2012; Course reviewed: June 2013; Course expires: June 2014

TIME: Schedule will be coordinated by the Manager, Patient Safety Simulation Laboratory, Melody McNally.

CONTACT: MelodyM@BaptistHealth.net

LOCATION: Baptist Hospital, Simulation Laboratory

CREDIT HOURS APPLIED FOR: 3 Category 1 each Note: Revised (6/25/12) to reflect 3 credit hours based on SIM tests.

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

CONFERENCE DIRECTOR: William Smalling, M.D.

TARGET AUDIENCE (NICU Simulation Training) Neonatologists, Neonatal Nurse Practitioners, Neonatal Nursing Staff, Respiratory Therapists, Obstetricians and Labor and Delivery Nurses. 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 and nurses in the practice of neonatal resuscitation. In addition, any other specialists or staff who may participate in high-risk delivery and newborn resuscitation.

EXPECTED NUMBER OF ATTENDEES: 100-110 annually 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
- Internet-Home Study
- Question & Answer
- Case Studies
- Other (specify): Simulation Laboratory Training

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

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

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap. Physicians may not be aware of the value of successful team behavior and effective communication techniques and their impact on patient outcomes. High acuity and rare events occur during the delivery and resuscitation of neonates. This may present stressful scenarios in which a practitioner may have limited experience.

WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like'?) 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 physician:
- Knowledge (They do not know that they need to be doing something.)
- Competence (They do not know how to do it)
- Performance (They know how to do it but are non-compliant - or are not doing it properly)
DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☐ Competence? -☐ Performance? -☐ Patient Outcomes*? (Check all that apply.) *(NOTE: If 'patient outcomes' is selected, there must be an achievable measurement plan.)

► Neonatologists, Obstetricians & any other nursing or medical staff who participate in the simulation laboratory will improve function and communicate effectively during a crisis situation to enhance teamwork and ultimately to identify and correct systems problems and improve patient outcomes.

Goal: At the conclusion of one year, all BCH Neonatal physicians will have completed simulation training.

*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 course, participants should be better able to:

▪ Effectively communicate within a multidisciplinary, multispecialty team during neonatal resuscitation to optimize patient outcomes and improve patient safety.
▪ Implement crisis resource management principles in clinical practice.
▪ Manage neonatal emergencies following guidelines set forth by the Neonatal Resuscitation Program.
▪ Utilize human patient simulator experience to identify system problems, formulate and implement system changes to improve patient outcomes.

FORMAT AND SCENARIOS: NICU Simulation Lab case scenarios designed to simulate situations requiring neonatal resuscitation. Examples including but not limited to diaphragmatic hernia, pneumothorax, placental abruption and cardiac tamponade.

A. Introduction & Orientation: Participants will be given an orientation of the simulation room lay-out and location of supplies. Participants will be asked to sign a confidentiality agreement stipulating they will not disclose any information regarding the scenarios presented.
B. Case Scenarios: Participants will go through at least one crisis scenarios which will take about fifteen to twenty minutes to complete.
   ► Scenario I: UAC dislodged
   ► Scenario II: Diaphragmatic Hernia
C. Debriefing: A thirty minute debriefing session will follow each scenario during which participants will review their performance with a course facilitator.
D. Handouts: Based on participants’ performance they will receive evidence-based resources as reinforcement and reference tools. These evidence-based resources include but are not limited to practice bulletins, protocols and guidelines.

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: Review of NRP Performance Evaluation

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

► As a result of what your participation in the simulation training, 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 during this simulation training, please list any barriers or obstacles that might keep you from doing so:

SIMULATION TRAINING COURSE FACILITATORS:

Maria Victoria Lopez, M.D.
Obstetrician and Gynecologist
Conference Director and Course Facilitator
Patient Safety Simulation Lab at Baptist Hospital

Paul Gluck, M.D.
Course Facilitator
Patient Safety Simulation Lab at Baptist Hospital

Melody McNally ARNP, BC
Manager, Patient Safety Simulation Lab at Baptist Hospital

William Smalling M.D.
Neonatologist
Conference Director, Neonatology Simulation Training

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 ☒ Continuing Medical Education Dept. Leadership and Staff
☒ Continuing Medical Education Committee ☒ Conference Director (see above)
☐ Others (i.e.: Conference Coordinator, Planning Group etc.):

Core Group of Contributors: Ernesto Valdes, M.D, Phuket Tantivit, M.D, Alreca Daly, R.N, Norma Bonilla, R.N. and Allison Diaz R.N

CONFIDENTIALITY: Due to the nature of this course, participant performance and the clinical case scenarios discussed are confidential. All participants will be asked to sign a confidentiality agreement at the time of the training by the course facilitator. Participants’ performance can not be used as an outcomes measurement.

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

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

This course is intended to improve teamwork and communication among healthcare providers in labor and delivery by simulating real-life emergency scenarios commonly seen in this area.

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)

In support of the CME Program mission, this activity was developed to improve to patient care, safety and treatment outcomes by bringing about change in physician behavior during a crisis situation. The impact of this activity will be measured and documented through evaluation data collected immediately after simulation training session.

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: Articles: Medical Memo and Foundation News articles.
Handouts: Based on participants’ performance they will receive evidence-based resources selected by Dr. Maria Victoria Lopez, Dr. William Smalling and/or Dr. Ernesto Valdes. These resources will include but are not limited to bulletins, protocols and practice guidelines.

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 is planned in collaboration with the Department of Ob/Gyn and NICU at Baptist Hospital.

DATE REVIEWED: July 12, 2013 REVIEWED BY: ☒ EXECUTIVE COMMITTEE ☐ CHAIRMAN

APPROVED: ☐ YES ☐ NO Category 1 Credits: 3.0 Continuing Psychology Education Credits: 0 ☐ N/A
CME ACTIVITY TITLE: Reducing Transfusions and Phlebotomy

DATE: Ongoing

CREDIT HOUR APPLIED FOR: 1.25 Cat. 1

Original Approval: July 2012

Course reviewed: July 2013

Course expires: July 2014

CONFERENCE DIRECTOR: Ricardo Estape, M.D.

CONFERENCE COORDINATOR: Leticia Sosa, R.N.

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

TARGET AUDIENCE: Hospitalists, House Physicians, Surgeons, Emergency Medicine Physicians, Physicians Assistants and Nurses. 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 inpatient management. In addition, physicians that identify conditions and refer patients to a hematologist, and those specialists to whom a house physician and hospitalists 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: 30-35

CHARGE: 0

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

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
- Best practice parameters
- 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. The Blood Conservation Program at South Miami Hospital has identified that the number of inpatient blood transfusions are higher than desired.

WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?) Physicians will recognize risk associated with unnecessary transfusion and alter their clinical practice to improve patient care.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to physician:
- Knowledge (They do not know that they need to be doing something.)
- Competence (They do not know how to do it)
- Performance (They know how to do it but are non-compliant - or are not doing it properly)
DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)

And will this result in □ 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 reduce the number of unnecessary inpatient blood transfusions ordered at South Miami Hospital.

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

► As the risks of allogeneic blood transfusion (ABT)-transmitted viruses were reduced to exceedingly low levels in the US, transfusion-related acute lung injury (TRALI), hemolytic transfusion reactions (HTRs), and transfusion-associated sepsis (TAS) emerged as the leading causes of ABT-related deaths. Since 2004, preventive measures for TRALI and TAS have been implemented, but their implementation remains incomplete. Infectious causes of ABT-related deaths currently account for less than 15% of all transfusion-related mortality, but the possibility remains that a new transfusion-transmitted agent causing a fatal infectious disease may emerge in the future. Aside from these established complications of ABT, randomized controlled trials comparing recipients of non-white blood cell (WBC)-reduced versus WBC-reduced blood components in cardiac surgery have documented increased mortality in association with the use of non-WBC-reduced ABT. ABT-related mortality can thus be further reduced by universally applying the policies of avoiding prospective donors alloimmunized to WBC antigens from donating plasma products, adopting strategies to prevent HTRs, WBC-reducing components transfused to patients undergoing cardiac surgery, reducing exposure to allogeneic donors through conservative transfusion guidelines and avoidance of product pooling, and implementing pathogen-reduction technologies to address the residual risk of TAS as well as the potential risk of the next transfusion-transmitted agent to emerge in the foreseeable future. (Blood. 113(15):3406-17, 2009 Apr 9.)

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

- Recognize risks associated with blood transfusion and describe alternative strategies to red blood cell transfusion for anemia and bleeding.
- Minimize non-essential phlebotomy in hospital patients.
- Implement evidence-based blood management guidelines.

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)
Minimum passing score on examination 75% or higher.

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State) (If necessary, attach a list.)
Steven Fein, M.D.
Hematologist and Oncologist
Baptist Hospital, South Miami, Homestead, Mariners, Doctors, and West Kendall Baptist Hospitals

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

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

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

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)
- [X] 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)

- [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 meeting has been planned in collaboration with Blood Conservation Program at South Miami Hospital.

**DATE REVIEWED:** July 12, 2013  REVIEWED BY: ✗ EXECUTIVE COMMITTEE  ☐ CHAIRMAN

**APPROVED:** ✗YES  ☐ NO  Category 1 Credits: 1  Continuing Psychology Education Credits: ___  ☐ N/A

Original approval: July 2012; Course reviewed: July 2013; Course expires: July 2014

TIME: Schedule will be coordinated by the Human Patient Simulation Laboratory Coordinator.

LOCATION: Baptist Hospital, Simulation Laboratory

CREDIT HOURS APPLIED FOR: 3 Category 1 each

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

CONFERENCE DIRECTOR: Luis A. De La Cruz, M.D.

TARGET AUDIENCE (Anesthesia and Perioperative Simulation Training) Obstetricians, Neonatologists, Anesthesiologists, Nurse Anesthetists (CRNAs), Perioperative Nurses, Labor and Delivery Nurses. 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 anesthesiology, perioperative medicine. In addition, those specialists who may participate in perioperative crisis resource management and members of the hospital care team, i.e.: perioperative nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 50-60 annually 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 (specify): Simulation Laboratory Training

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
- [ ] Research/literature review
- [ ] Process improvement initiatives (C16 & 21)
- [ ] 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 the value of successful team behavior and effective communication techniques and their impact on patient outcomes. High acuity and rare events in the operating room, perioperative areas and labor and delivery are stressful scenarios in which a practitioner may have limited experience.

WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'? ) 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 physician:
- [ ] Knowledge (They do not know that they need to be doing something.)
- [ ] Competence (They do not know how to do it)
- [ ] Performance (They know how to do it but are non-compliant - or are not doing it properly)
DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)

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

► Obstetricians, Anesthesiologists, Neonatologists on Medical Staff, Perioperative nurses and Labor & Delivery nurses participate in the simulation laboratory to improve function and communicate effectively during a crisis situation to enhance teamwork and ultimately to identify and correct systems problems and improve patient outcomes.

Goal: At the conclusion of one year, at least half of all BHM anesthesiologists physicians would have completed simulation training.

*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)

As the obstetric demographic becomes older and more obese, new technologies and strategies can assist in controlling maternal death and major morbidity secondary to anesthesia complications. Lipid resuscitation appears to be an effective treatment for toxicity induced by lipophilic medications and may be useful in treating systemic toxicity in the pregnant patient. Obstetric care providers should be aware of lipid resuscitation and consider its use as described by American Society of Regional Anesthesia and Pain Medicine guidelines. (Current Opinion in Anesthesiology 2011,24:262–267)

EDUCATIONAL OBJECTIVES:

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

▪ Effectively communicate within a multidisciplinary, multispecialty team in the intra-operative and/or perioperative setting during a crisis situation to optimize patient outcomes and improve patient safety.

▪ Implement crisis resource management principles in clinical practice.

▪ Manage anesthesia related intra-operative and/or perioperative emergencies.

▪ Utilize human patient simulator experience to identify system problems, formulate and implement system changes to improve patient outcomes.

FORMAT AND SCENARIOS:

Anesthesia and Perioperative Simulation Lab case scenarios including but not limited to maternal hemorrhage, shoulder dystocia and pre-eclampsia

A. Introduction & Orientation: Participants will be given an orientation of the simulation room lay-out and location of supplies. Participants will be asked to sign a confidentiality agreement stipulating they will not disclose any information regarding the scenarios presented.

B. Case Scenarios: Participants will go through at least two crisis scenarios which will take about fifteen to twenty minutes each to complete.

► Scenario I: Local Anesthetic Toxicity Scenario

► Scenario II: High Spinal/Epidural in an Obstetrical Patient

C. Debriefing: A thirty minute debriefing session will follow each scenario during which participants will review their performance with a course facilitator.

D. Handouts: Based on participants’ performance they will receive evidence-based resources as reinforcement and reference tools. These evidence-based resources include but are not limited to practice bulletins, protocols and guidelines.

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 your participation in the simulation training, what do you intend to do differently? What new strategies will you apply to your practice?
SIMULATION TRAINING COURSE FACILITATORS:
Luis A. De La Cruz, M.D.
Cardiac Anesthesiologist and Intensivist
Conference Director and Course Facilitator
Patient Safety Simulation Lab at Baptist Hospital

Maria Victoria Lopez, M.D.
Obstetrician and Gynecologist
Course Facilitator
Patient Safety Simulation Lab at Baptist Hospital

Melody McNally ARNP, BC
Manager, Patient Safety Simulation Lab at Baptist Hospital

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).
- Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
  Yes ☒ No ☐ Continuing Medical Education Dept. Leadership and Staff
  ☒ Continuing Medical Education Committee ☒ Conference Director (see above)
  ☐ Others (i.e.: Conference Coordinator, Planning Group etc.): Core Group of Contributors: Melody A. McNally, ARNP
  Maria Victoria Lopez and Luis de la Cruz, M.D.

CONFIDENTIALITY: Due to the nature of this course, participant performance and the clinical case scenarios discussed are confidential. All participants will be asked to sign a confidentiality agreement at the time of the training by the course facilitator. Participants' performance can not be used as an outcomes measurement.

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

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

This course is intended to improve teamwork and communication among healthcare providers in labor and delivery by simulating real-life emergency scenarios commonly seen in this area.

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)

In support of the CME Program mission, this activity was developed to improve to patient care, safety and treatment outcomes by bringing about change in physician behavior during a crisis situation. The impact of this activity will be measured and documented through evaluation data collected immediately after simulation training session.

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: Articles: Medical Memo and Foundation News articles. Handouts: Based on participants’ performance they will receive evidence-based resources selected by Dr. Luis A. de la Cruz. These resources will include but are not limited to bulletins, protocols and practice guidelines.

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 is planned in collaboration with the Department of Anesthesiology and the department of Ob/Gyn at Baptist Hospital.

DATE REVIEWED: July 12, 2013 REVIEWED BY: ☒ EXECUTIVE COMMITTEE ☐ CHAIRMAN
APPROVED: ☐ YES ☒ NO Category 1 Credits: 3.0 Continuing Psychology Education Credits: 0 ☐ N/A
CME ACTIVITY TITLE: Neonatology Crisis Resource Management – Team Training

DATES: July 2013 to July 2014

TIME: Schedule will be coordinated by the Melody McNally, Manager, Patient Safety Simulation Laboratory

LOCATION: Baptist Hospital of Miami, Patient Safety Simulation Laboratory

CREDIT HOURS APPLIED FOR: 3.0 Category 1

CLINICAL LEARNING COURSE APPROVALS
Course Name: Neonatal Crisis Resource Management Course- Team Training
CE Broker number:

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

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

TARGET AUDIENCE Neonatologists, Neonatal Nurse Practitioners, Neonatal Nursing Staff, Respiratory Therapists, Obstetricians and Labor and Delivery Nurses. 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 and nurses in the practice of neonatal resuscitation. In addition, any other specialists or staff who may participate in high-risk delivery and newborn resuscitation.

EXPECTED NUMBER OF ATTENDEES: 50-55

CHARGE: $1,400 for up to 6 participants per course. Group discount available for entities booking 3 or more groups at one time.

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

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: ___________________________
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. High acuity and rare events occur during the delivery and resuscitation of neonates. This may present stressful scenarios in which a practitioner may have limited experience.

WHAT IS THE OPTIMAL PRACTICE***? (In a ‘perfect world’, what would doctors be doing? What does optimal practice ‘look like’?) 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 physician:
- Knowledge (They do not know that they need to be doing something.)
- Competence (They do not know how to do it)
- Performance (They know how to do it but are non-compliant - or are not doing it properly)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☑ Competence? -or- ☑ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.)
*(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)
- Practitioners will communicate effectively during a crisis situation to enhance teamwork and ultimately to identify and correct systems problems and improve patient outcomes.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
- Simulation-based training has opened up a new educational application in medicine. Evidence-based practices can be put into action by means of protocols and algorithms, which can then be practiced via simulation scenarios. Teamwork training conducted in the simulated environment may also offer an additive benefit to the traditional didactic instruction, enhance performance, and possibly also reduce errors. The cost-effectiveness of potentially expensive simulation-based medical education and training should be examined in terms of improvement of clinical competence and its impact on patient safety. Perhaps, with the adoption of simulation as a standard of training and certification, health care systems will be viewed as more accountable and ethical by the population they serve. (J Emerg Trauma Shock. 2010 Oct-Dec; 3(4): 348–352. Simulation-based learning: Just like the real thing)
- Sentinel Event #30 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_30.PDF)
- Resuscitating neonates is a critical skill set for obstetric and neonatal care providers. Simulation-based training is gaining more recognition in healthcare as a method of training that incorporates adult learning theory, real-time clinical situations, and video debriefing of the scenario to allow a healthcare team an opportunity to practice skills and evaluate their performance. (Journal of Perinatal & Neonatal Nursing. Making the move from tradition neonatal education to simulation-based training, 22 (2):154-8, 2008 Apr-Jun.)

EDUCATIONAL OBJECTIVES:
Upon completion of this course, participants should be better able to:
- Effectively communicate within a multidisciplinary team during neonatal resuscitation to optimize patient outcomes and improve patient safety.
- Implement crisis resource management principles in clinical practice.
- Manage neonatal emergencies following guidelines set forth by the Neonatal Resuscitation Program

FORMAT AND SCENARIOS: NICU Simulation Lab case scenarios designed to simulate situations requiring neonatal resuscitation. Examples including but not limited to diaphragmatic hernia, pneumothorax, placental abruption and cardiac tamponade.
A. Introduction & Orientation: Participants will be given an orientation of the simulation room lay-out and location of supplies. Participants will be asked to sign a confidentiality agreement stipulating they will not disclose any information regarding the scenarios presented.
B. Case Scenario: Participants will go through one crisis scenario which will take about fifteen to twenty minutes to complete.
- Scenario I: UAC dislodged
C. Debriefing: A thirty minute debriefing session will follow the scenario during which participants will review their performance with a course facilitator.

D. Handouts: Based on participants’ performance they will receive evidence-based resources as reinforcement and reference tools. These evidence-based resources include but are not limited to practice bulletins, protocols and guidelines.

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
- Other:

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

SCENARIO/S (Strongly Agree 5 - Strongly Disagree 1)

Regarding the scenario/s in which you participated, to what extent would you agree that:

- The content of the scenario/s was current and relevant to my practice.
- The scenario/s was/were realistic.

DEBRIEFING

Regarding the debriefing, to what extent would you agree that:

- The debriefing encouraged open dialogue.
- I felt at ease throughout the debriefing discussion.
- The debriefing helped me discover areas of improvement.

Would you recommend this course to your colleagues in Labor and Delivery?

What did you take away from the debriefing process? In what ways did you benefit from the discussion?

Give an example of how the debriefing discussion changed your perspective on how to apply crisis resource management in your clinical practice.

SIMULATION TRAINING COURSE FACILITATORS:

Norma Bonilla, R.N.
Nurse, Baptist Hospital of Miami
Course Facilitator, Patient Safety Simulation Lab

Alreca Daly, R.N.
Clinical Educator I
NICU, Baptist Hospital of Miami
Course Facilitator, Patient Safety Simulation Lab

Maria Victoria Lopez, M.D.
Medical Director, Patient Safety Simulation Lab
Baptist Health South Florida

Melody McNally ARNP, BC
Manager, Patient Safety Simulation Lab
Baptist Health South Florida

William Smalling M.D.
Neonatologist, Baptist Hospital of Miami
Course Facilitator, Patient Safety Simulation Lab

Ernesto Valdes, M.D.
Neonatologist, Baptist Hospital of Miami
Course Facilitator, 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
- Continuing Medical Education Dept. Leadership and Staff
- Continuing Medical Education Committee
- Conference Director (see above)
- Others (i.e.: Conference Coordinator, Planning Group etc.): Core Group of Contributors: The following contributed to scenario development and design. Norma Bonilla, R.N., Alreca Daly, R.N., William Smalling M.D. and Ernesto Valdes, M.D.
CONFIDENTIALITY: Due to the nature of this course, participant performance and the clinical case scenarios discussed are confidential. All participants will be asked to sign a confidentiality agreement at the time of the training by the course facilitator. Participants’ performance can not be used as an outcomes measurement.

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

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners? ☑ Yes ☐ No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers. This course is intended to improve teamwork and communication among healthcare providers by simulating real-life emergency scenarios commonly seen in this area.

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: Handouts: Based on participants' performance they will receive evidence-based resources selected by Dr. Maria Victoria Lopez or Melody McNally. These resources will include but are not limited to bulletins, protocols and practice guidelines.

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 is planned in collaboration with the Baptist Health Patient Safety Simulation Lab.

DATE REVIEWED: August 2, 2013 REVIEWED BY: ☐ Executive Committee ☑ Chairman APPROVED: ☑ YES ☐ NO ■ Credits: AMA/PRA Category 1 Credits: # 3.0 ■ Continuing Psychology Education Credits: # N/A ■ Continuing Dental Education Credits: # N/A

Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>8:45 a.m.</td>
<td>Registration and Refreshments</td>
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<tr>
<td>9:00 a.m.</td>
<td>Welcome and Introductions</td>
</tr>
<tr>
<td>9:15 a.m.</td>
<td>Crisis Resource Management Lecture</td>
</tr>
<tr>
<td>9:40 a.m.</td>
<td>Orientation to the Simulation Lab</td>
</tr>
<tr>
<td>10:00 a.m.</td>
<td>Scenario 1 with Debriefing</td>
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<tr>
<td>11:00 a.m.</td>
<td>Scenario 2 with Debriefing</td>
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<tr>
<td>12:00 noon</td>
<td>Closing Remarks &amp; Course Evaluation</td>
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<tr>
<td>12:15 p.m.</td>
<td>Adjourn</td>
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</tbody>
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CME ACTIVITY TITLE: Multidisciplinary Approach to Development of a Maternal Hemorrhage Management Plan

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

Original Approval: July 2012  Course Reviewed: July 2013  Course Expiration Date: August 2014

PLANNING GROUP: K. Magalie Apollon, M.D./Luis A. de la Cruz, M.D./Victoria Lopez-Beecham, 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
- PI CME activity
- Live activity
- Enduring Material (DVD)
- Internet-Home Study
- Other (specify)

TARGET AUDIENCE: OB/GYNs, Anesthesiologists, Emergency Medicine Physicians and Intensivists. 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 ob/gyn, anesthesiology and critical care medicine.

EXPECTED NUMBER OF ATTENDEES: 10-15 a year  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 (DVD)
- 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): Protocol 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 (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. There is currently no system-wide maternal hemorrhage plan.

WHAT IS THE OPTIMAL PRACTICE**? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like'? ) Physicians apply concepts learned at Baptist Hospital to collaborate within their institution to develop a comprehensive multidisciplinary maternal hemorrhage plan.

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

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

► Physicians collaborate to develop and implement a comprehensive maternal hemorrhage plan within their institution.

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

► Baptist Hospital Departments of Ob/Gyn, Anesthesia and Pharmacy collaborated to develop a multidisciplinary, evidence-based maternal hemorrhage plan. Physician leaders, Dr. Luis de la Cruz and Dr. Katia Apollon will share their experience and explain the best practices implemented at Baptist Hospital. The plan was developed based in part on evidence-based guidelines published and developed by the California Maternal Quality Care Collaborative. (http://www.cmqcc.org/resources/ob_hemorrhage/ob_hemorrhage_care_guidelines_checklist_flowchart_tablechart_v1_4)

EDUCATIONAL OBJECTIVES:

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

- Collaborate within an institutional setting to develop an evidence-based multidisciplinary hemorrhage plan.
- Incorporate best practices regarding post-partum hemorrhage in clinical practice.
- Utilize evidence-based prevention approaches to coagulopathy in post-partum hemorrhage.

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)

Luis A. de la Cruz, M.D.
Anesthesiologist and Critical Care Medicine Specialist
Baptist Hospital of Miami

K. Magalie Apollon, M.D.
Obstetrician and Gynecologist
Baptist Hospital

Melody McNally, ARNP, BC
Baptist Hospital of Miami

Jennifer Cummings, RNC
Baptist Hospital of Miami

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

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

☒ Yes ☐ No ☒ 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.
Explain: The Baptist Hospital departments of Ob/Gyn and Anesthesia are collaborating within the BHSF system to facilitate education for physicians regarding the process involved in developing an evidence-based multidisciplinary maternal hemorrhage plan.

**DATE REVIEWED:** August 2, 2013  REVIEWED BY:  ☒ Executive Committee  ☐ Chairman
APPROVED:  ☐ YES  ☐ NO  Credits: AMA/PRA Category 1 Credits: #  _1_
Continuing Psychology Education Credits: #  _0_  N/A  Continuing Dental Education Credits: #  _ __  N/A
CME ACTIVITY TITLE: Internet Point of Care Learning

LOCATION: Online available through BaptistHealth.net/IPoCLearning

CREDIT HOUR(S) APPLIED FOR: .5 Category 1 per submission. Physicians may claim up to 20 AMA PRA Category 1 credits™ per year, for this activity.

TARGET AUDIENCE: All physicians, physician assistants and nurse practitioners who claim AMA PRA Category 1 credit™ and who participate in practice-based self-directed online learning in support of specific patient care.

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 that are self-identified and relevant to a physician’s current practice of medicine.

EXPECTED NUMBER OF SUBMISSIONS: 10 submissions per year

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): Internet Point of Care Learning

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): Self-directed point of care learning

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: Self-directed learning allows physicians to address factors outside of CME department control.

PROFESSIONAL PRACTICE GAP (C2)

WHAT IS THE CURRENT PRACTICE and PRACTICE GAP? Current Physician Practice will be identified by participants through the step 1: Clinical Question, What is the clinical question you are researching?

WHAT IS THE OPTIMAL PRACTICE? Optimal practice will be identified through physicians’ research and will be documented through step 3 “Document the References You Used”.

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

References: Internet POC is a relatively new method for obtaining CME credits. It is a method of structured, self-directed, online physician learning about topics relevant to clinical practice. Baptist Health’s Continuing Medical Education (CME) Department values real-time learning and recognizes its impact on improving delivery of patient care. Internet PoC learning, although predicated on the delivery of relevant clinical information when most needed, offers physicians considerable flexibility in choosing when to access electronic clinical resources and document the application of their searches to practice. (AMA CME CPPD Report, Spring 2005, Number 16)

DESIRED OUTCOMES (GOAL): Will this result in a change in Competence? -or- Performance? -or- Patient Outcomes? (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?

► Physicians will follow internet point of care learning process to research and cite resources to answer clinical question and apply this information to clinical practice.

EDUCATIONAL OBJECTIVES:
Upon completion of a PoC CME activity, participants should be better able to:
• Apply appropriate recommendations to patient care based on research of valid evidence-based sources for practice recommendations.
• Participate in a reflective process which includes documentation of their clinical question, the sources consulted and the application to practice.

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: Evaluation feedback will be summarized on an annual basis.

OUTCOMES MEASUREMENT: (C11)
Step 5: Evaluation and Credit Submission
1. My participation in this Internet PoC learning process resulted in a change in my: (Please check all that apply)
   □ Competence (Learned how to do something new).
   □ Performance as measured by application to clinical practice (Learned something new and did it).
   □ Patient outcomes (Performance resulted in improvement in patient health status).
2. Please check all that apply to the outcomes of your Internet PoC learning process.
   □ Reinforced my clinical decision.
   □ Confirmed a diagnosis.
   □ Reviewed a condition not managed recently or regularly.
   □ Applied a new clinical guideline to my practice.
   □ Translated knowledge into clinical practice.
   □ Improved patient’s clinical outcomes.
   □ Other
3. If the course of management and/or diagnosis was changed, how was it changed? (check all that apply) *
   □ Choice in treatment/management
   □ Changes in pharmaceutical therapy
   □ Monitoring of therapy
   □ Referral for a consultation
   □ Changes in diagnostic tests
   □ Recommendations for preventive care
   □ Change in differential diagnosis
   □ Other
4. Would you use this method of learning again?
   □ Yes
   □ No

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 N/A ☐ Others (i.e.: Conference Coordinator, Planning Group etc.) __________

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

BARRIERS TO PHYSICIAN CHANGE: (C19) Is this activity focused on ‘overcoming, addressing, or removing barriers to physician change’ applicable to our learners? ☒ Yes ☐ No If 'yes', list the barrier(s) identified and include relevant data and information about the barriers.
Physicians have limited time to participate in live CME activities; this format allows physicians to claim time spent on point of care learning. Education is available as physicians need the information at the bedside, directly improving delivery of patient care.
**OVERALL PROGRAM CHANGES:** Does this CME activity reflect implementation (C14) of any interventions or changes that came about as a result of our overall CME program evaluation and analysis (C13) to meet the CME mission?  
Yes [x] 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  
- [x] Reminders (Posters, mailings, email blasts)  
- [ ] New order sheets  
- [x] Other tools or tactics  

Explain: Hard copies of Internet PoC forms will be placed in Medical Libraries to facilitate access to forms.

**COLLABORATION:** Are we engaged in collaborative and cooperative projects with other internal or external stakeholders that are related to this CME activity? (C20) Are we collaborating in partnership with other organizations in a purposeful manner to achieve common interests?  
Yes [x] No  

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

Internet PoC offered in collaboration with Performance Improvement VP and Medical Library to bring learning to the point of care.

**DATE REVIEWED:** April 07, 2010  
**REVIEWED BY:** EXECUTIVE COMMITTEE [ ] CHAIRMAN [x]  
**APPROVED:** YES [x] NO  
**Category 1 Credits:** .5 per submission  
**Continuing Psychology Education credits:** 0  

**Course Reviewed & Renewed:** 9/28/2010; September 9, 2011; September 2012; September 2013
CME ACTIVITY TITLE: Peripartum Hemorrhage and Disseminated Intravascular Coagulation- Diagnosis and Treatment

DATE/TIME: Ongoing

Original Approval: September 2012; Course Reviewed: September 2013; Course Expiration: September 2014

LOCATION: CME Internet Course & Archive Page    CREDIT HOUR(S) APPLIED FOR: 1.25 Cat. 1

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

TARGET AUDIENCE: Obstetricians and Gynecologists. 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 obstetrics and gynecology and those specialists to whom a ob/gyn 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
- Internet-Home Study
- Enduring Material
- Question & Answer
- Case Studies
- Panel
- Internet-Home Study
- Other (specify)

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

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

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

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

- Physicians are not screening for iron deficiency in advance. Physicians are not certain of what is considered clinically significant peripartum hemorrhage and DIC and which interventions are most appropriate in each scenario.

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

- Physicians consistently screen for iron deficiency in advance. Physicians are able to identify clinically significant peripartum hemorrhage and DIC and implement the appropriate course of treatment.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
- Knowledge (Doctors do not know that they need to be doing something.)
- Competence (Doctors do not know how to do it)
- Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)
DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in □ Competence? -or- □ Performance? -or- □ Patient Outcomes*? (Check all that apply.)
*(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Peripartum hemorrhage is an important source of maternal and fetal morbidity and mortality. The prognosis for both mother and child can be markedly improved if the risk factors for hemorrhage are recognized and the problem is treated rapidly and appropriately when it arises. (Deutsches Ärzteblatt International Dtsch Arztebl Int 2008; 105(37): 629–38)
The diagnosis of DIC is based on the presence of typical clinical features (bleeding, shock, respiratory distress, renal failure) supported by laboratory findings of coagulopathy. The key elements in managing the pregnant woman with DIC are to identify and treat the underlying disorder and provide supportive care, particularly replacement of blood products. (uptodate.com, Disseminated Intravascular Coagulation During Pregnancy, May 2012)

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
 Define and identify clinically significant peripartum hemorrhage and disseminated intravascular coagulation (DIC).
 Prescribe appropriate interventions for peripartum hemorrhage and DIC.
 Implement strategies to consistently screen pregnant patients for iron deficiency to minimize the impact of peripartum hemorrhage.

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.)

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

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

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

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.

DATE REVIEWED: September 28, 2012 REVIEWED BY: Executive Committee Chairman
August 23, 2013
APPROVED: Yes No

Credits: AMA/PRA Category 1 Credits: #1.25
Continuing Psychology Education Credits: #0 N/A
Continuing Dental Education Credits: #0 N/A
CME ACTIVITY TITLE: Cardiovascular Conference Series: Diabetes and Cardiovascular Disease – New Strategies to Reduce CVD Risk

DATE: Thursday, September 12, 2013  TIME: 12 noon- 1 p.m.  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

LOCATION: BHM, 5BCVI, VC to HH Phys Dining Rm, SMHC Conf. Room and Live Webcast

CONFERENCE DIRECTOR: Jonathan Roberts, M.D.

TARGET AUDIENCE: Cardiologists, Interventional Cardiologists, Interventional Radiologists, Family Medicine Physicians, Emergency Medicine Physicians, Endocrinologists, Hospitalists, Nurses and other interested healthcare providers. In addition, describe how the content of the activity is aligned with the target learners' current or potential scope of practice (C4). This activity addresses professional practice gaps relevant to physicians in the practice of cardiology. In addition, physicians that identify conditions and refer patients to an endocrinologist, and those specialists to whom a family 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:  50-60  CHARGE:  0

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

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): ________________

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 properly controlling hyperglycemia nor other CVD risk factors in patients with diabetes.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like’?)
Physicians adequately control both hyperglycemia and other CVD risk factors in patients with diabetes to improve care outcomes.

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

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
Will this result in a change in ☑ Competence? -or- ☑ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.)
*(NOTE: If 'patient outcomes’ is selected, there must be an achievable measurement plan.)
► Physicians will identify risk factors for DVD in diabetic patients and implement prevention strategies.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Diabetes mellitus is a common disorder which is frequently misunderstood and often not treated optimally. Although usually thought of in terms of the acute symptoms and long term consequences associated with elevated glucose levels, diabetes is a complex metabolic disorder with abnormalities in carbohydrate, lipid, and protein metabolism. Declines in CVD mortality in this country in the past 30 years have been smaller among diabetics than among non-diabetics. Most diabetic patients die of cardiovascular disease (CVD), with CVD rates in diabetics two to four times those of the non-diabetic population. This
increased CVD risk, along with the increasing prevalence of obesity and increasing numbers of elderly and minorities in the U.S. population, means that diabetes-associated CVD will become an even greater public health problem in the future. Diabetes can increase the risk of CVD in several ways, including the effects of elevated blood sugar (e.g., acute alterations in blood lipids and coagulation factors, protein glycosylation causing damage to the kidneys and secondary hypertension, direct toxic effects on the vasculature potentiating the development of atherosclerosis), the combination of hyperglycemia with other CVD risk factors to exacerbate the risk for a given profile of non-glucose CVD risk factors, and the worsening of multiple other CVD risk factors levels (insulin resistance syndrome). Due to these complex co-morbid conditions, control of hyperglycemia, although important, may not be sufficient to substantially reduce morbidity and mortality.

Diabetes is not a single disease and although common forms of diabetes are associated with an increased risk of CVD, the type of diabetes may have implications for the approach to preventing its cardiovascular complications. Current recommendations for CVD prevention generally apply to both Type 1 and Type 2 diabetes. In the U.S., approximately 10 percent of diabetic patients have Type 1 diabetes (previously called insulin dependent diabetes or IDDM) while approximately 90 percent have Type 2 diabetes (previously called non-insulin dependent diabetes or NIDDM)

While glucose control also appears important for Type 2 patients, it is critical not to overlook treatment of other associated CVD risk factor abnormalities. For prevention of cardiovascular complications, control of these other risk factors may have a greater effect than glucose control. Nevertheless, several recent studies indicate that in clinical practice, neither hyperglycemia nor other CVD risk factors are adequately controlled in patients with diabetes.

http://www.nhlbi.nih.gov/funding/initls/archive/cardior.htm

Category: Diabetes/ Endocrinology/ Metabolism
Condition/Procedure: Diabetes
Age Group: All Adults, Ages 18+
Time Period: October 2011 through September 2012
Time Period (15 Day Readmission rate): April 2011 through March 2012

<table>
<thead>
<tr>
<th>Facility</th>
<th>Total Hospitalizations</th>
<th>Charges Low</th>
<th>Charges High</th>
<th>Average Length of Stay</th>
<th>15 day Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
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<td>$31,218</td>
<td>3.4 days</td>
<td>7.48%</td>
</tr>
<tr>
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<td>$42,116</td>
<td>3.5 days</td>
<td>★★ 3.39%</td>
</tr>
<tr>
<td>DOCTORS HOSPITAL</td>
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<td>$48,921</td>
<td>6.2 days</td>
<td>★★ 6.63%</td>
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<tr>
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<td>$15,918</td>
<td>$31,526</td>
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<td>★ 12.92%</td>
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<tr>
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<td>$37,210</td>
<td>2.8 days</td>
<td>★★ 3.64%</td>
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<tr>
<td>WEST KENDALL BAPTIST HOSPITAL</td>
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<td>$21,826</td>
<td>$42,484</td>
<td>3.3 days</td>
<td>★★ 6.05%</td>
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</tbody>
</table>

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
- Identify the risk factors for cardiovascular disease (CVD) in diabetes and implement prevention strategies.
- Assess new drugs for diabetes management with potential CVD benefits.
- Evaluate available strategies to reduce risk of CVD through control of lipids, blood pressure, and glycemia, and utilization of coronary revascularization techniques to improve outcomes for diabetic patients.

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 TreatmentModalities ☐ Limited or No Diagnostic Modalities
Other: ___________________________

COMPETENCIES: What desirable physician attributes (e.g. professional competencies) set forth by national organizations of medicine (e.g.: IOM, ACGME, ABMS) does this activity address? (C6)
☒Patient Care ☒Medical Knowledge ☐ Interpersonal and Communications Skills
**EVALUATION METHOD(S):** Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

- [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:

<table>
<thead>
<tr>
<th>FACULTY:</th>
<th>(Name, Specialty and/or Title(s), Institution(s), City, State)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard W. Nesto, M.D.</td>
<td>Executive Vice President and Chief Medical Officer</td>
</tr>
<tr>
<td></td>
<td>Professor of Medicine</td>
</tr>
</tbody>
</table>

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

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

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

**BARRIERS TO PHYSICIAN CHANGE:** Is this activity focused on 'overcoming, addressing, or removing barriers to physician change' applicable to our learners?  

- [x] 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 (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.

- [x] 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)

- [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.

**DATE REVIEWED:** August 2, 2013  
**REVIEWED BY:**  
**APPROVED:**  
**Credits:**  
**Continuing Psychology Education Credits:**
**Continuing Dental Education Credits:**

[ ] N/A
CME ACTIVITY TITLE: Cardiovascular Conference Series: Hot Topics in Endovascular Medicine: An Overview of Renal Denervation

DATE: Friday, September 13, 2013
TIME: 12 noon – 1 p.m.

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

CONFERENCE DIRECTOR: Harry Aldrich, M.D.

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


This activity addresses professional practice gaps relevant to physicians in the practice of cardiology. In addition, physicians that identify conditions and refer patients to a cardiologist, and those specialists to whom a cardiologist might refer for further evaluation or treatment, are also included in the target audience, as are members of the hospital care team, i.e.: nurses, technologists, etc.

EXPECTED NUMBER OF ATTENDEES: 35-40
CHARGE: 0

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

NEEDS ASSESSMENT RESOURCES- HOW ARE EDUCATIONAL NEEDS IDENTIFIED? (Check all that apply and explain in professional practice gap.)
- Best practice parameters
- Consensus of experts
- Joint Commission initiatives
- Mortality/morbidity statistics
- National Pt Safety Goals
- National/regional data
- Other (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.
- Physicians may not be aware of the benefits of renal denervation (RDN) to reduce hypertension.

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

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
- Knowledge
- Process
- Systems
- Resources
- Environment
- Leadership
- Other:

New or updated policy/protocol
Patient care data
Peer review data
Process improvement initiatives (C16 & 21)
Research/literature review
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 effectively identify patients with resistant hypertension who may benefit from renal denervation (RDN) procedure and refer for appropriate treatment.

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

Resistant hypertension is defined in the 2008 American Heart Association guideline as blood pressure that remains above goal in spite of concurrent use of three antihypertensive agents of different classes, one of which should be a diuretic. Patients whose blood pressure is controlled with four or more medications are considered to have resistant hypertension. Patients with resistant hypertension are at high risk for adverse cardiovascular events and are more likely than those with controlled hypertension to have a secondary cause, which is usually at least in part reversible.
An essential component of the treatment of resistant hypertension is identification and treatment of potentially reversible causes of secondary hypertension. The most common are obstructive sleep apnea, primary aldosteronism and renal artery stenosis.

Catheter-based radiofrequency ablation of the renal sympathetic nerves lowers blood pressure in patients with resistant hypertension. This procedure was tested in the Symplicity-HTN-2 trial of 106 patients with resistant hypertension despite treatment with an average of five antihypertensive medications including a diuretic. The patients were randomly assigned to renal sympathetic denervation or maintenance of previous medical therapy. At six months, radiofrequency ablation significantly decreased the office blood pressure from 178/97 to 143/85 mmHg compared with no decrease in blood pressure in patients maintained on baseline antihypertensive therapy. Long-term data regarding efficacy and safety of radiofrequency ablation remain limited. http://www.uptodate.com/contents/treatment-of-resistant-hypertension?detectedLanguage=en&source=search_result&search=renal+denervation&selectedTitle=1%7E5&provider=nonProvider

EDUCATIONAL OBJECTIVES
Upon completion of this conference, participants should be better able to:
• Review the principles of renal denervation (RDN) for treatment of poorly controlled hypertension.
• Assess indications for, limitations, complications and identify appropriate candidates who will benefit from this procedure.
• Recognize some of the new therapies poised to impact immediate future of endovascular interventions.

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

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

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

FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)
James F. Benenati, M.D.
Medical Director, Peripheral Vascular Laboratory
Interventional Radiologist
Baptist Cardiac & Vascular Institute
### 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?
  - Yes ☑️
  - No ☐

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

This event was planned in collaboration with the South Miami Heart Center.

### DATE REVIEWED:
- September 3, 2013

### REVIEWED BY:
- Executive Committee – Accelerated Approval
- 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: Inaugural SIM WARS Competition

DATE: Saturday, September 21, 2013  TIME: 9- 2:30 p.m.

LOCATION: South Miami Hospital, Auditorium  CREDIT HOUR(S) APPLIED FOR: 3.50

CONFERENCE DIRECTOR: Maria Victoria Lopez Beecham, M.D.

CONFERENCE COORDINATOR: Geri Schimmel, RN, MS, LHRM, CPPS

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, Respiratory Therapists and Social Workers. 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 [insert primary specialty(ies)]. In addition, physicians that identify conditions and refer patients to a [insert primary specialty(ies)], and those specialists to whom a [insert primary specialty(ies)] 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: 125  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) Simulation

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.
- Practitioners may not be aware of the simulation capabilities that are available at Baptist Health and how these resources can be utilized to improve individual and team performance, outcomes and safety. Practitioners may not be utilizing effective teamwork and communication skills.

WHAT IS THE OPTIMAL PRACTICE***? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
- Practitioners appreciate the value of simulation to teach Crisis Resource Management, to identify latent safety hazards and to improve process planning.

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.)
Practitioners implement crisis management techniques as a tool for improving patient safety.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
Simulation-based training has opened up a new educational application in medicine. Evidence-based practices can be put into action by means of protocols and algorithms, which can then be practiced via simulation scenarios. Teamwork training conducted in the simulated environment may also offer an additive benefit to the traditional didactic instruction, enhance performance, and possibly also reduce errors. The cost-effectiveness of potentially expensive simulation-based medical education and training should be examined in terms of improvement of clinical competence and its impact on patient safety. Perhaps, with the adoption of simulation as a standard of training and certification, health care systems will be viewed as more accountable and ethical by the population they serve. (J Emerg Trauma Shock. 2010 Oct-Dec; 3(4): 348–352. Simulation-based learning: Just like the real thing)
Sentinel Event #30 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_30.PDF)

EDUCATIONAL OBJECTIVES
Upon completion of this conference, participants should be better able to:
• Identify team behaviors that are essential for effective crisis management.
• Assess how simulation is an effective tool for improving patient safety.
• Explain what simulation capabilities are currently available at the Baptist Health Patient Safety Simulation Lab.
• Apply evidence-based practices from simulation-based medical education and training to improve clinical competence and patient safety.

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:
► Which type of simulation scenario presented will most impact your clinical practice and why? (List different types of SIMs presented.)
► As a result of your participation, please explain how simulation education can improve patient safety on your unit?
FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

Geri Schimmel, RN, MS, LHRM, CPPS
Director, Patient Safety Partnership
Baptist Health South Florida

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

Melody McNally ARNP, BC
Manager, Baptist Health Patient Safety Simulation Lab

Zulma Berrios, 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) 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 has been planned in collaboration with the Baptist Health Patient Safety Partnership and the Patient Safety Simulation Lab.

DATE REVIEWED: July 3, 2013
REVIEWED BY: ☒ Executive Committee   ☐ Chairman
APPROVED: ☒ YES   ☐ NO   ■ Credits: AMA/PRA Category 1 Credits: # 3.5
Continuing Psychology Education Credits: # N/A   ■ Continuing Dental Education Credits: # N/A

SCHEDULE
9 a.m.    Registration
9:15 a.m. Welcome and Introductions
9:30 a.m. SIM Wars
10:30 a.m. Debriefing lessons learned and discussion
10:45 a.m. SIM Wars
11:45 a.m. Lunch
12:45 p.m. SIM Wars
1:45 p.m. Debriefing lessons learned and discussion
2:00 p.m. Awards Presentation
2:30 p.m. Adjourn
CME ACTIVITY TITLE: Risk Management and Patient Safety: Diversity and Simulation Training

DATE: Wednesday, September 25, 2013
TIME: 5:30 Registration and Dinner; 6-8 p.m.

LOCATION: South Miami Hospital, Auditorium, Baptist Hospital, Auditorium, Homestead Hospital, Lime Room and West Kendall Baptist Hospital, Classroom 3 and Mariners Hospital, Main Conference Room

CREDIT HOURS APPLIED FOR: 2 Cat. 1

CONFERENCE COORDINATORS: Gerri Schimmel & Yvonne Zawodny

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

TARGET AUDIENCE: Physicians and all 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 as well as related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 50-55
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
☐ Enduring Material
☐ Panel
☐ Internet-Home Study
☒ Other (specify) Mock SIM

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

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

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

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

WHAT IS/ARE THE CURRENT PRACTICE* AND/OR THE PRACTICE GAP**? What are physicians doing (or not doing) that needs to change? Describe the practice gap.
► Physicians may not be aware of the procedures to utilize language access services with limited English proficiency (LEP) patients.
Physicians may not be familiar with the triadic interview process when conducting a clinical interview with the assistance of an interpreter.
Physicians may not know that there are medical-legal risks incurred if their culturally different and/or limited English proficiency (LEP) patients do not understand instructions and/or do not follow up with their treatments and as a result of this end up with severe complications.
Physicians may not be aware of importance of crisis resource management techniques.
WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)*
► Physicians will be more cognizant of cultural diversity and tailor their communication and interaction with patients and families. Physicians appreciate the importance of crisis resource management techniques.

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 successfully utilize language access services and triadic interview process. Physicians appreciate the importance of crisis resource management techniques and access available training through patient safety simulation lab.

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

EDUCATIONAL OBJECTIVES
Upon completion of this conference, participants should be better able to:
- Appreciate the importance of delivering culturally and linguistically appropriate medical care.
- Explain the legal ramifications of transculturally appropriate medical care.
- Utilize language access services with limited English proficiency (LEP) patients to help deliver appropriate medical care.
- Implement the triadic interview process appropriately.
- Explain the importance of crisis resource management communication techniques and consider the impact on delivery of safe, quality care.

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

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

OUTCOMES MEASUREMENT: (List strategy measurement questions and/or other measurement plans.) (C11)
► As a result of what you learned at this conference what do you intend to do differently? What new strategies will you apply to your practice?
► If you do not plan to implement any new strategies learned at this conference, please list any barriers or obstacles that might keep you from doing so: ____________________________
FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)

Ian Nisonson, M.D.
Urologist
Baptist and South Miami Hospitals

Maria Victoria Lopez, M.D.
Medical Director, Baptist Health Patient Safety Simulation Lab
Obstetrician and Gynecologist

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 planned in collaboration with the departments of Risk Management & Patient Safety and the Office of Diversity.

DATE REVIEWED: August 2, 2013 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: Pediatric Multispecialty Conference Series: A Practical Approach to the Diagnosis of Common Genetic Disorders in Infancy and Childhood

DATE: Tuesday, October 1, 2013
TIME: 6:00 – 7:15 p.m.

LOCATION: Baptist Hospital, Auditorium
CREDIT HOUR(S) APPLIED FOR: 1.25 Cat. 1

CONFERENCE DIRECTOR: Ernesto Valdes, M.D.

CME ACTIVITY TITLE:
Pediatric Multispecialty Conference Series: A Practical Approach to the Diagnosis of Common Genetic Disorders in Infancy and Childhood

DATE: Tuesday, October 1, 2013
TIME: 6:00 – 7:15 p.m.

LOCATION: Baptist Hospital, Auditorium
CREDIT HOUR(S) APPLIED FOR: 1.25 Cat. 1

CONFERENCE DIRECTOR: Ernesto Valdes, M.D.

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

TARGET AUDIENCE:
Pediatricians, Internists, Neurologists, Neonatologists, Pediatric Emergency Medicine Physicians, Pediatric Oncologists and Psychologists.

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 pediatrics and pediatric emergency medicine. In addition, physicians that identify conditions and refer patients to a pediatric geneticist are also included in the target audience, as are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 40-45
CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- 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
- Research/literature review
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- 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.
► Pediatricians do not know which diagnostic test to use with rare genetic disorders including inborn errors of metabolism. Physicians have difficulty explaining treatment expectations for genetic disorders to parents.

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

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

- Utilize genetic and metabolic testing more effectively to reduce costs and improve care.
- Explain the limitations of genetic and metabolic testing.
- Ascertain key family history and determine when to refer patient and family for genetic counseling.
- Discuss patient and family options for diagnosis and management of genetic disorders.

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

- Utilize genetic and metabolic testing more effectively to reduce costs and improve care.
- Explain the limitations of genetic and metabolic testing.
- Ascertain key family history and determine when to refer patient and family for genetic counseling.
- Discuss patient and family options for diagnosis and management of genetic disorders.

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

- Patient Care
- Medical Knowledge
- Interpersonal and Communications Skills
- Professionalism
- Systems-based Practice
- Practice-based Learning and Improvement
EVALUATION METHOD(S): Analyze the overall changes in competence, performance, or patient outcomes as a result of this CME activity. (C11) List the planned method(s) of evaluation:

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

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

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

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

Olaf A. Bodamer, M.D., Ph.D., FACMG, FAAP
Professor of Human Genetics, Biochemistry and Molecular Biology
Division of Clinical and Translational Genetics
Dr. John T. Macdonald Foundation Department of Human Genetics
University of Miami Miller School of Medicine
Miami, Florida

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty). 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) 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 to meet the educational needs they have identified.

DATE REVIEWED: July 1, 2013 REVIEWED BY: ☑ Executive Committee  ☑ Chairman

APPROVED: ☑ YES  ☑ NO  ■ Credits: AMA/PRA Category 1 Credits: #1.25

Continuing Psychology Education Credits: # N/A  ■ Continuing Dental Education Credits: # N/A
CME ACTIVITY TITLE: 2013 Baptist Health South Florida Research Summit: Managing Change in Clinical Research

DATE: Friday, October 4, 2013
TIME: 8:30am – 3:30pm

LOCATION: Marriott Miami Dadeland
9090 South Dadeland Boulevard
Grand Ballroom

CREDIT HOUR(S) APPLIED FOR: 5.25 Cat. 1

SUMMIT DIRECTOR: Thinh H. Tran, M.D.
SUMMIT COORDINATOR or PLANNING GROUP (if applicable): Lisa Trebbi, MBA, RN
Josefina Sanchez, CCRC

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, nurses and other healthcare professionals interested in pursuing medical research or those who are actively conducting medical research, as well as clinical research coordinators, research assistants and medical students.

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 involved in clinical research which can have a significant impact on patient care and the quality of that care. Also included are those related members of the care team who are involved in the research process, i.e.: nurses, coordinators etc.

EXPECTED NUMBER OF ATTENDEES: 120
CHARGE:
- Physicians $85
- Nurses and Research Coordinators $65
- BHSF Employees: $35
- FIU Students (Non-medical): $35

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

EXPECTED NUMBER OF ATTENDEES: 120

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): FDA regulations update and The Affordable Care Act provisions on clinical research trial eligibility and coverage effective January 1, 2014.

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.
- FDA regulations regarding clinical research trials are constantly changing and it is up to the researcher to stay on top of those updates in order to remain compliant. In addition, the clinical trials coverage provision of The Affordable Care Act becomes effective January 1, 2014 will have an even greater impact on eligibility requirements. Physicians and coordinators
involved in clinical research are likely not aware of all of these regulatory updates and how these changes will impact their research and the patients participating in clinical trials.

http://www.asco.org/sites/default/files/faq_clinical_trials_coverage_statute.pdf

► Numerous trends are converging to enable far broader and deeper participation in clinical research by patients and their families. These trends include: the proliferation of electronic health records, the availability of broadband and smartphones to more of the population, the growth of web-based tools to enable easier capture of patient information, and evolving views of privacy. These trends impact the conduct of clinical research. Further, examples will be provided of ways in which patient engagement is dramatically changing the end points and outcomes of clinical studies. As more and more of the healthcare workforce takes part in the ‘knowledge-capture’ part of clinical research, it’s important to take stock of the rapidly changing landscape of clinical research.  http://www.hhs.gov/secretary/about/goal1.html

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like’?)
► All principal investigators and research coordinators conducting research focus on research practices that will have a significant impact on patient care and the quality of that care by following the proper FDA regulations, and protocols as set forth by the advent of the Affordable Care Act.

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

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☒ Competence? -or- ☒ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.)
*(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)
► Physicians and research coordinators identify innovative strategies, data sources and trends to remain compliant with upcoming regulatory challenges that affect researchers, while engaging the patients to increase their participation. Principal investigators conduct research focused on data and tissue collection which will have a significant impact on patient care and the quality of that care.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
The Affordable Care Act provides long-term funding for patient centered outcomes research, which should give physicians and patients the clinical and research information they need to make better informed and personalized decisions.  http://www.pcori.org/assets/PFA-Improving-Healthcare-Systems-05222012.pdf

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
 Analyze the regulatory changes poised to impact the future of research.
 Apply provisions set forth by the Affordable Care Act for clinical research trial practice.
 Discuss the stages and steps of future use in research.
 Identify the strategic and compliance priorities of industry in conducting future-use research.
 Implement best practices in the acquisition, storage and exportation of clinical samples and data.
 Examine technological advances that will significantly impact patient engagement in clinical research and shift the patient’s role from research subject to research partner.
 Identify examples of web-based platforms for patient-engaged clinical research and patient consent.
 Explain how increased patient engagement is dramatically changing the endpoints and outcomes of clinical studies.
 Discuss potential and real challenges and opportunities the Affordable Care Act is expected to bring to sponsored research and patient recruitment.
 Examine select clinical research projects to determine the impact on quality of 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:

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 Attached 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.

Baptist Health Center for Research and Grants is collaborating with researchers from University of Miami and Florida International University Herbert Wertheim College of Medicine and an internationally renowned attorney to elevate and expand the quality research coordinated through Baptist Health South Florida.

Baptist Health Center for Research and Grants and Internal Review Board collaborate to achieve compliance with conflict of interest requirements recently mandated by Baptist Health South Florida.

DATE REVIEWED: August 6, 2013

REVIEWED BY: ☐ Executive Committee ☐ Chairman

APPROVED: ☐ YES ☐ NO

Credits: AMA/PRA Category 1 Credits: # 5.25

Continuing Psychology Education Credits: # 5.25 ☐ N/A ☐ Continuing Dental Education Credits: # N/A

Overview

During this cross-disciplinary forum participants will examine innovative strategies for dealing with the challenges researchers face today and the impending impact the Affordable Healthcare Act (ACA) will bring to the world of medical research. Featured sessions include case studies from principal investigators and a multidisciplinary panel of experts who will analyze the ACA from academic, legal, medical and financial perspectives. In addition, physicians, nurses and research coordinators in the South Florida Community will benefit from the valuable opportunity to network with colleagues involved in various facets of medical research.
Schedule

7:30 a.m.  Registration and Breakfast

8:30 a.m.  Welcome and Introductions
            Thinh Tran, M.D.

8:40 a.m.  State-of-the-Union Address: Developments in the Research Regulatory World
            Jennifer Geetter, Esq.

9:10 a.m.  How to Conduct Research Driven by Data and Tissue Collection
            Jennifer Geetter, Esq.

10:10 a.m. Break

10:25 a.m. The Patients Are Coming! The Patients Are Coming! Turbocharging Clinical Research with Engaged Patients
            Richard Bookman, Ph.D.

11:30 a.m. Lunch

12:30 p.m. The Impact of the Affordable Health Care Act on Research: Perspectives from Financial, Medical, Legal and Academic Experts
            Panelists: Richard J. Bookman, Ph.D. (Academic); Ralph Lawson, CFO (Financial); Mike Novo, Esq. (Legal); Barry Katzen, M.D. (Medical), and Cristina Lopez-Penalver, M.D. (Medical)
            Moderator: Thinh Tran, M.D.

2:00 p.m.  Break

2:15 p.m.  Principal Investigators' Case Studies
            Baptist Health Clinical Research Faculty
            Richard J. Bookman, Ph.D.

3:15 p.m.  Closing Remarks
            Thinh Tran, M.D.

3:20 p.m.  Adjourn

FACULTY

Thinh Tran, M.D.
Symposium Director
Chief-Medical and Quality Officer, Corporate Vice President
Baptist Health South Florida
Miami, Florida

Jennifer S. Geetter, J.D.
Partner, McDermott, Will & Emery
Health Care Specialist
Washington, DC

Richard J. Bookman, Ph.D.
Senior Advisor for Program Development and Science Policy
University of Miami Miller School of Medicine
Miami, Florida

Ralph Lawson
Executive Vice President, Chief Financial Officer
Baptist Health South Florida
Jennifer S. Geetter, Esq.
State of the Union Address: Developments in the Research Regulatory World

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

- Analyze the regulatory changes poised to impact the future of research.
- Apply provisions set forth by the Affordable Care Act for clinical research trial practice.

Current Practice / Gap: FDA regulations regarding clinical research trials are constantly changing and it is up to the researcher to stay on top of those updates in order to remain compliant. In addition, the clinical trials coverage provision of the Affordable Care Act becomes effective January 1, 2014 will have an even greater impact on eligibility requirements. Physicians and coordinators involved in clinical research are likely not aware of all of these regulatory updates and how these changes will impact their research and the patients participating in clinical trials.

Optimal practice: Physicians and patients have the clinical and research information they need to make better informed and personalized decisions.

Reference: In general, PHS Act section 2709(a),(6) as added by the Affordable Care Act, states that if a group health plan or health insurance issuer in the group and individual health insurance market provides coverage to a qualified individual (as defined under PHS Act section 2709(b)), then such plan or issuer: (1) may not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) may not discriminate against the individual on the basis of the individual's participation in the trial. (April 29, 2013) http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html

Jennifer S. Geetter, Esq.
How to Conduct Research Fueled by Data and Tissue Collection

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

- Discuss the stages and steps of future use in research.
- Identify the strategic and compliance priorities of industry in conducting future use research.
- Implement best practices in the acquisition, storage and exportation of clinical samples and data.

Current Practice / Gap: The current lack of representative sample sets makes it difficult to rapidly identify subpopulations of responders within a trial or to ensure that retrospective analysis results are broadly applicable to individuals within subpopulations of responders or nonresponders. It is essential that collected samples are representative of clinical study populations and are collected with consent allowing for broad future use. Unrepresentative sample sets will result in underpowered and potentially biased pharmacogenomic studies.

Optimal practice: The goal of future use sampling is to obtain sample collections highly representative of the clinical study population for future research that will allow companies to investigate safety and efficacy.


Richard J. Bookman, Ph.D.
The Patients are Coming! The Patients are Coming! Turbo-charging Clinical Research with Engaged Patients
Educational Objectives
Upon completion of my presentation, participants should be better able to:

- Examine technological advances that will significantly impact patient engagement in clinical research and shift the patient's role from research subject to research partner.
- Identify examples of web-based platforms for patient-engaged clinical research and patient consent.
- Explain how increased patient engagement is dramatically changing the end points and outcomes of clinical studies.

Reference
Numerous trends are converging to enable far broader and deeper participation in clinical research by patients and their families. These trends include: the proliferation of electronic health records, the availability of broadband and smartphones to more of the population, the growth of web-based tools to enable easier capture of patient information, and evolving views of privacy. These trends impact the conduct of clinical research. Further, examples will be provided of ways in which patient engagement is dramatically changing the end points and outcomes of clinical studies. As more and more of the healthcare workforce takes part in the 'knowledge-capture' part of clinical research, it's important to take stock of the rapidly changing landscape of clinical research.


Panel Discussion: The Impact of Affordable Health Care Act in Research: Perspectives from financial, medical, legal and academic experts
- Discuss potential and real challenges and opportunities the Affordable Care Act is expected to bring to sponsored research and patient recruitment.

Principal Investigators' Case Studies
- Examine select clinical research projects to determine impact on quality of patient outcomes.
CME ACTIVITY TITLE: Eleventh Annual Sleep Center Symposium

DATE:  Saturday, October 5, 2013    TIME:  7:45 a.m. – 12:25 p.m.

LOCATION:  SMH Auditorium    CREDIT HOUR(S) APPLIED FOR:  4.25 Cat. 1

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

AMA/PRA LEARNING FORMAT:
- Live activity
- Question & Answer
- Didactic Lecture
- Case Studies
- Panel

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

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

► There is a documented need for increased public and clinician awareness with respect to proactively identifying signs and symptoms of sleep disorders, a better understanding of their adverse impact upon morbidity and mortality, and their negative impact upon socioeconomic and academic potential.

WHAT IS THE OPTIMAL PRACTICE**? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
Physicians screen all patients who present with sleep symptomatology in order to appropriately diagnose and treat disorders. This will ultimately reduce 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.

COMPETENCI": 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:
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 Medial 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: 07.22.2013  REVIEWED BY: ☐ Executive Committee  ☒ Chairman

APPROVED: ☒ YES  ☐ NO  Credits: AMA/PRA Category 1 Credits: # 4.25
Continuing Psychology Education Credits: # 4.25  ☐ N/A  Continuing Dental Education Credits: #  N/A

Eleventh Annual Sleep Center Symposium
Victor E. Clarke Education Center, Miami, Florida
Saturday, October 5, 2013
7:45 a.m. – 12:25 p.m.

Schedule

7:30 a.m.  Registration and Continental Breakfast

7:45 a.m.  Welcome and Introductions
Timothy L. Grant, M.D. and Jeremy I. Tabak, M.D.

7:50 a.m.  Fifty Shades of Hypersomnolence
Timothy L. Grant, M.D.

8:20 a.m.  Nocturnal Ventilation and Central Sleep Apnea
Jeremy I. Tabak, M.D.

8:50 a.m.  CPAP Compliance: An Educational Model
Christopher J. Lettieri, M.D., FACP, FCCP, FAASM, LTC, MC, USA

9:35 a.m.  Sleep and Epilepsy
Alberto Pinzon-Ardelia, M.D.

10:05 a.m.  Break and Visit Exhibits

10:25 a.m.  Another Day in the Life of Dr. Snooze: Case Presentations to Tickle your Palate
Timothy L. Grant, M.D.

10:55 a.m.  Current Insights on Insomnia: A Behavioral Perspective
Marcy Wasman, Ph.D.

11:25 a.m.  Sleepiness and Human Performance
Christopher J. Lettieri, M.D., FACP, FCCP, FAASM, LTC, MC, USA

11:55 a.m.  Update on Sleep Apnea
Jeremy I. Tabak, M.D.

12:25 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

Christopher J. Lettieri, M.D., FACP, FCCP, FAASM, LTC, M.C.
Assistant Deputy Commander for Medicine
Program Director, Sleep Medicine Fellowship
Walter Reed National Military Medical Center
Professor of Medicine, Uniformed Services University
Bethesda, Maryland

Alberto Pinzon-Ardila, M.D.
Neurologist
Baptist, Doctors, South Miami and West Kendall Baptist Hospitals
Miami, Florida

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

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

Timothy L. Grant, M.D., FAASM
Fifty Shades of Hypersomnolence
Educational Objectives:
- Recognize the classifications of sleep disorders, including sleep architecture.
- Identify and assess the impact of non-REM and REM sleep characteristics on sleep disorders and daytime sleepiness.
- Differentiate among sleep disorders associated with hypersomnolence and implement appropriate treatment options.

Reference:
Persistent daytime hypersomnolence is associated with significant morbidity and mortality, but its prevalence in the population has been poorly documented. These study findings highlight the need for increased public and clinician awareness with respect to proactively identifying signs and symptoms of sleep disorders, a better understanding of their adverse impact upon morbidity and mortality, and their negative impact upon socioeconomic and academic potential.

http://ovidsp.tx.ovid.com/sp-3.8.1a/ovidweb.cgi?&S=DENAFNCEMDDGDJLNCOKDDIBBAMAAA00&Complete+Reference=S.sh.42%7c2%7c1

Jeremy I. Tabak, M.D. FCCP, FAASM
Nocturnal Ventilation and Central Sleep Apnea
Educational Objectives:
- Recognize the characteristics of central sleep apnea and determine optimal treatment.
- Identify underlying co-morbid conditions and adjust treatment plans to improve patient outcomes.

Reference:
The central sleep apnea syndromes (CSAS) are characterized by sleep disordered breathing associated with diminished or absent respiratory effort, coupled with the presence of symptoms including excessive daytime sleepiness, frequent nocturnal
awakenings, or both. Novel therapies that are being examined include positional therapy for patients with CSAS and heart failure, exercise therapy, as well as new ventilation/positive airway pressure treatments for patients with and without heart disease. While significant progress has been made in developing therapies for CSAS, the current review underscores the need to enhance the quality, quantity, as well as the scope of future studies to optimize patient care strategies for the treatment of these disorders.


Christopher J. Lettieri, M.D., FACP, FCCP, FAASM, LTC, MC

CPAP Compliance: An Educational Model

Educational Objectives:
- Implement a patient education model to overcome challenges with patient adherence to continuous positive airway pressure (CPAP) therapy.
- Identify and effectively discuss common barriers to adherence to CPAP therapy with patients and their families.
- Recognize the limitations of CPAP therapy, and implement alternative treatments to meet the patients needs.

Reference:
Continuous positive airway pressure (CPAP) is the first-line therapy for obstructive sleep apnea (OSA), but patient compliance is a major barrier to long-term effectiveness. Flexible pressure delivery of PAP reduces pressure during early exhalation with the aim of improving comfort and, therefore, compliance, leading to subsequent symptoms improvement. Various technologic modifications of CPAP have been developed with the rationale of improving compliance; these include the addition of pressure ramping at sleep onset and humidification of applied air, which are now standard in most CPAP devices. Automatically adjusting positive airway pressure (AutoPAP) and flexible pressure devices also have been marketed as improving compliance. Flexible pressure contrasts with the constant pressure delivery of CPAP by reducing pressure for the first part of exhalation then restoring it to a therapeutic level for the latter part of expiration and subsequent inhalation. It has been reported that there is no difference in inspiratory flow limitation between flexible pressure and CPAP, but flexible pressure may lead to a decrease in expiratory time compared with CPAP.


Alberto Pinzon-Ardila, M.D.
Sleep and Epilepsy

Educational Objectives:
- Evaluate the epileptic patient for underlying sleep disorders.
- Explain the association between sleep and epileptic syndromes.
- Differentiate between NREM parasomnias and nocturnal frontal lobe seizures.

Reference:
We need to sleep not only to rest and recharge but sleep is increasingly recognized as consisting of active brain states during which a number of processes occur such as synaptic plasticity and memory consolidation. The relationship between epilepsy and sleep is complex as seizures may be exacerbated by sleep deprivation and some seizures mainly occur during sleep. Further, there is a possibility of nocturnal seizures being misdiagnosed as parasomnia and vice versa. Finally, sleep disorders may aggravate epilepsy and epilepsy may aggravate certain sleep disorders. There are multiple links between epilepsy and sleep. Sleep and sleep deprivation may influence interictal epileptiform discharge (IED) and seizures. Primary sleep disorders such as obstructive sleep apnea (OSA) may worsen epilepsy and treatment of these sleep disorders can lead to improved seizure control. Seizures may interfere with night-time sleep structure and cause excessive day-time somnolence (EDS). Differentiating between NREM parasomnias and nocturnal frontal lobe seizures remains a challenge even using video–EEG telemetry and further characterization of semiology is needed to facilitate differential diagnosis and explore the possibility of a common pathogenic background.

Current Opinion in Neurology. 24(2):171-6, 2011 Apr., Epilepsy and sleep, Sofia H. Eriksson http://ovidsp.tx.ovid.com/sp-3.8.1a/ovidweb.cgi?WebLinkFrameset=1&S=DCMBFPCIMMDDLCHNNCKF0BCIGNA00&returnUrl=ovidweb.cgi%3f%26Full%2BText%3dL%257cS.sh.19.40%257c0%257c0019052-201104000-00014%257c%2526%257c0019052-201104000-00014.pdf&filename=Epilepsy+and+sleep.pdf_key=FPDDNCOBKFNMM00%2ffs047%2fsvg%2ffiive%2fgv024%2f0019052%2f0019052-201104000-00014.pdf

Timothy L. Grant, M.D., FAASM
Another Day in the Life of Dr. Snooze: Case Presentations to Tickle Your Palate

Educational Objectives:
- Diagnose common sleep disorders in clinical practice and implement treatment plans to improve patient outcomes.

Reference:
Sleep disorders are common and may result in significant morbidity. Examples of the major sleep disturbances in primary care practice include insomnia; sleep-disordered breathing, such as obstructive sleep apnea; central nervous system hypersomnias, including narcolepsy; circadian rhythm sleep disturbances; parasomnias, such as REM sleep behavior disorder; and sleep-related movement disorders, including restless legs syndrome. Diagnosis is based on meticulous inventory of the clinical history and careful physical examination. In some cases referral to a sleep laboratory for further evaluation with polysomnography, a sleep study, is indicated.

http://ovidsp.tx.ovid.com/sp-3.8.1a/ovidweb.cgi?&S=DENAPNCEMDDGDJLNCOKDDIBBAMAAA00&Complete+Reference=S.sh.58%7c7%7c1

Marcy I. Wasman, Ph.D., CBSM
Current Insights on Insomnia: A Behavior Perspective

Educational Objectives:
- Identify initial behavior patterns associated with insomnia.
- Recognize the correlation between insomnia behavior patterns and medical co-morbidities.
- Implement a behavior modification plan when developing insomnia treatment plans.

Reference:
Behavioral treatments for insomnia are safe and efficacious but may not be embraced by patients in primary care. Understanding factors associated with acceptability can enhance successful use of these modalities. Screening for dysfunctional beliefs about sleep may identify patients with interest in behavioral approaches. Improving self-efficacy for sleep may improve acceptance of behavioral insomnia therapies. Interest in behavioral and medication treatments are not mutually exclusive. However, the modest variance reported here suggests other factors impact acceptance of behavioral treatments.

http://www.jabfm.org/content/24/3/272.full.pdf+html

Christopher J. Lettieri, M.D., FACP, FCCP, FAASM, LTC, MC
Sleepiness and Human Performance

Educational Objectives:
- Differentiate characteristics of sleepiness and pathologic somnolence.
- Effectively communicate the detrimental effects of inadequate sleep on health, performance and quality of life with sleep disorder patients.

Reference:
Sleep is integral to the health and well-being of all people. Sleep disorders are on the rise and affect millions of people in America. Misconceptions about sleep are prevalent, and the negative effects of poor sleep on society are underrepresented. Poor sleep decreases human productivity and performance, and increases mortality and morbidity. The National Sleep Foundation estimates that poor sleep costs America billions of dollars each year and greatly compromises public safety and health. Possible solutions to the Nation's sleep problem may begin with promoting education and awareness of sleep disorders and their negative societal impact, research in sleep medicine, as well as public education about healthy sleep. The beginnings of these solutions lie in the hands of healthcare workers and educational institutions.

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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.
CME ACTIVITY TITLE: Homestead Hospital Conference Series: Sickle Cell Anemia Crisis Management

DATE: Wednesday, October 9, 2013 TIME: 12 noon - 1 p.m.

LOCATION: Homestead Hospital, Physicians’ Lounge CREDIT HOUR APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTOR: Andrew Renshaw, M.D.

AMA/PRA LEARNING FORMAT:
- [x] Live activity
- [ ] Enduring material
- [ ] Journal-based CME activity
- [ ] Manuscript review activity
- [ ] PI CME activity

TARGET AUDIENCE: Pediatricians, Emergency Medicine Physicians, Hospitalists, House Physicians, Nurse Practitioners, Physician Assistants and all interested healthcare providers. 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 providing primary care services. Also included in the target audience, are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 15-20 CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- [x] Live
- [x] Didactic Lecture
- [x] Question & Answer
- [ ] Case Studies
- [x] 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.)
- [x] Best practice parameters
- [x] Consensus of experts
- [ ] Joint Commission initiatives
- [ ] Mortality/morbidity statistics
- [ ] National Pt Safety Goals
- [ ] National/regional data
- [ ] Other (Explain): _____________________________

FACTORS OUTSIDE OUR CONTROL - List factors, outside our control and beyond learner performance that impact patient outcomes and contribute to the healthcare 'quality gap' being addressed. (C18)
- Resources: [ ] Institutional Capabilities [x] Physician Practice Limitations [x] 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.
- General practitioners are not aware of recent advances in sickle cell anemia crisis management.

WHAT IS THE OPTIMAL PRACTICE*? (In a ‘perfect world’, what would doctors be doing? What does optimal practice 'look like'?)
- General practitioners identify a sickle cell anemia crisis and implement appropriate management protocols.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
- [x] Knowledge (Doctors do not know that they need to be doing something.)
- [x] 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.)
► General practitioners appropriately manage sickle cell anemia crisis and improve delivery of care.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Proper management of sickle cell anemia (SCA) begins with establishing the correct diagnosis early in life, ideally during the newborn period. The identification of affected infants by neonatal screening programs allows early initiation of prophylactic penicillin and pneumococcal immunizations, which help prevent overwhelming sepsis. Ongoing education of families promotes the early recognition of disease-released complications, which allows prompt and appropriate medical evaluation and therapeutic intervention. Periodic evaluation by trained specialists helps provide comprehensive care, including transcranial Doppler examinations to identify children at risk for primary stroke, plus assessments for other parenchymal organ damage as patients become teens and adults. Treatment approaches that previously highlighted acute vaso-occlusive events are now evolving to the concept of preventive therapy. Liberalized use of blood transfusions and early consideration of hydroxyurea treatment represent a new treatment paradigm for SCA management.


EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
 Explain the pathophysiology of sickle cell anemia.
 Identify and manage a sickle cell anemia crisis.
 Implement prevention techniques to avoid a sickle cell anemia crisis.

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.)
Doured Daghistani, M.D.
Pediatric Hematologist Oncologist
Baptist Hospital of Miami

RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).
Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
☐ Yes ☐ No ☐ 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:** August 2, 2013 

**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

DATE: Friday, October 11, 2013

LOCATION: Baptist Hospital of Miami, Auditorium

CREDITS APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTOR: Wilfredo Alvarez, 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

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

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 obstetrics and gynecology and those specialists to whom a ob/gyn 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: 25-30

CHARGE: 0

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

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

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

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

Resources: Institutional Capabilities Physician Practice Limitations Community Service Limitations

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

Other: __________________________________________________________________________

PROFESSIONAL PRACTICE GAP (C2)

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

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

► Physicians may not be aware of all current pre-natal genetic testing available.

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

► Physician evaluate current pre-natal genetic testing available and make appropriate recommendation.

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 screen non-high risk and high-risk patients using current diagnostic testing modalities.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
The following ACOG recommendations are based on good and consistent scientific evidence:

- First-trimester screening using both nuchal translucency (NT), an ultrasound exam that measures the thickness at the back of the neck of the fetus, and a blood test is an effective screening test in the general population and is more effective than NT alone.
- Women found to be at increased risk of having a baby with Down syndrome with first-trimester screening should be offered genetic counseling and the option of CVS or mid-trimester amniocentesis.
- Specific training, standardization, use of appropriate ultrasound equipment, and ongoing quality assessment are important to achieve optimal NT measurement for Down syndrome risk assessment, and this procedure should be limited to centers and individuals meeting this criteria.
- Neural tube defect screening should be offered in the mid-trimester to women who elect only first-trimester screening for Down syndrome.

A new noninvasive blood test that measures cell free fetal DNA (cffDNA) to screen for three common genetic disorders early in pregnancy is extremely promising, according to a new Committee Opinion issued jointly today by The American College of Obstetricians and Gynecologists (The College) and the Society for Maternal-Fetal Medicine (SMFM). For now, The College and SMFM both say that cffDNA testing can be offered to pregnant women at increased risk for trisomy 13, 18, or 21. Women age 35 and older, women with a history of a child with trisomy, and women carrying a fetus that shows abnormalities on an ultrasound are at increased risk. The cffDNA test should not be offered to low-risk women or women carrying multiple fetuses because it has not been sufficiently tested in these groups.

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

- Counsel both non-high-risk and high-risk patients on available genetic screening modalities including patient-serum screening, nuchal translucency and non-invasive prenatal testing (NIPT).
- Identify high-risk patients that should seek prenatal genetic testing.

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.)

Dibe Martin, M.D.
Obstetrician and Gynecologist
Maternal and Fetal Medicine Specialist
Baptist, South Miami and West Kendall Baptist Hospitals

RELEVANT FINANCIAL RELATIONS: 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: (C14)** Does this CME activity reflect implementation 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 has been planned in collaboration with the Baptist Hospital Ob/Gyn Department.

**DATE REVIEWED:**  August 30, 2013  
**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: Second Annual Diabetes Symposium: Inpatient and Outpatient Treatment Principles and Guidelines.

DATE: Saturday, October 19, 2013 TIME: 8:00 a.m. – 1:15 p.m.

LOCATION: South Miami Hospital, Victor E. Clarke Education Center, Auditorium

CREDIT HOUR(S) APPLIED FOR: 5 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
- PI CME activity
- Journal-based CME activity
- Internet point-of-care 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: 125 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 point-of-care activity
- 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.

Hyperglycemia in hospitalized patients is a common and costly health care problem associated with poor hospital outcomes including prolonged hospital stay, infections and death. System improvements and consistent implementation of evidence-based protocols and procedures are required to facilitate the achievement of glycemic goals in patients with hyperglycemia and diabetes admitted in non-critical care and ICU settings. Additionally appropriate follow-up care must be implemented to assist discharged patients with managing blood sugar levels outside of the hospital setting.

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 both the inpatient and outpatient 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, in both the hospital and community setting.

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) ☑ 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:
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
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 diabetes care 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.

Second Annual Diabetes Symposium
Victor E. Clarke Education Center, Miami, Florida
Saturday, October 19, 2013
7:30 a.m. – 1:15 p.m.
Schedule

7:30 a.m.  Breakfast and Registration
7:55 a.m.  Welcome and Introductions
            Michael Fili, M.D.
8:00 a.m.  Hyperglycemia: Best Practices, Special Situations and Non-critical Care for Inpatient Diabetes
            Gregory Maynard, M.D., MSc, SFHM
8:45 a.m.  Management of Hyperglycemia Crises
            Guillermo E. Umpierrez, M.D.
9:30 a.m.  Anti-hyperglycemic Therapy in Type 2 Diabetes: What Drugs and When?
            Silvio E. Inzucchi, M.D.
10:15 a.m. Break and Exhibits
10:30 a.m. Improvement Techniques: Optimizing Diabetes and Hypoglycemia Management in the Inpatient Setting
            Gregory Maynard, M.D., MSc, SFHM
11:15 a.m. Inpatient Management of Hyperglycemia in Critical Care Units
            Guillermo E. Umpierrez, M.D.
12:00 p.m. Effective Use of Insulin in Type 1 and Type 2 Diabetes: What Types and How Much?
            Silvio E. Inzucchi, M.D.
12:45 p.m. Questions and Answers
1:15 p.m.  Adjourn

Faculty
Symposium Director
Michael Fili, M.D.
Endocrinologist
President, Medical Staff
EDUCATIONAL OBJECTIVES:

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

Gregory Maynard, M.D., MSc, SFHM

Hyperglycemia: Best Practices, Special Situations and Non-critical Care for Inpatient Diabetes
- Achieve goals for accurate hyperglycemic control in the acute inpatient care setting.
- Effectively manage hyperglycemic control when delivering enteral and parenteral nutrition, administering steroids and/or prescribing perioperative and post-operative care.

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 sc 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.


Guillermo E. Umpierrez, M.D.

Management of Hyperglycemia Crises
- Analyze recent epidemiologic data and pathophysiology of diabetic ketoacidosis (DKA) and hyperglycemic hyperosmolar state (HHS).
- Implement current recommendations for the management of hyperglycemic crisis.
- Execute strategies for the prevention of DKA recurrence and transition to long-term outpatient care.

Hyperglycemic crisis, which includes Diabetic Ketoacidosis and Hyperglycemic Hyperosmolar State, is a common diagnosis in high acuity hospital units and admission rates continue to increase despite preventive strategies. While diabetic ketoacidosis remains a common cause of death in children and adolescents with type 1 diabetes, in adults reported mortality is variable and depends on the severity of metabolic derangement and the presence of other acute and chronic conditions. Hyperosmolar hyperglycemic state, and the overlap syndrome of hyperosmolar ketoacidosis, have a higher overall mortality though outcomes are improving.

Steinkamp, Devin W.
Silvio E. Inzucchi, M.D.
Anti-hyperglycemic Therapy in Type 2 Diabetes: What Drugs and When?

- Determine the glycemic targets for type 2 diabetes patients based on their characteristics and disease stage.
- Identify the mechanisms of action of the major glucose-lowering drug classes.
- Develop rational mono-therapy and combination therapy strategies for individual patients.

Glycemic management in type 2 diabetes mellitus has become increasingly complex and, to some extent, controversial, with a widening array of pharmacological agents now available, mounting concerns about their potential adverse effects and new uncertainties regarding the benefits of intensive glycemic control on macrovascular complications. Many clinicians are therefore perplexed as to the optimal strategies for their patients. Antihyperglycemic agents are directed at one or more of the pathophysiological defects of type 2 diabetes, or modify physiological processes relating to appetite or to nutrient absorption or excretion. Ultimately, type 2 diabetes is a disease that is heterogeneous in both pathogenesis and in clinical manifestation—a point to be considered when determining the optimal therapeutic strategy for individual patients.

Ideally, an insulin treatment program should be designed specifically for an individual patient, to match the supply of insulin to his or her dietary/exercise habits and prevailing glucose trends, as revealed through self-monitoring. Anticipated glucose-lowering effects should be balanced with the convenience of the regimen, in the context of an individual's specific therapy goals.


S.E. Inzucchi and D.R. Matthews were co-chairs for the Position Statement Writing Group. R.M. Bergenstal, J.B. Buse, A.L. Peters, and R. Wender were the Writing Group for the ADA. M. Diamant, E. Ferrannini, M. Nauck, and A. Tsapas were the Writing Group for the EASD.

Gregory Maynard, M.D., MSc, SFHM
Improvement Techniques: Optimizing Diabetes and Hypoglycemia Management in the Inpatient Setting

- Examine a model for multidisciplinary inpatient management that improved glycemic control and significantly decreased hypoglycemic events.
- Recognize and avoid important and dynamic risk factors in order to significantly reduce iatrogenic hypoglycemia.

Iatrogenic hypoglycemia is pervasive and is the major barrier to achieving improved inpatient glycemic control. The treatment of iatrogenic hypoglycemia is often suboptimal, and improvement efforts should focus on simplifying hypoglycemia protocols and monitoring adherence to institutional standards of treatment, assessment, notification and documentation of hypoglycemia episodes. Multidisciplinary efforts to increase the frequency of monitoring, initiate appropriate adjustment of antihyperglycemic medication, and increase carbohydrate supply in the face of these risk factors should result in significant reductions in iatrogenic hypoglycemia without significant loss of glycemic control.


Guillermo E. Umpierrez, M.D
Hyperglycemia Management in Critical Care Units

- Examine the impact of glycemic control on clinical outcomes for surgical patients in the ICU setting.
- Implement strategies for achieving reasonable and safe glycemic targets from ICU admission to discharge.
- Discuss emerging evidence that non-insulin regimens (incretin therapy) may improve glycemic control and reduce the need for insulin administration in hyperglycemic ICU patients.

Hyperglycemia in hospitalized patients is a common and costly health care problem associated with poor hospital outcomes including prolonged hospital stay, infections and death. There is ample evidence that hyperglycemia has short-term adverse effects on the immune system, the vascular system, and wound healing. Similarly, there is evidence that improvement of glycemic control improves outcomes, particularly in the surgical setting. Current guidelines for the management of hyperglycemia in ICU patients recommend the use of intravenous continuous insulin infusion targeting reasonable, achievable and safe glucose target. Increasing evidence suggest that non-insulin regimens (incretin therapy) may improve glycemic control and reduce the need for insulin administration in ICU patients.


Silvio E. Inzucchi, M.D.

Effective Use of Insulin in Type 1 and Type 2 Diabetes: What Types and How Much?

- Describe the pharmacokinetic profiles of the various forms of insulin currently available.
- Implement rational insulin programs for patients with Type 1 and Type 2 diabetes.
- Recognize the normal insulin secretory dynamics before diabetes occurs.

Management of both type 1 and type 2 diabetes represents a continually evolving area as new therapies continue to emerge, and among these evolving therapies is insulin in its various forms. Insulin therapy can be categorized as long-acting, or basal, insulin and short-acting, or prandial, insulin. Short-acting insulin is also used for acute correction for hyperglycemia. Advances in insulin development have allowed for improved glycemic control with fewer adverse reactions. Formerly, insulin was from porcine and bovine sources, until the development of recombinant human insulin. Since then, human insulin has been the most commonly used until recently. The development of insulin analogs has changed our approach to insulin therapy and improved our ability to achieve target glycemic control. The approach to insulin therapy for patients with type 1 and type 2 diabetes is widely variable, and each regimen should be tailored to the individual, depending on glycemic control, patient lifestyle, patient preference, and compliance.


http://ovidsp.tx.ovid.com/sp3.8.1a/ovidweb.cgi?&S=KEOCFPFFDDOCAFNOCOFBDLMLAA00&Complete+ReferenS.sh
CME ACTIVITY TITLE: Pediatric Multispecialty Conference Series: A Practical Approach to the Diagnosis of Common Genetic Disorders in Infancy and Childhood

DATE: Tuesday, October 1, 2013  
TIME: 6:00 – 7:15 p.m.

LOCATION: Baptist Hospital, Auditorium  
CREDIT HOUR(S) APPLIED FOR: 1.25 Cat. 1

CONFERENCE DIRECTOR: Ernesto Valdes, M.D.

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

TARGET AUDIENCE:
Pediatricians, Internists, Neurologists, Neonatologists, Pediatric Emergency Medicine Physicians, Pediatric Oncologists and Psychologists.

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 pediatrics and pediatric emergency medicine. In addition, physicians that identify conditions and refer patients to a pediatric geneticist are also included in the target audience, as are related members of the hospital care team, i.e.: nurses, etc.

EXPECTED NUMBER OF ATTENDEES: 40-45  
CHARGE: 0

TYPE OF MEETING (FORMAT): Must be appropriate to the setting, objectives and desired results (C5). Check all that apply.
- Live
- Didactic Lecture
- ARS
- Question & Answer
- Case Studies
- Panel
- Enduring Material
- Internet-Home Study
- 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.
► Pediatricians do not know which diagnostic test to use with rare genetic disorders including inborn errors of metabolism. Physicians have difficulty explaining treatment expectations for genetic disorders to parents.

WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?*)
Pediatricians include the use of genetic consult in inpatient and outpatient services as well as use of diagnostic tests following the guidelines from the American College of Medical Genetics and the World Health Organization. Physicians require proper newborn screening tests and provide proper coordinated care with the specialists.

**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*? *(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:

- A high level of suspicion by the primary care practitioner and early referral to the pediatric oncologist are necessary for optimal treatment of children with cancer. Referral to tertiary care centers may facilitate rapid and accurate diagnosis, effective treatment, and enrollment in clinical trials. [http://www.uptodate.com/contents/clinical-assessment-of-the-child-with-suspected-cancer?source=search_result&search=Molecular+genetics+in+the+diagnosis+and+treatment+of+childhood+cancer&selectedTitle=38%7E150](http://www.uptodate.com/contents/clinical-assessment-of-the-child-with-suspected-cancer?source=search_result&search=Molecular+genetics+in+the+diagnosis+and+treatment+of+childhood+cancer&selectedTitle=38%7E150)

- The use of molecular approaches has become part of the standard of care in the management of pediatric cancer patients. Molecular approaches are now included in the initial diagnosis, definition of prognostically distinct patient subgroups, selection of patients for specific therapies, prediction of risk for toxicities to therapy, and monitoring of patients receiving both conventional and novel targeted therapies. This clinical application of molecular medicine has been based on a growing molecular understanding of cancer biology. Studies of pediatric cancers have contributed to this understanding in many ways. We present a model for understanding cancer biology, using specific examples taken from pediatric oncology, and then discuss the application of molecular techniques to the clinical management of pediatric cancer patients. [http://www.annualreviews.org/doi/abs/10.1146/annurev.med.57.121304.131247](http://www.annualreviews.org/doi/abs/10.1146/annurev.med.57.121304.131247)

- Collaboration among health care professionals – The report also outlines the roles of other health care professionals that are necessary to the successful operation of a newborn screening system and provision of optimal care to infants and their families. Prenatal health care clinicians (eg, obstetricians) should educate expectant parents on the importance of newborn screening and identifying the medical home for their newborn infant. Birthing facilities are responsible for obtaining, processing, and delivery of a high-quality specimen to the designated screening laboratory. Identification of the medical home should be established as a condition for discharge. Discharge documents should clearly indicate whether or not screening was performed. They should identify the name of the physician responsible for the birth hospitalization and the name of the primary care provider providing clinical care after discharge, who are contacts for any abnormal result. Pediatric medical subspecialists provide coordinated care with the primary care clinician when a child is diagnosed with a specific disorder. Genetic counseling, testing of other family members, and family support services should be facilitated. Subspecialists should also provide guidance to the states in the development of screening programs including educational material. Children with PKU, congenital hypothyroidism, and congenital adrenal hyperplasia identified by newborn screening programs may have behavioral changes resulting from these disorders, although intellectual disability (mental retardation), learning difficulties, and some behavior problems are reduced. Thus, long-term follow-up, including neuropsychological testing, should be provided. The role of the state is to design, coordinate, and manage an effective newborn screening system. However, the effectiveness of state newborn screening programs in the follow-up of infants varies. Clinicians need to be aware of the level of services provided by the screening program in their area of practice. [http://www.uptodate.com/contents/newborn-screening?detectedLanguage=en&source=search_result&search=genetic+testing+in+infants&selectedTitle=9%7E150&provider=noProvider#H6](http://www.uptodate.com/contents/newborn-screening?detectedLanguage=en&source=search_result&search=genetic+testing+in+infants&selectedTitle=9%7E150&provider=noProvider#H6)

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

- Utilize genetic and metabolic testing more effectively to reduce costs and improve care.
- Explain the limitations of genetic and metabolic testing.
- Ascertain key family history and determine when to refer patient and family for genetic counseling.
- Discuss patient and family options for diagnosis and management of genetic disorders.

<table>
<thead>
<tr>
<th>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)</th>
</tr>
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<tbody>
<tr>
<td>✒ Patient Care</td>
</tr>
<tr>
<td>✒ Professionalism</td>
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</tbody>
</table>
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.)

Olaf A. Bodamer, M.D., Ph.D., FACMG, FAAP
Professor of Human Genetics, Biochemistry and Molecular Biology
Division of Clinical and Translational Genetics
Dr. John T. Macdonald Foundation Department of Human Genetics
University of Miami Miller School of Medicine
Miami, Florida

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

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

DATE REVIEWED: July 1, 2013 REVIEWED BY: ☒ Executive Committee ☐ Chairman

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

Continuing Psychology Education Credits: # ☐ N/A ☒ Continuing Dental Education Credits: # ☐ N/A
CME ACTIVITY TITLE: Radiology Grand Rounds: Critical Findings In OB Imaging

DATE: Monday, October 28, 2013

LOCATION: South Miami Hospital Auditorium

CONFERENCE DIRECTOR: Hao Vuong, M.D.

AMA/PRA LEARNING FORMAT:

- Live activity
- Didactic Lecture
- ARS

- Question & Answer
- Case Studies
- Panel

- Enduring material
- Journal-based CME activity

- Test-item writing activity
- Manuscript review activity

- Internet point-of-care activity
- PI CME activity

TARGET AUDIENCE: Radiologists, Obstetrics and Gynecology physicians, Family Medicine Physicians and all interested allied health 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 diagnostic and interventional radiology. Physicians who identify conditions and refer patients to interventional radiologists, and those specialists to whom a radiologist 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, and other allied health professionals, 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): _____________________________

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.

► Radiology reports do not clearly communicate imaging results to ordering physicians. Thereby, critical imaging findings are missed, leading to inadequate communication between radiologists and ordering physicians.

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

► Radiologists follow the National Patient Safety guidelines and American College of Radiology recommendations on reporting critical findings to accurately communicate imaging results to ordering physicians.

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.)

▶ Physicians follow evidence-based guidelines when ordering tests for their OB/GYN patients to ensure clear condition-specific communication of imaging results from the radiologists. Radiologists follow the ACR’s practice guidelines for a structured format of the radiology report.

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

The ACR Appropriateness Criteria® are evidence-based guidelines for specific clinical conditions that are reviewed every two years by a multidisciplinary expert panel. The guideline development and review include an extensive analysis of current medical literature from peer reviewed journals and the application of a well-established consensus methodology (modified Delphi) to rate the appropriateness of imaging and treatment procedures by the panel. In those instances where evidence is lacking or not definitive, expert opinion may be used to recommend imaging or treatment.


▶ Communication is fundamental in assuring delivery of quality and safe health care. For that reason, in 2011, the Joint Commission established communication of critical results as one of its top goals for its National Patient Safety Standards. Prior to the Joint Commission establishing this goal, several studies described how physicians often failed to address critical results promptly due to poor communication. The result of missing these critical results compromised patient care and resulted in several malpractice lawsuits. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3243237/

▶ The primary purpose of the radiology report is for radiologists to clearly communicate imaging results to ordering physicians. Practice guidelines for the communication of diagnostic imaging findings by the American College of Radiology (ACR) outlines a structured format of the radiology report. In their guidelines, the ACR states that imaging findings are contained in the body of the report, while specific diagnosis should be given in the separate ‘impression’ section.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3243237/

▶ Transvaginal ultrasonography is also the cornerstone in the evaluation of bleeding in the second trimester. The primary goals are to determine whether the placenta is covering the cervical os (placenta previa), whether there is evidence of decidual hemorrhage causing placental separation (ie, abruptio placenta), and whether the cervix shows signs suggestive of cervical insufficiency (short length, dilated internal os, prolapse of the fetal membranes).


EDUCATIONAL OBJECTIVES:

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

- Implement the National Patient Safety guidelines and American College of Radiology recommendations on reporting critical findings.
- Identify first trimester and miscarriage-related conditions that can be life-threatening and require intervention.
- Define common and uncommon causes of bleeding and/or pain in the second and third trimester, and order appropriate imaging tests for these cases.
- Review unusual cases that have critical impact on patient outcomes if not recognized.

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 ☐ Practice-based Learning and Improvement

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

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

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

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

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

<table>
<thead>
<tr>
<th>FACULTY: (Name, Specialty and/or Title(s), Institution(s), City, State. For more than 2, include list at end of application.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann Podrasky, M.D.</td>
</tr>
<tr>
<td>Radiologist</td>
</tr>
<tr>
<td>Baptist Health South Florida</td>
</tr>
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</table>

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<tr>
<th>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)</th>
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<td>☒ Yes ☐ No</td>
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</tr>
<tr>
<td>☒ CME Committee</td>
</tr>
<tr>
<td>☒ Conference Director (see above)</td>
</tr>
<tr>
<td>☐ Others (i.e.: Conference Coordinator, Planning Group etc.)</td>
</tr>
</tbody>
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<table>
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</tr>
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</tr>
<tr>
<td>If yes, list collaborative efforts related to this CME activity that support achievement of our CME Mission.</td>
</tr>
<tr>
<td>Radiology Department</td>
</tr>
</tbody>
</table>

| DATE REVIEWED: September 4, 2013 |
| REVIEWED BY: ☒ Executive Committee ☐ Chairman |

| APPROVED: ☒ YES ☐ NO |
| Credits: AMA/PRA Category 1 Credits: # 1.5 |
| Continuing Psychology Education Credits: # ☒ N/A |
| Continuing Dental Education Credits: # ☒ N/A |
CME ACTIVITY TITLE: Mariners Hospital Conference Series: Incontinence – Current Practice Recommendations

DATE: November 5, 2013  TIME: 6-7 p.m.

LOCATION: Main Conference Room  CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTOR: Eileen Turbessi, M.D.

AMA/PRA LEARNING FORMAT:
- Live activity
- Enduring material
- Journal-based CME activity
- Test-item writing activity
- Manuscript review activity
- Internet point-of-care activity
- Internet-home study
- Other (specify)

TARGET AUDIENCE: General Internists, Family Practitioners, Urologists, Emergency Medicine Physicians and all other interested healthcare providers.

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 internal medicine and family practice. In addition, physicians that identify conditions and refer patients to a urologists and those specialists to whom a general internist or 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: 10-15  CHARGE: 0

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

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

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.

► As the population groups in the Florida Keys ages, physicians are not consistently utilizing recommended screening tools for urinary and fecal incontinence. Physicians are not implementing timely initial interventions for incontinence and do not know when it is necessary to escalate interventions to improve patients quality of life.

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

► Physicians assess risk factors for incontinence and follow evidence-based guidelines to screen patients who may be a risk. Physicians implement initial incontinence interventions and continually assess a patient’s progress to determine when it is necessary to escalate treatment.
WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
- Knowledge (Doctors do not know that they need to be doing something.)
- Competence (Doctors do not know how to do it)
- Performance (Doctors know how to do it but are non-compliant - or are not doing it properly.)

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☐ Competence? -or- ☐ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.)
*(NOTE: If ‘patient outcomes’ is selected, there must be an achievable measurement plan.)
► Physicians implement initial interventions for incontinence and alter treatment plans when necessary to improve patients’ quality of life.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► Fecal incontinence is a distressing, embarrassing and potentially life-changing condition that affects individuals’ quality of life. The aim of care is to improve symptoms and make individuals feel more in control. This can only be done after a thorough assessment has been completed to establish the cause and differential diagnosis. Following assessment, a patient-centered management plan can be initiated, starting with simple conservative management and moving on to specialist management if symptoms of fecal incontinence persist. Nurses, both general and specialist, are well placed to manage the care of these individuals in all healthcare environments, thereby improving their quality of life.
http://ovidsp.tx.ovid.com/sp-3.10.0b/ovidweb.cgi?WebLinkFrameset=1&S=EPCIFPAGOLDDGMMMCNCNKMCNCNKEHAA00&returnUrl=ovidweb.cgi%3f%26Full%26bText%3dL%25257cS.sh.52.57%25257c0%25257c00002311-201206200-00040%26S%3dEPCIFPAGOLDDGMMMCNCNKMCNCNKEHAA00&directlink=http%3a%2f%2fgraphics.tx.ovid.com%2fovftpdfs%2fFPDDNCGCMCMOL00%2fff046%2fovft%2flive%2fgov023%2ff00002311%2ff00002311-201206200-00040.pdf&filename=Faecal+incontinence%3a+causes%2c+assessment+and+management.&pdf_key=FPDDNCGCMCMLO00&pdf_index=/fs046/ovft/live/gv023/00002311/00002311-201206200-00040&D=medf

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
- Assess risk factors for incontinence and promote risk awareness in your practice.
- Implement screening tools for urinary and fecal incontinence.
- Evaluate evidence-based recommendations supporting treatment interventions for incontinence.
- Develop initial diagnosis and treatment strategies for incontinence and properly assess results to escalate interventions when necessary.

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.)
Jaime Sepulveda-Toro, M.D.
Obstetrician and Gynecologist
South Miami Hospital
RELEVANT FINANCIAL RELATIONSHIPS: List individuals in control of the content of this CME activity (other than faculty).

Have all relevant financial interests been identified and resolved? (C7; SCS 2.1, 2.2, 2.3)
- [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  [x] 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
- [x] 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)
- [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 meeting had been planned in collaboration with Mariners Hospital to meet the educational needs of the medical staff.

DATE REVIEWED: 09.16.13  REVIEWED BY:  [ ] Executive Committee  [ ] Chairman

APPROVED: [ ] YES  [x] 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: Diagnostic Radiology: CT in the Emergency Department

DATE: Wednesday, November 13, 2013    TIME: 12 noon - 1 p.m.

LOCATION: Homestead Hospital, Physicians’ Dining Room    CREDIT HOUR APPLIED FOR: 1 Cat. 1

CONFERENCE DIRECTOR: Andrew Renshaw, M.D.

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

TARGET AUDIENCE: Emergency Medicine Physicians, Hospitalist, House Physicians Cardiologists and Family Physicians. 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, cardiology and family medicine. Also included in the target audience, 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
- 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.
- Physicians may not be familiar with appropriate criteria for CT scans.

WHAT IS THE OPTIMAL PRACTICE***? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)
- Physicians follow appropriate criteria when ordering imaging studies for common conditions.

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

DESIRED OUTCOMES (GOAL): What are the desired or expected outcomes of this conference? What should change or improve as a result of this CME activity? (C3)
And will this result in a change in ☐ Competence? -or- ☐ Performance? -or- ☐ Patient Outcomes*? (Check all that apply.)
► Physicians accurately identify diseases to improve quality and decrease healthcare costs.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► The ACR Appropriateness Criteria® are evidence-based guidelines to assist referring physicians and other providers in making the most appropriate imaging or treatment decision for a specific clinical condition. Employing these guidelines helps providers enhance quality of care and contribute to the most efficacious use of radiology. acr.org/Quality-Safety/Appropriateness-Criteria/Diagnostic

EDUCATIONAL OBJECTIVES
Upon completion of this conference, participants should be better able to:
Upon completion of my presentation, participants should be better able to:
● Implement evidence-based criteria when ordering imaging studies for common conditions and presentations.
● Describe the latest developments in identification of disease pathways combined with imaging that can lead to improved quality and decrease costs in healthcare.

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.)
Ricardo Cury, M.D., FSCCT
Director of Cardiac Imaging, Baptist Hospital of Miami and Baptist Cardiac & Vascular Institute
Clinical Associate Professor in Radiology, Herbert Wertheim College of Medicine, Florida International University
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?

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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)

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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.

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Other tools or tactics

Explain: ______________________________________________________________________________

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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)

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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.

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DATE REVIEWED: July 3, 2013

REVIEWED BY: Executive Committee

APPROVED: Yes

Credits: AMA/PRA Category 1 Credits: # 1

Continuing Psychology Education Credits: # N/A

Continuing Dental Education Credits: # N/A
CME ACTIVITY TITLE: Radiology Grand Rounds: Pitfalls & Errors in Body CT – What Are They and How to Avoid Them

DATE: Monday, November 18, 2013
TIME: 6 - 7:30 p.m.

LOCATION: Baptist Cardiac & Vascular Institute, 5th Floor conference room & Webcast
CREDIT HOUR(S) APPLIED FOR: 1.5 Cat. 1

CONFERENCE DIRECTOR: Myer H. Roszler, M.D.

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

TARGET AUDIENCE: Radiologists, Obstetrics and Gynecology physicians, Neonatologists, Family Medicine Physicians and all interested allied health 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 diagnostic and interventional radiology. Physicians who identify conditions and refer patients to interventional radiologists, and those specialists to whom a radiologist 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, and other allied health professionals, 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): _____________________________
- New or updated policy/protocol
- Patient care data
- Peer review data
- Process improvement initiatives (C16 & 21)
- Research/literature review

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

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

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

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

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

Other: _____________________________

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

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

► Physicians may not be aware of the pitfalls of misinterpreting computed tomography (CT) scans. Physicians using CT guidance should have a sound knowledge of relevant CT image acquisition techniques and image interpretation to ensure high rates of technical success.
WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'?)

► Physicians accurately use CT guidance and have a sound knowledge of relevant CT image acquisition techniques and image interpretation to ensure high rates of technical success. Patients receive treatments that are appropriate for their condition.

WHAT IS THE REASON FOR THIS GAP? Indicate if the gap is related to either/or:
 финс Knowledge (Doctors do not know that they need to be doing something.)
 финс Competence (Doctors do not know how to do it)
 финс 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 identify the appropriate indications for using CT guidance and have a sound knowledge of relevant CT image acquisition techniques and image interpretation to ensure high rates of technical success.

*REFERENCES supporting the current practice and/or the optimal practice and/or practice gap:
► The use of CT guidance for spinal interventional pain procedures is largely guided by physician preference and ease of access to specific imaging modalities. Physicians using CT guidance should have a sound knowledge of relevant CT image acquisition techniques and image interpretation to ensure high rates of technical success. Comprehensive knowledge of appropriate radiation dose reduction strategies is crucial to reduce dose to the patient, physician and all staff involved.

 ► CT guided spinal interventional procedures may result in longer on-table procedural time and greater radiation doses to the patient and the physician compared to conventional fluoroscopy. While the quick-check CTF method may result in reduced needle placement procedural time and radiation dose compared to conventional fluoroscopy, the addition of the initial planning CT scan results in higher total radiation dose to the patient. Almost 90% of the total radiation dose during CTF guided procedures occurs during planning CT scans. Utilization of CT guidance requires access to a CT scanner, which may be less readily accessible compared to conventional fluoroscopy. Moreover, successful and safe use requires a sound understanding of CT acquisition techniques and image interpretation. While some patient motion and consequent adjustment of needle trajectory is easily accommodated when using conventional fluoroscopic guidance, similar motion during CT guidance may necessitate repeat imaging, prolonged procedural times and increased radiation dose.

 ► Proper interpretation of PET-CT images requires knowledge of the normal physiological distribution of the tracer, frequently encountered physiological variants, and benign pathological causes of FDG uptake that can be confused with a malignant neoplasm. In addition, not all malignant processes are associated with avid tracer uptake. A basic knowledge of the technique of image acquisition is also required to avoid pitfalls such as misregistration of anatomical and scintigraphic data.

EDUCATIONAL OBJECTIVES:
Upon completion of this conference, participants should be better able to:
• Analyze the potential pitfalls in full body computed tomography (CT) scans and how to avoid them.
• Identify strategies for optimal scan analysis.
• Discuss the role of Multi-planar Reconstruction (MPR) and 3D in image analysis.

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)
 финс Patient Care  финс Medical Knowledge  финс Interpersonal and Communications Skills
 финс Professionalism  финс Systems-based Practice  финс 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:
 финс Baptist Health CME Evaluation Form (post-Conference)  финс Follow-up Survey
 финс Review of Hospital, Health System or Other Data  финс 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.)
Elliot K. Fishman, M.D.
Professor of Radiology, Surgery and Oncology
Director of Diagnostic Imaging and Body CT
Johns Hopkins Hospital
Baltimore, Maryland

**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)

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☒ 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.

Radiology Department

**DATE REVIEWED:** August 8, 2013  
**REVIEWED BY:** ☒ Executive Committee  ☐ Chairman

**APPROVED:** ☒ YES  ☐ NO  
[ ] Credits: AMA/PRA Category 1 Credits: # 1.5

Continuing Psychology Education Credits: # N/A  
[ ] Continuing Dental Education Credits: # N/A
CME ACTIVITY TITLE: Dentistry & Medicine Conference Series: Oral Manifestations of Human Papillomavirus (HPV)

DATE: Tuesday, November 19, 2013
TIME: 6:30 p.m. – 7:30 p.m.

LOCATION: Baptist Hospital of Miami, 5 BCVI

CREDIT HOUR(S) APPLIED FOR: 1 Cat. 1 Credit and 1 Dental CE

CONFERENCE DIRECTOR: Fred Pedroletti, DMD

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

TARGET AUDIENCE: Primary Care Physicians, Dentists, Otolaryngologists, Medical Oncologists, Oral Maxillofacial Surgeons, Plastic Surgeons, Pathologists, Hematologists, Pediatricians, and Infectious Disease Physicians.

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
- 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 and dentists can be the first professionals to suspect or identify HPV oral diseases. Their abilities to evaluate and treat human papillomavirus (HPV) vary greatly with their experience and training. Physicians and dentists do not typically screen their patients to identify those symptoms related to HPV.
WHAT IS THE OPTIMAL PRACTICE*? (In a 'perfect world', what would doctors be doing? What does optimal practice 'look like'? )

► Dentists work as part of a multidisciplinary team with other healthcare professionals to provide a comprehensive diagnostic evaluations and optimal treatment approaches to patients with human papillomavirus.

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

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

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

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

Physicians and dentists collaborate in a multidisciplinary team approach to properly diagnose and treat patients with HPV.

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

► Public awareness of human papillomavirus (HPV) as the causal agent of cervical cancer and of the availability of HPV vaccines has increased. As a result, more patients are asking their dentists about oral HPV infection and its prevention by means of vaccination. Parents of pediatric dental patients also may be concerned when their children have HPV-associated oral lesions, because HPV infection still often is considered a purely sexually transmitted disease. Persistent HPV infection in the oral mucosa might increase the risk of developing oral cancer. Regular and meticulous clinical examination is the dentist’s most important tool in detecting HPV-associated changes in the oral mucosa. HPV-associated oral cancer may affect a population younger than that typically affected by HPV-independent oral cancer. Alcohol and tobacco use increase the risk of developing oral cancer, so good practice includes encouraging patients to avoid these habits. The available HPV vaccines cover the HPV genotypes found most commonly in the oral mucosa, but their protective effect against oral cancer remains to be elucidated. http://www.ncbi.nlm.nih.gov/pubmed/21804057

► Dental health care personnel (DHCP) should be knowledgeable about the role of HPV in carcinogenesis, the association of HPV with oropharyngeal cancers and HPV vaccines, and they should be prompt in referring patients with suggestive symptoms for evaluation. DHCP can play an important role in increasing patients’ knowledge about HPV and oropharyngeal cancers. http://www.ncbi.nlm.nih.gov/pubmed/21804058


► More than 100 types of HPV exist, more than 40 of which can infect the genital area. Most HPV infections are asymptomatic, unrecognized, or subclinical. http://www.cdc.gov/std/treatment/2010/hpv.htm

EDUCATIONAL OBJECTIVES

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

• Describe the pathogenesis of human papillomavirus (HPV) and identify oral manifestations of HPV diseases.
• Examine the usefulness of HPV testing.
• Implement regular and meticulous clinical examination of the oral mucosae in clinical practice to improve detection of HPV diseases.

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:
Ines Velez, DDS, M.S.
Professor and Director
Oral and Maxillofacial Pathology
Nova Southeastern University
Davie, Florida

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

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

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

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

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

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

DATE REVIEWED: August 9, 2013 REVIEWED BY: □ Executive Committee □ Chairman
APPROVED: □ YES □ NO □ Credits: AMA/PRA Category 1 Credits: # __________
Continuing Psychology Education Credits: # __________ □ N/A □ Credits: Continuing Dental Education Credits: # __________ □ N/A
CME ACTIVITY TITLE:  Miami Neuro Symposium
NEW Pre-symposium Session: Miami Neuro Nursing Symposium

DATE: Thursday, December 5, 2013    TIME: 7:00 a.m.–5:15 p.m.
Friday, December 6, 2013           7:30 a.m.–4:30 p.m.
Saturday, December 7, 2013         7:30 a.m.–12:30 p.m.

TIME: LOCATION: Biltmore Hotel, Coral Gables, Florida    EXPECTED NUMBER OF ATTENDEES: 130-175

CREDIT HOUR(S) APPLIED FOR:  
Friday and Saturday, December 6-7 10.5 Cat. 1
Thursday, December 5               7.75 Cat. 1

SYMPOSIUM DIRECTORS:  
Stroke: Guilherme Dabus, M.D., Italo Linfante, M.D.
Neurocritical Care: Karel Fuentes, M.D.
Tumor Management: Sergio Gonzalez-Arias, M.D. Ph.D.

Baptist Health Neuroscience Center Planning Coordinators  
★ Marguerite Rowell, MSN, MSM/HM, MBA, ONC, Director of Nursing, Baptist Neuroscience Center
★ Cris Alegria-Agurto, MBA, Manager, Neuroscience 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, 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:

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*Group discounts available for three or more physicians who register together as a group by November 23. No add-ons. Call for details. **Registration must be accompanied by a letter from the Fellowship/Residency Director.

Note: The Inaugural 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  ☒ Didactic Lecture  ☒ Panel
☒ Question & Answer  ☒ Case Studies  ☒ Internet-Home Study
☒ Enduring Material  ☒ 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 □ □ □ □ □ □ □ □ □ □ □ □ □ □ 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
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.
► Knock Out Stroke: Despite years of research and pioneering clinical work, stroke remains a massive public health concern. Specific references provides along with educational objectives.
► Fundamentals of 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 provides along with educational objectives.
► Brain Tumor Management: Most of the advanced MRI technologies that have existed for more than a decade are less than ideal for imaging brain tumors. Specific references provides along with educational objectives.

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

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:
► 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

► 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.  

► Brain Tumor Management: 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.  

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

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:
- 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).
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:

- BHM is currently preparing for Comprehensive Stroke Center certification through the Joint Commission in Summer 2014 concurrent with the 3rd Primary Stroke Center certification onsite visit. 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). The symposium will showcase the multidisciplinary treatment approach, incorporate education on the specific complex patient care and how it reflects on positive outcomes.
- CEA/CAS and Neuro interventional doctor’s order sets are a work in progress under the leadership of Neuro intervention and vascular physicians. The order sets will include evidence based practice and topics are being addressed at this symposium.
- Vascular Surgery is partnering with Neuroscience to implement a protocol and to cohort stroke patients requiring CEA/CAS on 2 Clarke unit.
- A dashboard is being created to monitor performance on a monthly basis to showcase comprehensive stroke patient outcomes.

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 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 participated as a beta site center in Joint Commission Comprehensive Stroke Center data metrics pilot study from October 2012 through March 2013. Data submission was completed by July 2013. Additional performance measures will be finalized by TJC at the end of 2013 to possibly include 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 currently considered a Comprehensive Stroke Center through the state of Florida (ACHA). 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.
- 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).
- BHM Stroke Committee collaborates with Fire Officers Association of Miami-Dade (FOAM-D) EMS Stroke Network 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 as they implement a reporting infrastructure for all participating hospitals to incorporate at their entity.
- Working collaborative with Center for Research & Grants to hire a PhD neuroscience researcher, a nurse clinical abstractor, and data entry personnel to incorporate a Neuroscience Research Infrastructure along with the 2 current 2 stroke data analyst/educators. Researcher will lead tracking comprehensive stroke performance measures and other neuroscience research projects in the near future. 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 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 neurological complications, hypothermia, 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 6, 2013   REVIEWED BY: □ Executive Committee   □ Chairman

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

FACULTY

**Knock Out Stroke**

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Fundamentals of Neurocritical Care
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J. Javier Provencio, M.D., FNCS, FCCM, FAAN
Associate Professor of Medicine, Lerner College of Medicine at Case Western Reserve University
Associate Director, Neurocritical Care Fellowship
Faculty, Neuroinflammation Research Center
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Brain Tumor Management
Sergio Gonzalez-Arias, M.D., Ph.D., FAANS, FACS
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SCHEDULE
Friday, December 6

SESSION I
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. Imaging Assessment in Ischemic and Hemorrhagic Stroke
Kevin Abrams, M.D.
8:20 a.m. Interventional Management of Acute Ischemic Stroke
Italo Linfante, M.D.
8:40 a.m. Unruptured Intracranial Aneurysms: How Should They Be Managed?
Guilherme Dabus, M.D.
9:00 a.m. From Basic Science to Clinical Practice: Are Flow Diverters Here to Stay?
Ajay Wahkloo, M.D.
9:30 a.m. Break and Visit Exhibits
10:00 a.m. Flow Diversion: Large Clinic Experience From the Mayo Clinic
Ricardo Hanel, M.D.
10:30 a.m. Dural Arteriovenous Fistula: Why and How Should It Be Treated?
Guilherme Dabus, M.D.
10:50 a.m. Brain AVM Treatment: What Have We Learned So Far?
Italo Linfante, M.D.
11:10 a.m. Carotid Stenting and CEA: Have Our Practices Changed After CREST?
James Benenati, M.D.
11:30 a.m. Case Presentations With Panel Discussion
Italo Linfante, M.D., Guilherme Dabus, M.D., Ricardo Hanel, M.D., Ajay Wahkloo, M.D.,
James Benenati, M.D., Mario Martinez-Gàldamez, M.D.
12:00 noon Adjourn Session I
12:05 p.m. Lunch

SESSION II
Fundamentals of Neurocritical Care (3.5 Cat. 1)
Moderator: Karel Fuentes, M.D.
12:55 p.m. Welcome and Introductions
Karel Fuentes, M.D.
1:00 p.m. Prevention of Nosocomial Infections in the Neuro ICU
Javier Provencio, M.D.
1:30 p.m. Patient Safety in the Neuro ICU
Romergryko Geocadin M.D.
2:00 p.m. Neurological Emergencies: The First 24 Hours
Karel Fuentes, M.D.
2:30 p.m. Break and Visit Exhibits
3:00 p.m. Continuous EEG Monitoring in the Neuro ICU
Jan Claassen, M.D.
3:20 p.m. Management of Status Epilepticus
Jan Claassen, M.D.
4:00 p.m. Medical Management of Vasospasm After Subarachnoid Hemorrhage
Saturday, December 7

SESSION III

Brain Tumor Management (3.5 Cat. 1)
Moderator: Sergio Gonzalez Arias, M.D., Ph.D.
7:15 a.m.  Registration and Continental Breakfast
7:50 a.m.  Welcome and Introductions
Sergio Gonzalez Arias, M.D., Ph.D.
8:00 a.m.  Multi-modal Brain Tumor Imaging
Kevin Abrams, M.D.
8:30 a.m.  Seizures and Brain Tumors
Alberto Pinzon Ardila, M.D., Ph.D.
9:00 a.m.  Multifunctional Nanoparticles for Drug Delivery to Treat Neuro-AIDS and Drug Addiction
Madhavan Nair, Ph.D.
9:30 a.m.  Break and Visit Exhibits
10:00 a.m. Advancing Neurosurgery Through Image-guided Robotics
Garnette Sutherland, M.D.
10:30 a.m. Surgery of Tumors in the Eloquent Cortex
Vitaly Siomin, M.D.
11:00 a.m. State-of-the-Art Surgical Management of Skull Base Tumors
Armando Basso, M.D.
11:30 a.m. Case Presentations with Panel Discussion and Questions
Moderator: Sergio Gonzalez Arias, M.D., Ph.D.
Kevin Abrams, M.D., Alberto Pinzon Ardila, M.D., Ph.D., Madhavan Nair, Ph.D., Garnette Sutherland, M.D., Vitaly Siomin, M.D., Armando Basso, M.D.
12:00 noon  Adjourn Symposium

EDUCATIONAL OBJECTIVES AND REFERENCES

Friday, December 6

SESSION I: Knock Out Stroke

Imaging Assessment in Ischemic and Hemorrhagic Stroke
Kevin Abrams, M.D.
Educational Objectives
Upon completion of this presentation, participants should be better able to:
● Implement the best approach to imaging assessment of suspected ischemic and hemorrhagic stroke patients considering benefits and limitations of CT, CTA and perfusion CT.
References
Computed Tomography (CT) workup of patients suspected of acute ischemic stroke: perfusion computed tomography (PCT) adds value compared with clinical evaluation, noncontrast computed tomography, and computed tomography angiogram (CTA) in terms of predicting outcome. http://www.ncbi.nlm.nih.gov/pubmed/23404718
Noncontrast CT is typically the first diagnostic study in patients with suspected stroke. The main advantages of CT are widespread access and speed of acquisition. CT is highly sensitive for the diagnosis of hemorrhage in the acute setting. http://www.uptodate.com/contents/overview-of-the-evaluation-of-stroke?

Interventional Management of Acute Ischemic Stroke
Italo Linfante, M.D.
Educational Objectives
Upon completion of this presentation, participants should be better able to:
● Cite the benefits of recanalization as a strong predictor of good outcome secondary to large vessel occlusion.
References
Recanalization of acute large artery occlusions is a strong predictor of good outcome. The development of thrombectomy devices resulted in a significant improvement in recanalization rates compared to thrombolytics alone. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3234448/
Unruptured Intracranial Aneurysms: How should they be managed?
Guilherme Dabus, M.D.
Educational Objectives
Upon completion of my presentation, participants should be better able to:
● Analyze and apply optimal treatment strategies for unruptured intracranial aneurysms considering the risks vs. benefits of treatment vs. non-treatment.
References
Most small AUIAs (≤ 5 mm) do not rupture, and the risks of treatment are substantial. Most small AUIAs can therefore be managed conservatively. Endovascular coiling or surgical clipping of larger aneurysms (> 5 mm) should be considered on a case-by-case basis. [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2592324/]

From Basic Science to Clinical Practice: Are Flow Diverters Here to Stay?
Ajay Wahkloo, M.D.
Educational Objectives
Upon completion of my presentation, participants should be better able to:
● Evaluate non-surgical treatment methods for unruptured intracranial aneurysms, and discuss safety and efficacy compared to surgical treatment.
References
Technological advances in imaging modalities, along with increased understanding of natural history and prevalence of aneurysms, have increased detection of asymptomatic unruptured intracranial aneurysms. Treatment methods include two major intervention options: clipping of the aneurysm and endovascular methods such as coiling, stent-assisted coiling, and flow diversion stents. Endovascular treatment of unruptured intracranial aneurysms provides a safe and effective alternative to surgical treatment. [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3134887/]

Flow Diversion: Large Clinical Experience from Mayo Clinic
Ricardo Hanel, M.D.
Educational Objectives
Upon completion of my presentation, participants should be better able to:
● Recognize indications for use of flow diverters considering an efficacy and safety comparison study of flow diversion and standard endovascular approaches for the treatment of intracranial aneurysms.
References
Flow diverters achieve a much higher rate of complete angiographic obliteration compared with other standard endovascular techniques in the treatment of internal carotid artery aneurysms. [http://www.ajnr.org/content/early/2012/07/12/ajnr.A3207.full.pdf]

Dural Arteriovenous Fistula: Why and How Should it be Treated?
Guilherme Dabus, M.D.
Educational Objectives
Upon completion of my presentation, participants should be better able to:
● Describe the natural history of dural arteriovenous fistula, and determine optimal treatment options.
References
Epidural arteriovenous fistula is an uncommon entity and may be related to trauma, neurofibromatosis or surgery, but is usually spontaneous. Endovascular treatment is the method of choice whenever feasible [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3396030/]

Brain AVM Treatment: What Have We Learned So Far?
Italo Linfante, M.D.
Upon completion of my presentation, participants should be better able to:
● Explore technological advances that have improved the endovascular approach to the treatment of cerebral aneurysms and arteriovenous malformations.
References
Advancements in technology are rapidly improving the endovascular approach to the treatment of cerebral aneurysms and arteriovenous malformations. [http://stroke.ahajournals.org/content/38/4/1411.long]

Carotid Stenting and CEA: Have Our Practices Changed After CREST?
James Benenati, M.D.
Educational Objectives
Upon completion of my presentation, participants should be better able to:
● Review the recent findings of the Carotid Revascularization Endarterectomy Versus Stenting Trial (CREST), and discuss how clinical practice has changed as a result of these findings.
References

New results from the Carotid Revascularization Endarterectomy Versus Stenting Trial (CREST) show that after two years of follow-up, restenosis is infrequent and similar whether patients underwent carotid artery stenting (CAS) or carotid endarterectomy (CEA) to address carotid stenosis. http://www.theheart.org/article/1349103.do

Session II: Fundamentals of Neurocritical Care

Prevention of Nosocomial Infections in the Neurocritical Care Unit
Javier Provencio, M.D.

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

- Identify important nosocomial infections in patients with neurological diseases.
- Implement evidence-based, state-of-the-art strategies to prevent or reduce nosocomial infections in the neurocritical care unit and explore future infection prevention strategies.

Reference

Development of nosocomial infections is a commonly encountered problem for critically ill patients. Approximately half of all nosocomial pneumonias in the neurointensive care unit are associated with ventilator-associated pneumonia. Prompt diagnosis with appropriate specimen analysis is required in order to prevent increased morbidity. Ortíz R. Lee K., Current Neurology & Neuroscience Reports. 6(6):525-30, 2006.

Korinek AM. Neurosurgery. 41(5):1073-9; 1997

Nosocomial infection will be prevented by monitoring the patients in fully-equipped intensive care units, the rapid termination of invasive procedures, appropriate antibiotic therapy and discharging the patient, significantly.


Patient Safety in the Neuro ICU
Romergyko Geocadin, M.D.

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

- Recognize the importance of utilizing DVT chemoprophylaxis in the neurocritical care patient.
- Identify risk factors for ventilator-associated pneumonia in the neurocritical care unit.
- Implement preventive and corrective measures to improve communication and reduce medical errors in the neurocritical care setting.

References

Venous thromboembolism is a complication that affects approximately 30% of moderate and severe traumatic brain injury patients when pharmacologic prophylaxis is not used. A PTP protocol in the NSICU is useful in controlling the number of complications from DVT and pulmonary embolism while avoiding additional IH. Increasing the percentage of patients receiving PTP during their hospitalization; whether long-term patient outcomes are affected is a potential goal for future study. http://www.ncbi.nlm.nih.gov/pubmed/23099845

Lobar or segmental collapse of the lung in mechanically ventilated patients is a common occurrence in the intensive care unit. Management is labor and time intensive and not highly effective. http://www.ncbi.nlm.nih.gov/pubmed/23266402

Third-line antiepileptic drug therapies with sedating or anesthetic effects predicted poor outcome and death in status epilepticus. These findings may inform decision making on drug therapy in status epilepticus and help develop safer and more effective treatment strategies to improve outcome. http://www.ncbi.nlm.nih.gov/pubmed/22732291

Clear communication is imperative if teams in any industry expect to make improvements. An estimated 85% of errors across industries result from communication failures. http://www.ncbi.nlm.nih.gov/pubmed/12800116

Medical errors account for ~98,000 deaths per year in the United States. They increase disability and costs and decrease confidence in the health care system. http://www.ncbi.nlm.nih.gov/pubmed/22053736

Neurological Emergencies: The First 24-hours
Karel Fuentes, M.D.

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

- Implement essential components in the evaluation, diagnosis and treatment of neurological emergencies in order to optimize patient outcomes.

References

Neurological emergencies are common and frequently devastating. Every year, millions of Americans suffer an acute stroke, severe traumatic brain injury, subarachnoid hemorrhage, status epilepticus, or spinal cord injury severe enough to require medical intervention. Full evaluation of the diseases in the acute setting often requires advanced diagnostics, and treatment frequently necessitates transfer to specialized centers. Delays in diagnosis and/or treatment may result in worsened outcomes therefore optimization of diagnostics is critical. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2885257/
Continuous EEG monitoring in the Neuro ICU
Jan Claassen, M.D.

Upon completion of my presentation, participants should be better able to:
● Implement recommended strategies for identification and monitoring of non-conclusive seizures (NCSz) in the neuro intensive care patient.
● Examine the prevalence of NCSz, and discuss patient outcomes.

References

It is now possible to record and monitor the continuous digital electroencephalogram (EEG) of many critically ill patients simultaneously. Continuous EEG monitoring (cEEG) provides dynamic information about brain function that permits early detection of changes in neurologic status, which is especially useful when the clinical examination is limited. Prolonged continuous digital video and electroencephalographic monitoring (EEG) for critically ill patients is becoming standard practice in many locations and is rapidly spreading in use. http://www.ncbi.nlm.nih.gov/pubmed/19608827

Management of Status Epilepticus
Jan Claassen, M.D.

Upon completion of my presentation, participants should be better able to:
● Implement evidence-based first-line and second-line strategies for the acute treatment of status epilepticus (SE) in critically ill patients considering the latest evidence-based treatment paradigm.
● Determine the optimal management of refractory SE, and assess expected outcomes.

References

The new Neurocritical Care Society Status Epilepticus Guideline’s, released in 2012, were developed to address evaluation and management of SE in critically ill adults and children.

Status epilepticus treatment strategies vary substantially from one institution to another due to the lack of data to support one treatment over another.

These guidelines have revised the traditional SE treatment paradigm to emergent initial therapy, urgent control therapy, and refractory therapy. SE patient’s refractory to initial therapy may be best treated in experienced, high volume centers.

Because only two-thirds of patients in SE respond to the first treatment [30] it is increasingly important to understand the underlying pathophysiology of refractoriness to treatment so better interventions can be developed.


Medical Management of Vasospasm after Subarachnoid Hemorrhage
Javier Provencio, M.D.

Upon completion of my presentation, participants should be better able to:
● Explain the pathophysiology of cerebral vasospasm after subarachnoid hemorrhage.
● Recognize the limitations of current monitoring strategies and treatments.
● Explore current and emerging therapeutic interventions

References

Cerebral vasospasm is a major source of morbidity and mortality in patients with aneurysmal subarachnoid hemorrhage (aSAH). Evidence suggests a multifactorial etiology and this concept remains supported by the assortment of therapeutic modalities under investigation. Currently, the strongest evidence supports use of prophylactic oral nimodipine and initiation of triple-H therapy for patients in cerebral vasospasm.

http://dx.doi.org/10.1155/2013/462491; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3053416/
Vergouwen, MD, Neurocrit Care (2011) 15: 308-311; Hanggi, D, Neurocrit Care (2011) 15: 318-323

Saturday, December 7
Session III: Brain Tumor Management

Multi-modal Brain Tumor Imaging
Kevin Abrams, M.D.

Upon completion of my presentation, participants should be better able to:
● Cite the benefits and limitations of MR perfusion, MR spectroscopy and PET/CT in the evaluation of the brain tumor patient.

References

Perfusion imaging appears to have a significant impact on clinical decision-making and subspecialist physicians’ confidence in management plans for patients with brain tumor. http://www.ajnr.org/content/33/3/556.full
Neuroradiologic imaging is the major diagnostic modality in the evaluation of brain tumors. These studies are critical for preoperative planning, and they often provide information about the etiology of a mass lesion.
Although neuroimaging cannot definitively establish the specific histology, the characteristic appearance of dural-based meningiomas often can allow a tentative diagnosis. http://www.uptodate.com/contents/clinical-presentation-and-diagnosis-of-brain-tumors?

Seizures and Brain Tumors
Alberto Pinzon, M.D.

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

● Identify tumors associated with secondary seizures (high frequency).
● Determine which antiepileptic drugs (AEDs) to use based on the most recent data.
● Examine indications for the use of prophylactic AEDs in treating patients with brain tumors.

References
Seizures are a relatively common problem in patients with brain tumors. Seizures may be the initial manifestation of a brain tumor or may occur during the course of disease. Seizures in and of themselves are an important source of morbidity and mortality in patients with primary and secondary brain tumors and require aggressive treatment.


Prophylactic antiepileptic drugs (AEDs) are generally not recommended for patients with a primary or metastatic brain tumor and without a history of antecedent seizure.

However, post-surgery AED prophylaxis is suggested for patients undergoing surgery for brain tumors. The data supporting this approach are drawn from observational studies and a limited number of small randomized trials, some but not all of which have shown a lower risk of early postoperative seizures in patients treated with a prophylactic AED. This recommendation places a high value on prevention of early postoperative seizures, which are uncommon but can be devastating, and a lower value on the potential adverse effects of AEDs, which are of particular concern for older AEDs such as phenytoin.


Because of the concern of drug-drug interactions, the pharmacological approach to epilepsy requires a multidisciplinary approach, specifically in a setting of rapidly increasing choices of agents both to treat cancer and cancer-associated epilepsy. http://www.ncbi.nlm.nih.gov/pubmed/22935237

Image-guided Drug Delivery to the Brain Using Nanotechnology
Madhavan Nair, Ph.D.

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

● Explore the unique application of nanotechnology combined with multiple imaging techniques in the diagnosis and treatment of central nervous system diseases.

References
Targeting across the blood-brain barrier (BBB) for treatment of central nervous system (CNS) diseases represents the most challenging aspect of, as well as one of the largest growing fields in, neuropharmaceutics. Combining nanotechnology with multiple imaging techniques has a unique role in the diagnosis and treatment (theranostics) (A combination of diagnostics and therapy IRM) of CNS disease. Such imaging techniques include anatomical imaging modalities, such as magnetic resonance imaging (MRI), ultrasound (US), X-ray computed tomography (CT), positron emission tomography (PET), single-photon emission computed tomography (SPECT), electron microscopy, autoradiography and optical imaging as well as thermal images.


Advancing Neurosurgery Through Image-guided Robotics
Garnette Sutherland, M.D.

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

● Describe the challenges associated with translating MRI technology into the operating room.
● Identify the processes related to technology creation from concept to commercial entity.
● Recognize the advantages and challenges related to the integration of robotic technology into neurosurgery.

References
Surgical robots have the potential to improve surgical precision and accuracy through motion scaling and tremor filters, although human surgeons currently possess superior speed and dexterity. Additionally, neuroArm's workstation has positive implications for technology management and surgical education. NeuroArm is a step toward a future in which a variety of machines are merged with medicine. http://www.ncbi.nlm.nih.gov/pubmed/23240694; http://www.ncbi.nlm.nih.gov/pubmed/23254806

Surgery of Tumors in Eloquent Cortex
Vitaly Siomin, M.D.

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

● Examine newer imaging techniques that better define the eloquent brain.
● Discuss patient selection criteria for awake craniotomy.

References
● Describe the technical aspects of surgery of the eloquent cortex.

**References**

Removal of brain tumors within eloquent brain regions can result in iatrogenic motor deficits, speech disorders, and complex cognitive deficits. However, for some tumors, including high grade gliomas, the extent of tumor removal is highly correlated with patient survival, pushing the surgeon to remove as much tumor as possible. Awake craniotomy with cortical mapping can facilitate maximal tumor removal and help avoid iatrogenic injury.

http://www.hindawi.com/crim/medicine/2013/401359/abs/


State-of-the-Art Surgical Management of Skull Base Tumors
Armando Basso, M.D.

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

● Define optimal surgical treatment approaches in difficult-to-manage skull base tumors.

**References**

Most patients with a skull base tumor complain of headache and intermittent diplopia. Gradually, headache worsens with upper clivus tumors and neck pain develops with lower clivus tumors. Magnetic resonance imaging (MRI) is the best technique to assess the soft tissue extent of tumor and visualize its dural extension. There are no randomized clinical trials and no large prospective series that define the optimal treatment for either chordomas or chondrosarcomas. Literature reviews of small retrospective series support a combined modality approach using maximal surgical resection and radiation therapy. Surgery is performed both to obtain tissue for diagnosis and to reduce the tumor burden. Tumors involving the skull base are difficult to manage as a result of their proximity to critical neural structures. Maximal surgical resection is the mainstay of therapy, but complete resections are difficult to achieve. http://www.uptodate.com/contents/chordoma-and-chondrosarcoma-of-the-skull-base?
10. Effectively coordinate team interventions to care for the patient with aneurysmal SAH by applying evidence-based approaches proven to optimize patient outcome.
11. Explain patient selection criteria for acute stroke intervention candidates.
13. Describe the physiology of vasospasms and the diagnostic studies to identify them.
14. Identify the presenting signs of vasospasms and the timing of the symptoms following SAH.
15. Compare approaches to prevent and treat vasospasms, including interventional and medical management and current research.
16. Discuss the oral anticoagulant and antiplatelet medications used in the care of stroke patients
17. Implement strategies for anticoagulant reversal in stroke patients.
18. Recognize important considerations for utilization of oral anticoagulant and antiplatelet medications when caring for stroke patients.
19. Explain the laboratory findings in diabetes insipidus (DI), syndrome of inappropriate secretion of antidiuretic hormone (SIADH) and cerebral salt-wasting syndrome (CSWS).
20. Compare and contrast the differential diagnosis of DI, SIADH and CSWS and initiate appropriate therapy.
22. Describe new and emerging technologies in neurological rehabilitation.
23. Explain determining factors for admitting stroke patients to an acute inpatient rehabilitation facility

FACULTY
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Neuro/Critical Care CNS, Mission Hospital
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Marguerite Rowell, MSN, MSM/HM, MBA, ONC, Director of Nursing, Baptist Neuroscience Center
Cris Alegria-Agurto, MBA, Product Line Manager, Baptist Health Neuroscience Center

SCHEDULE
Thursday, December 5 (7.75 CEU)
7:00 a.m.    Registration Continental Breakfast and Visit Exhibits
7:30 a.m.    Welcome and Introductions
7:45 a.m.    Stroke Clinical Decision Making and Management Utilizing Imaging
LECTURE-SPECIFIC OBJECTIVES AND REFERENCES

**Stroke Clinical Decision-making and Management Utilizing Imaging**
Lori Massaro, MSN, CRNP, ACNP-BC

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

- Discuss various diagnostic adjunctive modalities currently used in imaging the stroke patient.
- Compare the benefits of MRI and CT imaging in acute stroke diagnosis.

**REFERENCES:**

**Hypothermia Management in Neuro Patients**
Mary Kay Bader, MSN, CCNS, FAHA

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

- Correlate the pathophysiology of neurologic injury to the benefits of mild hypothermia in the treatment of neurologic disorders.
- Describe the practical techniques of therapeutic hypothermia.
- Explain the potential benefits and complications during the process of cooling and rewarming.

**REFERENCES:**

**Psychogenic Non-epileptic Seizures**
Shaun Smart, M.D.

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

- Recognize the pathophysiology and clinical presentation of a psychogenic non-epileptic seizure (PNES) patient.
Describe diagnostic and treatment approaches for PNES.

REFERENCES:
3. Lesser RP. Treatment and outcome of Psychogenic Non-epileptic seizures. Epilepsy Currents.3;6:2003 198-200
4. LAFrance WC, R. Management of psychogenic nonepileptic seizures. Epilepsia. 54; 2013; 53-67
5. Cervenka MC, Lesser R. Does the teddy bear sign predict psychogenic non-epileptic seizures. Epilepsy & Behavior. 28;2 2013 217-220

What's Hot and What's Not in the Treatment of Aneurysmal SAH
Mary Kay Bader, MSN, CCNS, FAHA

Upon completion of this lecture participants should be better able to:
• Identify the pathophysiological changes following aneurysmal subarachnoid hemorrhage (SAH).
• Examine the pathology, clinical presentation and potential complications associated with SAH.
• Effectively coordinate team interventions to care for the patient with aneurysmal SAH by applying evidence-based approaches proven to optimize patient outcome.

REFERENCES:

Neurointerventional Overview: Case Studies in Care of the NIVR
Rosanne Starr, MSN, ARNP, ACNP-BC

Upon completion of this lecture participants should be better able to:
• Explain patient selection criteria for acute stroke intervention candidates.
• Summarize pre- and post-procedure care of the intracranial stent implantation patient.

REFERENCES:

Vasospasms
Kendra Menzies Kent, MS, RN-BC, CCRN, CNRN, SCRN
Upon completion of this lecture participants should be better able to:

- Describe the physiology of vasospasms and the diagnostic studies to identify them.
- Identify the presenting signs of vasospasms and the timing of the symptoms following SAH.
- Compare approaches to prevent and treat vasospasms including interventional and medical management and current research.
REFERENCES:

Anticoagulation and Reversal: Practical Application for Nursing
Erika Dittmar, Pharm.D, BCPS and Sylvia Marrero, Pharm.D, C.Ph.

Upon completion of this lecture participants should be better able to:
1. Discuss the oral anticoagulant and antiplatelet medications used in the care of stroke patients
2. Implement strategies for anticoagulant reversal in stroke patients.
3. Recognize important considerations for utilization of oral anticoagulant and antiplatelet medications when caring for stroke patients.

REFERENCES:

Neurological Complications (DI, SIADH, CSWS)
Kendra Menzies Kent, MS, RN-BC, CCRN, CNRN, SCRN

Upon completion of this lecture participants should be better able to:
• Explain the laboratory findings in DI, SIADH, and CSWS.
• Compare and contrast the differential diagnosis of DI, SIADH and CSWS and initiate appropriate therapy.

REFERENCES:

Advances in Stroke Rehabilitation
Bradley Aiken, M.D.

Upon completion of this lecture participants should be better able to:
• Explore the role of neuroplasticity in post-stroke recovery.
• Describe new and emerging technologies in neurological rehabilitation.
• Explain determining factors for admitting stroke patients to an acute inpatient rehabilitation facility.

REFERENCES: