PATIENT SAFETY EVOLVING:

13TH Annual Maryland Patient Safety Conference
March 17, 2017 | Hilton Baltimore

Opening Keynote Speaker
David Marx, JD

Closing Keynote Speakers
Cal P. Sheridan and Susan Sheridan, MBA, MIM, DHL

This educational activity is jointly provided by AXIS Medical Education and the Maryland Patient Safety Center
## DAY-AT-A-GLANCE

### 7:00am
Registration, Breakfast, Visit Exhibitors and Patient Safety Poster Presentations, Key Ballroom Lobby/Foyer

### 8:00am - 8:15am
**Welcome & Introductions**, Key Ballroom: Jim Rost, MD, FAAP, Vice President, Chief Medical Officer, Washington Adventist Hospital

### 8:15am - 9:15am
**Opening Keynote Address: Three Dice: The Path to Highly Reliable Outcomes**, David Marx, JD, CEO Outcome Engenuity

### 9:15am - 9:30am
Recognition of the Minogue Award for Patient Safety Innovation Winner and Distinguished Achievement in Patient Safety Innovation Winner

### 9:30 - 10:00
Break, Visit Exhibitors and Patient Safety Poster Presentations: Key Ballroom Lobby & Foyer

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<thead>
<tr>
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<th>Key Ballroom B Track 2</th>
<th>Key Ballroom C Track 3</th>
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<td>Caring for Diverse Communication-Vulnerable Patients – a Patient Safety Challenge Matthew K. Wynia, MD, MPH, FACP Director, Center for Bioethics and Humanities University of Colorado</td>
<td>FY16 Office of Health Care Quality Patient Safety Update Anne Jones, RN, BSN, MA Nurse Program Consultant Office of Health Care Quality</td>
<td>It’s Time to Regulate: Antimicrobial Stewardship Standards in Acute Care Settings Emily L. Hell, PharmD, BCPS-AQID Assistant Professor – Infectious Diseases University of Maryland School of Pharmacy</td>
<td>Ransomware as a Disruptive Force in Healthcare Ron Galloway Researcher and Filmmaker</td>
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### 10:00 - 11:00
11:15 - 12:15
**The Evolution of Patient- and Family-Centered Teamwork Training: Cracking the Code for Our Most Important Team Members**
Jim Rost, MD, FAAP Jennifer Ustianov, MS, BSN, RN, IBCLC TeamSTEPPS Elite, Inc.

**Making a PACCT to CARE: Leveraging Community Resources to Educate, Engage and Empower Patients**
Karen Twigg, BSN, RN, CMCN Director, Care Coordination & Integration Calvert Memorial Hospital

**Mimogue Award for Patient Safety Innovation Winner: Accountable Care Unit Model Creates Culture Change of Shared Accountability to Patient Safety and Quality Goals**
Susan Mani, MD, FACC Chief Quality Officer/Chair of Medicine Northwest Hospital

**Primum Non Tacere, or Why Don’t We Speak Up?**
John Banja, PhD Professor, Department of Rehabilitation Medicine Medical Ethicist, Center for Ethics Emory University

### 12:15 - 1:00
Lunch, Visit Exhibitors and Patient Safety Poster Presentations: Key Ballroom Lobby & Foyer

### 1:00 - 2:00
**Healthcare Information Technology (HIT) and Patient Safety: A Two Edged Sword**
James Battles, PhD Battles Consulting

**Preventing Suicide in Psychiatric and Acute Care Settings, Including Prevention of Post-Discharge Events**
Robert Roca, MD, MPH, MBA Vice President and Medical Director Ellen M. Mongan, MD Director, Resident & Medical Student Education Sheppard Pratt Health System

**Distinguished Achievement in Patient Safety Innovation Winner: A Team-Based, Innovative Approach to Reducing the Incidence of Chronic Lung Disease in the Premature Newborn**
Mike Sukumar, MD Neonatologist Adventist HealthCare Shady Grove Medical Center

**Diagnostic Error: Overview, Challenges and Recommendations**
John Banja, PhD Professor, Department of Rehabilitation Medicine Medical Ethicist, Center for Ethics Emory University

### 2:00 - 2:30
Break, Visit Exhibitors and Patient Safety Poster Presentations: Key Ballroom Lobby & Foyer

### 2:30 - 3:30
**Closing Keynote Address: #It’sWhat’sinYou**
Cal P. Sheridan and Sue Sheridan, MBA, MIM, DHL

### 3:30
Closing Remarks and Adjournment:
Robert Imhoff, President & CEO, Maryland Patient Safety Center
10:00 am - 11:00 am  
Caring for Diverse Communication-Vulnerable Patients – a Patient Safety Challenge
According to The Joint Commission, by far the most common root cause of sentinel events is ineffective communication. Ethically, effective communication is necessary to provide quality care that is in alignment with patients’ values, priorities and goals. Yet several common barriers stand in the way of excellent communication with patients from diverse backgrounds. This session will explore these barriers, methods for addressing them, and a unique toolkit that can help organizations measure their performance in meeting the communication needs of diverse patients.

Learning objectives:
1. Describe the complex interplay between individual clinicians’ communication skills and the organizational environment in which care is provided
2. Review the role of collecting validated data on organizational performance as a strategy for performance improvement in the area of effective communication

Presenter:
Matthew Wynia, MD, MPH, FACP
Director, Center for Bioethics and Humanities
University of Colorado

11:15 am – 12:15 pm  
The Evolution of Patient- and Family-Centered Teamwork Training: Cracking the Code for Our Most Important Team Members
This session will provide an overview of TeamSTEPPSTM and the evolution of incorporating patients and families into the teamwork training process with a focus on the emerging evidence and practical strategies for implementation in ambulatory and acute care settings.

Learning Objectives:
1. Describe the evidence-based TeamSTEPPSTM program
2. Describe connections between family-centered care and TeamSTEPPSTM events and tools

Presenters:
Jim Rost, MD, FAAP
Jennifer Ustianov, MS, BSN, RN, IBCLC
TeamSTEPPSTM Elite, Inc.

12:15 pm – 1:00 pm  
Lunch and Visit Exhibitors and Patient Safety Poster Presentations

1:00 pm – 2:00 pm  
Healthcare Information Technology (HIT) and Patient Safety: A Two Edged Sword
Expanded use of Healthcare Information Technology (HIT) has been offered as a solution to solving a number of problems associated with patient safety and the prevention of harm to patients. Yet despite the many benefits of HIT, it can also be the source of error and the cause of harm. HIT is truly a two-edged sword. This presentation will discuss the benefits and the risk of HIT as they relate to patient safety.

Learning Objectives:
1. Identify major sources of risks and hazards from HIT
2. List three benefits associated with HIT to prevent patient harm

Presenter:
James Battles, Ph.D.
3. Identify essential components of effective documentation of a robust suicide risk assessment and mitigation plan

Learning Objectives:
1. Describe the context of trends and meaningful single events
2. Identify better practices in analyzing and responding to adverse events

Presenter:
Anne Jones RN, BSN, MA
Nursing Program Consultant
Office of Health Care Quality

11:15 am - 12:15 pm
Making a PACCT to CARE: Leveraging Community Resources to Educate, Engage and Empower Patients
The philosophy behind the Calvert CARES Program is simple: build programs to fit patients, rather than bending patients to fit programs. Leveraging community relationships formed through their local healthcare coalition, PACCT, Calvert CARES succeeds by knocking down barriers and building bridges to care. The program consists of six building blocks, developed and implemented in collaboration with PACCT partners, which are focused on enhancing efficiency and effectiveness in optimizing patient outcomes. The CARES Team of physicians, pharmacists, social workers, and nurses actively listen to and collaborate with patients to develop a patient-centered strategic plan, targeted at building a healthier lifestyle to foster better healthcare management.

Learning Objectives:
1. Describe how to close gaps in resource access for patients who are unable to access appropriate care within five days after a care transition and/or afford essential medications and medical supplies
2. Evaluate synergy (connectivity, consistency, efficiency and effectiveness) of patient-centered chronic disease care planning, education and medication management, with a focus on long-term/post-acute care and high needs/complex patients
3. Identify ways to improve communication flow and patient-centered care coordination between community healthcare partners

Presenter:
Karen Twigg, BSN, RN, CMCN
Director, Care Coordination & Integration
Calvert Memorial Hospital

12:15 pm - 1:00 pm
Lunch and Visit Exhibitors and Patient Safety Poster Presentations

1:00 pm - 2:00 pm
Preventing Suicide in Psychiatric and Acute Care Settings, Including Prevention of Post-Discharge Events
This session will include information regarding current literature and data, key components of a comprehensive suicide risk assessment, clinical and environmental suicide prevention and mitigation strategies, the importance of robust means reduction, pre-discharge risk assessment recommendations and relevant medical record documentation considerations.

Learning Objectives:
1. Outline key components of a thorough suicide risk assessment
2. Review effective interventions for acute care suicide prevention
3. Identify essential components of effective documentation of a robust suicide risk assessment and mitigation plan

Presenter:
Emily L. Heil, PharmD, BCPS-AQ ID
Assistant Professor - Infectious Diseases
University of Maryland School of Pharmacy

11:15 am - 12:15 pm
Minoque Award for Patient Safety Innovation Winner
Accountable Care Unit Model Creates Culture Change of Shared Accountability to Patient Safety and Quality Goals
Recognizing the need for a construct that would replace the inherent silos of their healthcare system at the hospital unit based level, Northwest Hospital leveraged the Accountable Care Unit (ACU) model to foster a new culture of shared accountability to achieve the Triple Aim. Using a model first implemented at Emory in 2010, Northwest took the tenets implemented at an academic center and customized them to form an organization structure and process that could be adapted to any healthcare setting. The ACU model was piloted and then implemented organization-wide. Improvement was seen with significant reductions in CAUTI, CLABSI, C. Difficile, and falls. Increases were seen in adverse event reporting, supporting an improvement in the culture of patient safety. Built on the foundation of multidisciplinary collaboration, this model has led to a significant cultural change in the organization.

Presenters:
Robert Roca, MD, MPH, MBA
Vice President and Medical Director
Ellen M. Mongan, MD
Director, Resident & Medical Student Education
Sheppard Pratt Health System

Track 3 (Key Ballroom C)

10:00 am - 11:00 am
It's Time to Regulate: Antimicrobial Stewardship Standards in Acute Care Settings
Antimicrobial stewardship is a set of coordinated strategies to optimize the use of antimicrobial medications with the goals of reducing resistance to antimicrobials and enhancing patient health and safety outcomes. Antimicrobial stewardship programs have been well-established in some acute care institutions for many years, but given the societal value of antimicrobials and their decreasing effectiveness due to widespread resistance, regulatory support to ensure antimicrobial stewardship programs are present in all acute care settings has been developed. This presentation will discuss the goals of an antimicrobial stewardship program and also highlight the new Joint Commission and Centers for Medicare and Medicaid Services Condition of Participation for stewardship.

Learning Objectives:
1. Describe the patient safety benefits of having an effective antimicrobial stewardship program in an acute care hospital
2. Compare regulatory standards and policy changes related to antimicrobial stewardship in acute care settings

Presenter:
Sheppard Pratt Health System
Director, Resident & Medical Student Education
This session provides a deep dive into recent occurrences of invading medical devices in hospitals, causing further problems in patient transfers and delayed care. And now viruses are all files, leaving patient care at a standstill, even resulting in ransomware invading computers and encrypting around the country—both large and small—are experiencing records (EHR) encrypted and not available for access? How does Ransomware as a Disruptive Force in Healthcare

10:00 am – 11:00 am
Neonatologist
Adventist HealthCare Shady Grove Medical Center
Mike Sukumar, MD

Learning Objectives:
1. Describe chronic lung disease in the newborn and how the adoption of a QI bundle impacts culture and patient safety
2. Outline how to implement and sustain a safety improvement initiative that redesigns care for improved outcome in the NICU

Learning Objectives:
1. Review the Accountable Care Unit (ACU) model
2. Outline the process of creating an ACU model in an organization
3. Describe how an ACU model can result in culture change

Presenter:
Susan Mani, MD, FACC
Northwest Hospital
Chief Quality Officer/Chair of Medicine

12:15 pm – 1:00 pm
Lunch and Visit Exhibitors and Patient Safety Poster Presentations

1:00 pm – 2:00 pm
Distinguished Achievement in Patient Safety
Innovation Winner
A Team-Based, Innovative Approach to Reducing the Incidence of Chronic Lung Disease in the Premature Newborn

Chronic lung disease is a disease that is most common in premature babies. This diagnosis is directly associated with a significant increase in mortality as well as a number of important morbidities including neurodevelopmental delay, blindness, lung infections and readmissions. The Adventist HealthCare Shady Grove Medical Center NICU identified the incidence of chronic lung disease (CLD) as a diagnosis they wanted to work on decreasing in the infants in their NICU. Through implementation of the “Optimizing Respiratory Care” Bundle, developed and communicated through a multi-disciplinary team, standards of practice were provided. Adherence to the bundle was evaluated, through multi-disciplinary, family-centered rounds. Over two years the incidence of CLD decreased by 47% in infants 24-32 weeks gestation, and the percentage of patients cared for with mechanical ventilation decreased by 42%.

Learning Objectives:
1. Describe chronic lung disease in the newborn and how the adoption of a QI bundle impacts culture and patient safety
2. Outline how to implement and sustain a safety improvement initiative that redesigns care for improved outcome in the NICU

Presenter:
Mike Sukumar, MD
Adventist HealthCare Shady Grove Medical Center
Neonatologist

11:15 am – 12:15 pm
Primum Non Tacere, or Why Don’t We Speak Up?
This presentation will occur in three parts. The first part will offer a number of clinical examples wherein the failure to speak up and draw attention to various system failures contributed to markedly untoward results, e.g., especially harm-causing errors and maintaining suboptimal training environments as well as work environments marked by poor morale. The second part will explore reasons why health professionals and student health professionals often resist speaking up. In addition to the familiar fear of retribution, attention will be called to the ways that human beings rationalize or excuse their failure to call attention to latent system failures. The presentation will conclude with a host of recommendations whereby healthcare organizations can cultivate an environment that promotes constructive comment and action plans aimed at system improvement. Clearly, if health professionals refrain from speaking up, it is because they are not properly incentivized to do so. Recommendations will therefore target the need to create work environments wherein system operators feel safe and supported for speaking up, as well as experience a healthy sense of self from doing so.

Learning Objectives:
1. Explain the need to speak up regarding system failures
2. List organizational factors that hinder or that facilitate speaking up when a harm causing error is possible
3. Discuss helpful strategies to use in remedying employees’ problematic behaviors
4. Demonstrate helpful phrases to use in any difficult conversation bearing on another person’s problem behaviors

Presenter:
Ron Galloway, Researcher and Filmmaker

1:00 pm – 2:00 pm
Diagnostic Error: Overview, Challenges and Recommendations
Many physicians would be surprised to learn about the diagnostic error rates reported in the research literature which, depending on the clinical specialty, range from 3 to 30 percent. While a variety of strategies and tools such as computer-based decision supports, better feedback processes and more patient involvement have been recommended to reduce diagnostic error frequency rates, many clinicians and organizations do not use
them and sometimes frankly deny their value. The fact that diagnostic error frequency and severity often go unappreciated and, indeed, are unrecognized by clinicians and organizations is extremely troubling given diagnostic error’s high correlation with poor patient outcomes and its dubious status as the chief cause of medical malpractice claims. This presentation will examine various psychological features associated with the persistence of diagnostic error, especially ones that involve 1) the intersection of diagnostic error with the discomfort of uncertainty, 2) the reluctance of physicians to admit uncertainty, 3) the cultivation of overconfidence as a compensatory mechanism for the unpleasantness of uncertainty, and 4) the resulting inertia as a (non)response to remediation systems that invite or enable diagnostic error. Additionally, we will discuss the role of overconfidence as a response to production pressures as well as the phenomenon of few if any feedback mechanisms built into care delivery systems that might reduce the frequency of errors, mistakes, oversights, misses, etc.

Learning Objectives:
1. List ways of managing psychological variables that can compromise the calibration of feelings of diagnostic certainty in the face of a challenging or complex diagnosis
2. Identify ways of improving the provision of feedback to clinicians such that their diagnostic skill repertoire might improve
3. Describe the feasibility or prospects of injecting humility into the diagnostic process as a feature of medical training curricula and continuing education activities

Presenter:
John Banja, PhD
Professor, Department of Rehabilitation Medicine
Medical Ethicist, Center for Ethics Emory University

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Key Ballroom

2:30 pm - 3:30 pm Closing Keynote
#It’sWhat’sInYou

#It’sWhat’sInYou is a presentation delivered by a mom, Sue Sheridan, and her son, Cal, whose family experienced two significant diagnostic errors on different occasions that resulted in the death of Pat, the father, and permanent brain injury to Cal when he was a newborn. Sue will share the journey that she has chosen to help fill the gaps in our healthcare system by partnering with researchers, policy makers, educators, payers, accreditors, public health officials and others. Cal Sheridan, who aspires to make the world a better place for all through humor and his playwriting, will share personal traits that he embraces in life to be an agent of change that also applies to those passionate about improving our healthcare system. Together, Sue and Cal will share their commitments and challenge the audience to ask themselves “what’s in them” and to consider their commitment.

Presenters:
Cal P. Sheridan and Susan Sheridan, MBA, MIM, DHL

Learning Objectives:
1. Review recent data on diagnostic errors in our healthcare system from the IOM report “Improving Diagnosis in Healthcare” as well as current national initiatives addressing solutions including efforts by NQF, AHRQ, CMS, SIDM, CLIAC, Maryland Patient Safety Center and others
2. Outline the emerging evidence on the impact of patient engagement in research, policy making and healthcare system design and governance in achieving a safer healthcare system and better outcomes
3. Describe personal traits that are necessary to be an agent of change to contribute to transforming our healthcare system to be more patient centered with safer care and better outcomes

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Meet the Board of Directors

The strategic initiatives and priorities of the Maryland Patient Safety Center are guided by a voluntary board of directors.

James R. Rost, MD, FAAP
Chair
Vice President, Chair
Chief Medical Officer
Washington Adventist Hospital
David Horrocks
Vice-Chair
President
CRISP
Lawrence S. Linder, MD, FACEP, FAAEM
Secretary
President and CEO
University of Maryland Community Medical Group
Gerald Abrams
Treasurer
Director
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Kelly Corbi
Chief Operating Officer
Northland Hospital
Carmela Coyle
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Joseph DeMattos, Jr., MA
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FASHP, FPSMO
Medication Safety Officer
Johns Hopkins Hospital
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Center for Research on Health Benefits Innovation, Employee Benefit Research Institute
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Sherry Perkins, PhD, RN
Executive Vice President & COO
Dimensions Healthcare System
Stephen M. Ports
Former Principal Deputy Director
Health Services Cost Review Commission
Barbara Tachovsky, MSN, RN, NEA-BC, FACHE
Former President of Main Line Hospitals, Paoli, PA
Healthcare manager and Executive coach/mentor
Kathleen M. White, PhD, RN, NEA-BC, FAAN
Associate Professor,
Department of Acute and Chronic Care
The Johns Hopkins University School of Nursing
Michael R. Yochelson, MD, MBA, FACHE
Vice President of Medical Affairs & Chief Medical Officer
MedStar National Rehabilitation Network
ONLINE REGISTRATION CLOSES March 3, 2017

To Register:

- Visit MarylandPatientSafety.org. Complete all individual registration information, most importantly the registrant’s email address (You may include a secondary email address for others to receive correspondence regarding registration and program information).

- If you will be submitting a check request through your organization, please choose the “Register and Pay Later” option.

- You will receive correspondence directly from the Program Coordinator immediately following your submission of the registration online.

- If you do not receive a confirmation email or if you have any questions regarding our registration process, please contact Kelly Heacock Yost at 410.796.6239 or kyost@mhei.org.

FEE for all participants

FREE with Maryland Patient Safety Center membership (Register by March 3, 2017).

Early Registration and payment received by Friday, February 17, 2017: $299
Late Registration and payment received between February 18–March 3, 2017: $345
On-site Registration and payment (including those not yet paid): $399
Full-time Student: $99 (student ID required)

“No shows” and cancellations received after March 8 will be subject to a $125 cancellation fee per the Center’s policy.

All attendees, including Maryland Patient Safety Center member organizations and non-members, must register by March 3, 2017 to receive special pricing. All on-site registrations must provide payment of $399.

Breakfast and lunch will be provided.
While we do provide a vegetarian option, please contact Kelly Heacock Yost if you have any other dietary restrictions at kyost@mhei.org.

Weather Policy:
In the event of adverse weather conditions, the decision to cancel or delay the Conference will be made by 5:00 a.m. the morning of the Conference. To find out if the Conference is delayed or cancelled, please call 410-540-9210 after 5:00 a.m. on March 17.

Special Note:
The Maryland Patient Safety Center wishes to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently from other individuals because of the absence of auxiliary aids and services. If you need any of the auxiliary aids or services identified in the Americans With Disabilities Act, please contact Kelly Heacock Yost at kyost@mhei.org.
CONTINUING EDUCATION

Accreditation Statement

In support of improving patient care, AXIS Medical Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Credit Designation for Physicians
AXIS Medical Education designates this live activity for a maximum of 5.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Credit Designation for Pharmacists
This knowledge-based activity is approved for 5.0 contact hours of continuing pharmacy education credit.

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<th>ACTIVITY TITLE</th>
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Credit Designation for Nursing
AXIS Medical Education designates this continuing nursing education activity for 5.0 contact hours.

Learners are advised that accredited status does not imply endorsement by the provider or ANCC of any commercial products displayed in conjunction with an activity.

Quality Professionals
This program has been approved by the National Association for Healthcare Quality for 5 CPHQ continuing education hours.

Risk Managers
This program has been approved for a total of 5.0 contact hours of continuing education credit toward fulfillment of the requirements of ASHRM designations of fellow (FASHRM) and distinguished fellow (DFASHRM) and towards certified professional in healthcare risk management (CPHRM) renewal.

Long Term Care Administrators
This educational offering has been reviewed by the National Continuing Education Review Service (NCERS) of the National Association of Long Term Care Administrator Boards (NAB) and approved for 12 clock hours and 5 participant hours.

AXIS Contact Information
For information about the accreditation of this program please contact AXIS at 954-281-7524 or info@axismeded.org.

Disclosure of Conflicts of Interest
AXIS Medical Education requires instructors, planners, managers and other individuals and their spouse/life partner who are in a position to control the content of this activity to disclose any real or apparent conflict of interest they may have as related to the content of this activity. All identified conflicts of interest are thoroughly vetted by AXIS for fair balance, scientific objectivity of studies mentioned in the materials or used as the basis for content, and appropriateness of patient care recommendations.

The faculty reported the following financial relationships or relationships they or their spouse/life partner have with commercial interests related to the content of this continuing education activity:

<table>
<thead>
<tr>
<th>Name of Faculty/Presenter/Planner</th>
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<tr>
<td>John Banja, PhD</td>
<td>Nothing to disclose</td>
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<tr>
<td>James Battles, PhD</td>
<td>Nothing to disclose</td>
</tr>
<tr>
<td>Barbara Charen, RN, BSN, BA, CPHRM</td>
<td>Nothing to disclose</td>
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<tr>
<td>Ron Galloway</td>
<td>Nothing to disclose</td>
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<tr>
<td>Emily L. Hell, PharmD, BCPS-AQ ID</td>
<td>Consultant: Arik-Abelio</td>
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<tr>
<td>Anne Jones, RN, BSN, MA</td>
<td>Nothing to disclose</td>
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<td>Susan Mani, M.D., FACC</td>
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<td>David Marx, JD</td>
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<td>Elen M. Morgan, MD</td>
<td>Nothing to disclose</td>
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<td>Robert Roca, MD, MPH, MBA</td>
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<td>Jim Rost, MD, FAAP</td>
<td>Employee: TeamSTEPPS Elite, Inc.</td>
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<td>Cal Sheridan</td>
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<td>Dee Morgillo, MEd, CHCP</td>
<td>Nothing to disclose</td>
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<td>Ronald Voggiarsa, MD</td>
<td>Nothing to disclose</td>
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<tr>
<td>Alison Burrows, MBA, RN</td>
<td>Nothing to disclose</td>
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<td>Bonnie DiPetro, MS, RN, NEA-BC, FACHE</td>
<td>Nothing to disclose</td>
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<tr>
<td>Kelly Yost</td>
<td>Nothing to disclose</td>
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<tr>
<td>Robert Imhoff</td>
<td>Nothing to disclose</td>
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<tr>
<td>Mark Ruile, EdD</td>
<td>Nothing to disclose</td>
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Disclaimer

Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guide for patient management. Any procedures, medications, or other courses of diagnosis or treatment discussed in this activity should not be used by clinicians without evaluation of patient conditions and possible contraindications on dangers in use, review of any applicable manufacturer’s product information, and comparison with recommendations of other authorities.

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