WALK THE TALK:
The Consequence of Everyone as a Leader

Opening Keynote Speaker

Rudy Giuliani, Former Mayor of New York City

Closing Keynote Speaker

Mark R. Chassin, M.D., F.A.C.P., M.P.P., M.P.H., President of The Joint Commission
### Day-at-a-Glance

**7:00am – 7:45am**
Registration, Breakfast, Vendors, Storyboards

**8:00am – 8:15am**
Welcome & Introductions

**8:15am – 9:15am**
Opening Keynote Address: Rudy Giuliani, Former Mayor of New York City

**9:15am – 9:30am**
Recognition of the Minogue Award Recipients for Patient Safety Innovation

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| 10:00 – 11:00 | Office of Health Care Quality Annual Update on Reported Adverse Events  
Anne Jones, RN, BSN, MA, Health Facility Surveyor, Office of Health Care Quality  
Reese B. Webster, RN, Assistant Director for Hospitals, Laboratories and Patient Safety, Office of Health Care Quality | Cross-Cultural Communication: Saving Lives and Improving Outcomes  
Nan Prinipe Crockett, MA, Interpreting Services Manager, Frederick Memorial Hospital and  
Janet J. Harding, MS, PHR, Director, Cultural Awareness & Inclusion Frederick Memorial Hospital and  
Bruce Adelson, Esq., CEO, Federal Compliance Consulting | Want To Engage Patients? Let’s Talk!  
Jean Rexford, Executive Director, CT Center for Patient Safety and Helen Haskell, President, Mothers Against Medical Error, and Linda K. Kenney, MD, Director of Patient Safety and President of MITSS (Medically Induced Trauma Support Services, Inc.) | Dropping Out, Surviving, or Thriving? Peer Support Can Make the Difference  
Lori Payne, RN, MS, Director of Patient Safety and Armstrong Institute  
and Cheryl A. Connors, RN, MS, Patient Safety Specialist, Armstrong Institute | Weekly Safety Rounds: A Collaborative Approach to Patient Safety at the Bedside  
Mary Beth Baker, RN, BSN, CCRN, Patient Safety Lead/Education, Critical Care Unit, Mercy Medical Center | Personal Lessons from High Reliability Organizations  
E. Robert Feroli, Jr., PharmD, FASHP, Medication Safety Officer, John Hopkins Hospital |
| 11:15 – 12:15 | Disruptive Clinician Behavior: An Organizational Assessment and Interventions  
Jo M. Walrath, RN, MS, PhD, Co-investigator, Johns Hopkins School of Nursing and  
Sharon Strobel, RN, MS, Study Coordinator, Healthy Work Environment, Johns Hopkins Hospital | Measuring Disparities in Patient Safety  
Ernest Moy, MD, MPH, Medical Officer, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality (AHRQ)  
and Noel Eldridge, Senior Advisor and Public Health Analyst Center for Quality Improvement and Patient Safety Agency for Healthcare Research and Quality (AHRQ) | (continued)  
Want To Engage Patients? Let’s Talk!  
Jean Rexford, Executive Director, CT Center for Patient Safety and Helen Haskell, President, Mothers Against Medical Error, and Linda K. Kenney, MD, Director of Patient Safety and President of MITSS (Medically Induced Trauma Support Services, Inc.) | Development and Launch of a Critical Incident Stress Management Team in the Acute Care Setting: Year One  
Rita Rohme, RN, BSN, Program Coordinator for The Joint Center and  
Christine Frost, RN, MSN, NEA-BC, Director MSU/SCU, Anne Arundel Medical Center | Minogue Award for Patient Safety Innovation Winner | Medication Diversion Prevention—A Patient Safety Imperative  
Keith Berge, MD, Mayo Clinic |
| 12:15 – 1:30 | The State of Patient Experience Revisited: 5 Strategies for Success  
Jason Wolf, PhD, Executive Director, The Beryl Institute | Safety and Regulatory Viewpoint Regarding Intellectually Disabled and Psychiatric Special Populations  
Anne Jones, RN, BSN, MA, Health Facility Surveyor, Office of Health Care Quality and  
Mary Gall, RN, Nurse Surveyor, Office of Health Care Quality | Patient Safety/ Patient and Family Advisors—The Essential Piece  
Joanna Kaufman, RN, MS, Information Specialist, Institute for Patient- And Family-Centered Care and  
Rita Linnenkamp, BSN, RN, Patient Family Advisor, and  
Lauretta Jackson, Patient Family Advisor, Anne Arundel Medical Center | Addressing the Emotional Side When Things Go Wrong  
Linda K. Kenney, Executive Director and President of MITSS (Medically Induced Trauma Support Services, Inc.) | Distinguished Achievement in Patient Safety Innovation Winner | Safer Sign Out: Establishing a New Standard for Physician Hand-Offs  
Drew Fuller, MD, MPH, FACEP, Strategic Coordinator for Patient Safety Emergency Medicine Associates, Assistant Director, Emergency Department, Calvert Memorial Hospital and Peninsula Drew White, MD, MBA, FACEP, Michael Kerr, MD, FACEP, and Napoleon Magpanay, MD |
| 1:30 – 2:30 | The State of Patient Experience Revisited: 5 Strategies for Success  
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**2:45**
Closing Keynote Address: Transforming Healthcare to Achieve High Reliability  
Mark R. Chassin, MD, FACP, MPP, MPH, President, The Joint Commission

**3:45**
Closing Remarks
Leadership and Culture Track

10:00 am – 11:00 am
Office of Health Care Quality Annual Update on Reported Adverse Events
Representatives from the Office of Health Care Quality will present the 2012 statistics, trends, and interesting case studies gleaned from adverse events reported by hospitals in 2012.

Presenters:
Anne Jones, RN, BSN, MA
Health Facility Surveyor,
Office of Health Care Quality,
Renee B. Webster, RS
Assistant Director for Hospitals, Laboratories and Patient Safety, Office of Health Care Quality

11:15 am – 12:45 pm
90 minute session
Disruptive Clinician Behavior: An Organizational Assessment and Interventions
Researchers developed and validated a survey instrument entitled Disruptive Clinician Behavior Survey for Hospital Settings. The Survey is based on a conceptual framework, which includes four concepts: Triggers, Disruptive Behaviors, Responses and Impacts.

A sample of 1559 clinicians (RNs, MDs and Affiliate staff) completed the Survey. Results indicate that disruptive behavior in the study organization is both pervasive and persistent in duration. Many of the triggers and clinician responses to disruptive behavior are considered modifiable. These behaviors have negative impacts on clinicians, patients and the organization.

Because the disruptive behavior is chronic, persistent, and pervasive, multi-pronged interventions all in play simultaneously are needed to change the culture to one of mutual respect and collegiality at individual, team, and organizational levels.

Presenters:
Jo M. Walrath, RN, MS, PhD
Co-investigator, Johns Hopkins School of Nursing
Sharon Strobel, RN, MS, Study Coordinator, Healthy Work Environment, Johns Hopkins Hospital

1:30 pm – 2:30 pm
The State of Patient Experience Revisited: 5 Strategies for Success
In this presentation, Dr. Wolf will discuss findings from the study, “The State of Patient Experience Revisited.” He will examine the dynamic changes in today’s healthcare environment and its influence on the patient experience, and will also review five strategic keys to patient experience success as you build and drive your patient experience efforts for your own organization.

Presenter:
Jason Wolf, PhD
Executive Director, The Beryl Institute

Disparities in Healthcare Track

10:00 am – 11:00 am
Cross Cultural Communication: Saving Lives and Improving Outcomes
Why are hospitals moving toward improving language services to patients who are deaf, blind or Limited English Proficient? Because it’s sound healthcare management and it’s the law.

Join Nan Principe Crockett, Janet Harding and Bruce Adelson as they discuss how to improve access to high quality, equitable healthcare and prevent miscommunications, reduce readmissions, and comply with federal law.

This quickly paced workshop, presented from two facets of the healthcare spectrum, will be packed with real world stories, best practice recommendations and legal insights for healthcare organizations.

Presenters:
Nan Principe Crockett, MA
Interpreting Services Manager, Frederick Memorial Hospital
Janet J. Harding, MS, PHR
Director, Cultural Awareness & Inclusion, Frederick Memorial Hospital
Bruce Adelson, Esq.
CEO, Federal Compliance Consulting
Walk the Talk: The Consequence of Everyone as a Leader

11:15 am – 12:15 pm
Measuring Disparities in Patient Safety
Tracking and reporting on disparities in patient safety is a relatively new science. In this session, we will show work at AHRQ on measuring disparities in patient safety related to race, ethnicity, and socioeconomic status and on reporting these disparities in the National Healthcare Disparities Report. We will also provide a first look at disparities in select hospital-acquired conditions being tracked for Partnership for Patients.

Presenters:
Ernest Moy, MD, MPH
Medical Officer, Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality (AHRQ)
Noel Eldridge
Senior Advisor and Public Health Analyst
Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality (AHRQ)

1:30 pm – 2:30 pm
Safety and Regulatory Viewpoint Regarding Intellectually Disabled and Psychiatric Special Populations
This session will explore the hospital treatment of the intellectually disabled and psychiatric special populations, particularly as that treatment relates to avoidable adverse events and patient rights. The speakers will also explore some of the most common deficient practices found in Maryland hospitals related to special populations and discuss some strategies to provide safer, more patient-centered care.

Presenters:
Anne Jones, RN, BSN, MA
Health Facility Surveyor, Office of Health Care Quality
Mary Gall, RN
Nurse Surveyor, Office of Health Care Quality

Patient and Family Centered Care Track

10:00 am – 12:15 pm
Want To Engage Patients? Let’s Talk!
In this workshop, a panel of experienced consumer patient safety advocates will discuss their success in raising the patient safety bar by working with multiple stakeholders and will offer valuable suggestions about how to engage patients and families. Participants will leave this interactive session empowered to give patients and their families what they want most: To be at the center of the design and delivery of their care.

Presenters:
Jean Rexford
Executive Director, CT Center for Patient Safety
Helen Haskell
President, Mothers Against Medical Error
Linda K. Kenney
Executive Director and President of MITSS (Medically Induced Trauma Support Services, Inc.)

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Noel Eldridge
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Center for Quality Improvement and Patient Safety
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1:30 pm – 2:30 pm
Patient Safety/ Patient and Family Advisors—The Essential Piece
This presentation will discuss the core principles of patient- and family-centered care and describe methods for including patients and families in safety initiatives. In this presentation we describe how Anne Arundel Medical Center partners with patient and family advisors to improve safety, quality and the patient care experience.

Presenters:
Joanna Kaufman, RN, MS
Information Specialist
Institute for Patient- And Family-Centered Care
Rita Linnenkamp, BSN, RN
Patient Family Advisor, Anne Arundel Medical Center
Lucretia Jackson
Patient Family Advisor, Anne Arundel Medical Center

Care of the Healthcare Provider Track

10:00 am – 11:00 am
Dropping Out, Surviving or Thriving? Peer Support Can Make the Difference
Stress on healthcare workers is mounting. Involvement in unanticipated patient events or medical errors are among the many situations that healthcare workers may face that can be traumatic—impacting their confidence, productivity and future career decisions.

This session will discuss the concept of second victims and a novel peer support program for healthcare team members experiencing stressful events.

10:00 am – 12:15 pm
Two-hour session
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Patient Family Advisor, Anne Arundel Medical Center
**Walk the Talk: The Consequence of Everyone as a Leader**

**Presenters:**
Lori Paine, RN, MS  
Director of Patient Safety, Armstrong Institute  
Cheryl A. Conners, RN, MS  
Patient Safety Specialist, Armstrong Institute

**11:15 am – 12:15 pm**  
**Development and Launch of a Critical Incident Stress Management Team in the Acute Care Setting: Year One**

In this session, two nurses describe how they started a support team for hospital staff members following work-related critical incidences.

**Presenters:**
Rita Rohme, BSN, RN  
Program Coordinator for The Joint Center  
Christine Frost, RN, MSN, NEA-BC,  
Director MSU/SCU, Anne Arundel Medical Center

**1:30 pm – 2:30 pm**  
**Addressing the Emotional Side When Things Go Wrong**

While many healthcare organizations have launched major initiatives to reduce medical error, it often seems as if the need for structured support for patients, families and providers at the “sharp end” of an error has been overlooked. This presentation chronicles the journey of a patient and physician who transformed an adverse medical event—one that nearly took the patient’s life—into a movement that supports healing and restores hope. As a passionate advocate for patients and families, as well as providers, Ms. Kenney will discuss the need to raise the awareness of the emotional impact that the adverse medical event can have on ALL of those involved. She will share insight into what type of communication and support patients and families truly want and need following an adverse medical event.

Ms. Kenney will introduce and discuss tools and resources found in the MITSS Clinician Support Tool Kit for Healthcare that is available for free for any organization wanting to set up a support program for their providers.

**Presenter:**
Linda K. Kenney  
Executive Director and President of MITSS (Medically Induced Trauma Support Services, Inc.)
**Walk the Talk: The Consequence of Everyone as a Leader**

**10:00 am – 11:00 am**

**Personal Lessons From High Reliability Organizations**

High Reliability Organizations (HROs), such as aviation, are often cited during healthcare safety presentations. They are suggested as models for us to use as we continue our journey to improve the safety and quality of care provided to our patients. While most would agree that healthcare has not yet earned the HRO label, all of us in the safety community can identify institutional efforts that are helping us toward that goal. As we wait for our institution to become a HRO, there are things that we as individuals can do now. This talk will focus on characteristics shared by all HROs and explore ways in which each of us can incorporate these characteristics into our daily routines.

*Presenter:*
E. Robert Feroli, Jr., PharmD, FASHP
Medication Safety Officer, Johns Hopkins Hospital

**11:15 am – 12:15 pm**

**Medication Diversion Prevention—A Patient Safety Imperative**

This presentation will describe the growing problem of drug diversion from the healthcare workplace, and programs that have been created by the Mayo Clinic to address this threat to patient safety.

*Presenter:*
Keith Berge, MD  Mayo Clinic

**1:30 pm – 2:30 pm**

**Safer Sign Out: Establishing a New Standard for Physician Hand-Offs**

Due to the risk associated with communication errors during transitions of care, The Joint Commission has called for the standardization of hand-off procedures. Few models exist to help standardize physician practice in this area. Safer Sign Out is a new tool that provides a structured, practical, efficient and broadly accepted methodology for standardizing physician hand-offs in the high-risk field of emergency medicine.

Designed to focus on areas of vulnerability, the process is based on established evidence, expert consensus, and clinician feedback.

The Safer Sign Out process has been implemented in 12 hospital emergency departments in Maryland, Washington, D.C., Virginia and West Virginia with the intention to improve communication, teamwork, safety, as well as patient and clinician satisfaction.

This presentation and panel discussion will highlight valuable lessons and potential pitfalls for engaging physicians and implementing systems for standardizing communications in a single institution or across a healthcare system.

*Presenter:*
Drew Fuller, MD, MPH, FACEP
Strategic Coordinator for Patient Safety Emergency Medicine Associates
Assistant Director, Emergency Department, Calvert Memorial Hospital

*Panel Members include:*
- Drew Fuller, MD, MPH, FACEP
- Drew White, MD, MBA, FACEP – President of Medical Staff and Chair of the Department of Emergency Medicine, Washington Adventist Hospital
- Michael Kerr, MD, FACEP – President of the Medical Staff and Chair of the Department of Emergency Medicine, MedStar Montgomery Medical Center
- Napoleon Magpantay, MD – Safety Leadership Physician, Civista Medical Center

**2:45 pm – 3:45 pm**

**Mark R. Chassin, MD, FACP, MPP, MPH,**
**President, The Joint Commission**

Dr. Chassin will discuss how The Joint Commission is fostering the development of high reliability as an ultimate goal for hospitals and health systems. He will describe specific examples of how the Joint Commission’s Center for Transforming Healthcare is producing and disseminating solutions that support the provision of high reliability healthcare.
The strategic initiatives and priorities of the Maryland Patient Safety Center are guided by a voluntary board of directors

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To Register, Click Here

- 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 by Check” 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 Alli Cain at 410.796.6239 or acain@mhei.org.

FEE for all participants

Early Registration and payment received by Tuesday, February 5, 2013: $150
Late Registration and payment received by Friday, March 22, 2013: $200
Registration closes Friday, March 22, 2013
On-site Registration and payment (including those not yet paid): $300

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 April 5.

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 call Alli Cain at 410-796-6239.

PLEASE NOTE: Registration is online ONLY.
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