PATIENT SAFETY EVOLVING:

Inspiration. Innovation. Collaboration.

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

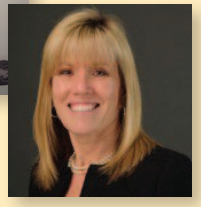
MARYLAND Patient Safety CENTER

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**

	Key Ballroom A Track 1	Key Ballroom B Track 2	Key Ballroom C Track 3	Key Ballroom D Track 4
10:00 - 11:00	**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*	**FY16 Office of Health Care Quality Patient Safety Update** **Anne Jones, RN, BSN, MA** Nurse Program Consultant *Office of Health Care Quality*	**It's Time to Regulate: Antimicrobial Stewardship Standards in Acute Care Settings** **Emily L. Heil, PharmD, BCPS-AQ ID** Assistant Professor – Infectious Diseases *University of Maryland School of Pharmacy*	**Ransomware as a Disruptive Force in Healthcare** **Ron Galloway** *Researcher and Filmmaker*
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*	***Minogue 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**			
	Key Ballroom			
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*			

Key Ballroom

8:15 am - 9:15 am
Opening Keynote
Three Dice: The Path to Highly Reliable Outcomes

We live in a world filled with inescapably fallible human beings. How then do we design a healthcare system to maximize our ability to keep our patients safe? David Marx will explore the concepts of reliable design, and safety-supportive cultures. He'll share his "secret sauce" for highly reliable outcomes.

Learning Objectives:
1. Describe how to build highly reliable clinical systems (three dice)
2. Identify how to think about human choices within those systems (hazards and threats)
3. Outline how to think about feedback loops (learning)

Presenter:
David Marx, JD
CEO, Outcome Engenuity

9:15 am - 9:30 am Recognition of 2017 Winners of Patient Safety Innovation Awards
9:30 am - 10:00 am Break and Visit Exhibitors and Patient Safety Poster Presentations

CONCURRENT SESSIONS

Track 1 (Key Ballroom A)

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 TeamSTEPPS™ 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 TeamSTEPPS™ program
2. Describe connections between family-centered care and TeamSTEPPS™ events and tools
3. Outline specific tools that patients and/or families can utilize to improve safety, family and patient-centered care
4. Outline one strategy for empowering families to use TeamSTEPPS™ tools

Presenters:
Jim Rost, MD, FAAP
Jennifer Ustianov, MS, BSN, RN, IBCLC
TeamSTEPPS 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.

Track 2 (Key Ballroom B)

10:00 am - 11:00 am
FY16 Office of Health Care Quality Patient Safety Update

This session presents adverse event cases reported through the Office of Health Care Quality's mandatory hospital reporting system. Trends in reported events, root causes, and corrective actions will be discussed, as will findings from submitted RCAs and individual case studies.

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

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

11:15 am – 12:15 pm
Minogue 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.

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

Track 4 (Key Ballroom D)

10:00 am - 11:00 am
Ransomware as a Disruptive Force in Healthcare

What would you do if you suddenly found your electronic health records (EHR) encrypted and not available for access? How does this impact patient safety? Ransomware is malicious software that can disable all your records in the blink of an eye. Hospitals around the country—both large and small—are experiencing the dilemma of ransomware invading computers and encrypting all files, leaving patient care at a standstill, even resulting in patient transfers and delayed care. And now viruses are invading medical devices in hospitals, causing further problems. This session provides a deep dive into recent occurrences of ransomware in healthcare, how best to prevent it and what to do if it happens to your hospital. Ron presents this in a manner that is clear, and to the point, with minimal geek-speak.

Learning Objectives:
1. Outline what hospitals can do to prevent ransomware
2. List seven practices all employees should know to prevent ransomware
3. Describe recent and new EHR hacks and their impact on patient safety

Presenter:
Ron Galloway, Researcher and Filmmaker

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 remediating employees' problematic behaviors
4. Demonstrate helpful phrases to use in any difficult conversation bearing on another person's problem behaviors

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

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

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 remediating system issues 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

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 playwright, 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

Meet the Board of Directors

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

REGISTRATION

13TH ANNUAL MARYLAND PATIENT SAFETY CONFERENCE
MARCH 17, 2017

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.

ACTIVITY TITLE	UAN	CONTACT HOURS	
Three Dice: The Path to Highly Reliable Outcomes	0592-9999-17-005-L05-P	Knowledge	1
Caring for Diverse Communication-Vulnerable Patients – a Patient Safety Challenge	0592-9999-17-006-L05-P	Knowledge	1
The Evolution of Patient- and Family-Centered Teamwork Training: Cracking the Code for Our Most Important Team Members	0592-9999-17-007-L04-P	Knowledge	1
Healthcare Information Technology (HIT) and Patient Safety: A Two Edged Sword	0592-9999-17-008-L05-P	Knowledge	1
FY16 Office of Health Care Quality Patient Safety Update	0592-9999-17-009-L05-P	Knowledge	1
Making a PACCT to CARE: Leveraging Community Resources to Educate, Engage and Empower Patients	0592-9999-17-010-L04-P	Knowledge	1
Preventing Suicide in Psychiatric and Acute Care Settings, Including Prevention of Post-Discharge Events	0592-9999-17-011-L01-P	Knowledge	1
It's Time to Regulate: Antimicrobial Stewardship Standards in Acute Care Settings	0592-9999-17-012-L01-P	Knowledge	1
Accountable Care Unit Model Creates Culture Change of Shared Accountability to Patient Safety and Quality Goals	0592-9999-17-013-L04-P	Knowledge	1
A Team-Based, Innovative Approach to Reducing the Incidence of Chronic Lung Disease in the Premature Newborn	0592-9999-17-014-L01-P	Knowledge	1
Ransomware as a Disruptive Force in Healthcare	0592-9999-17-015-L04-P	Knowledge	1
Primum Non Tacere, or Why Don't We Speak Up?	0592-999-16-016-L05-P	Knowledge	1
Diagnostic Error: Overview, Challenges and Recommendations	0592-9999-017-L05-P	Knowledge	1
#It'sWhat'sInYou	0592-9999-17-019-L05-P	Knowledge	1

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:

Name of Faculty/Presenter/Planner	Reported Financial Relationship
John Banja, PhD	Nothing to disclose
James Battles, PhD	Nothing to disclose
Barbara Charen, RN, BSN, BA, CPHRM	Nothing to disclose
Ron Galloway	Nothing to disclose
Emily L. Heil, PharmD, BCPS-AQ ID	Consultant: Alk-Abello
Anne Jones, RN, BSN, MA	Nothing to disclose
Susan Mani, M.D., FACC	Nothing to disclose
David Marx, JD	Nothing to disclose
Ellen M. Mongan, MD	Nothing to disclose
Robert Roca, MD, MPH, MBA	Nothing to disclose
Jim Rost, MD, FAAP	Employee: TeamSTEPPS Elite, Inc.
Cal Sheridan	Nothing to disclose
Susan Sheridan, MBA, MIM, DHL	Nothing to disclose
Mike Sukumar, MD	Nothing to disclose
Karen Twigg, BSN, RN, CMCN	Nothing to disclose
Jennifer Ustianov, MS, BSN, RN, IBCLC	Employee: TeamSTEPPS Elite, Inc.
Matthew Wynia, MD, MPH, FACP	Nothing to disclose

The **planners and managers** 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:

Name of Planners	Reported Financial Relationship
Dee Morgillo, MEd., CHCP	Nothing to disclose
Ronald Viggiani, MD	Nothing to disclose
Alison Burrows, MBA, RN	Nothing to disclose
Bonnie DiPetro, MS, RN, NEA-BC, FACHE	Nothing to disclose
Kelly Yost	Nothing to disclose
Robert Imhoff	Nothing to disclose
Mark Rulle, EdD	Nothing to disclose

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 guideline 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.

Disclosure of Unlabeled Use

This educational activity may contain discussion of published and/or investigational uses of agents that are not indicated by the FDA. The planners of this activity do not recommend the use of any agent outside of the labeled indications.

The opinions expressed in the educational activity are those of the faculty and do not necessarily represent the views of the planners. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings.

Americans with Disabilities Act

In compliance with the Americans with Disabilities Act, we will make every reasonable effort to accommodate your request. For any special requests, please contact Maryland Healthcare Education Institute at 410-796-6239 before the meeting date.

Requirements for credit:

- Attend/participate in the educational activity and review all course materials.
- Complete the CE Declaration/Evaluation form online by 11:59 pm ET on **April 7, 2017.** Instructions will be provided. If you do not complete the online evaluation by this date, you will not be able to get CME/CE credit for this event.
- Upon successful completion of the online form, your statement of completion will be presented to you to print. Pharmacists, your record will be automatically uploaded to CPE Monitor.