Minnesota Alliance for Patient Safety (MAPS) Conference: Partnering for Safer Care

Oct. 27-28, 2016
Marriott Northwest, Brooklyn Park

Keynote speaker: Regina Holliday

General session speakers: Mark Graber, MD, Dorothy Sisneros and Barbara Balik

20 educational breakout sessions
Thursday, Oct. 27

7:30 – 8:30 a.m.  
Registration

8:30 – 8:40 a.m.  
Welcome and Opening Remarks

8:40 – 9:40 a.m.  
Opening Keynote Address: Quality and Patient Safety

Regina Holliday, author, artist, speaker, patient advocate, founder of The Walking Gallery, Grantsville, MD
In this opening presentation, Holliday will share her experience of caring for her husband and his struggle to get appropriate care. Fred lost his life to cancer but never lost hope that patients and caregivers can help make the system better for other families. Backed by her own patient and caregiving experiences, Holliday will address ways of improving the quality of health care delivery as well as ways to enhance patient safety.

9:45 – 10:45 a.m.  
General Session: Sharing Our Stories — Expanding the Diagnostic Team

Andrew Olson, M.D., FACP, FAAP, assistant professor, director, sub-internship in Critical Care Clerkship, University of Minnesota Medical School; Phillip Kibort, M.D., MBA, vice president of medical affairs and chief medical officer, Children’s Hospitals and Clinics of Minnesota; Dan Berg and Welcome Jerde, Minneapolis, MN
This session will focus on methods to improve the diagnostic process through sharing the story of one local Minnesota family’s tragic experience with diagnostic error. This will be a facilitated interview focused on analyzing where the diagnostic process broke down and what changes can be made to avoid such errors in the future.

10:45 – 11:10 a.m.  
Break

11:10 a.m. – 12:10 p.m.  
Breakout Sessions

#1 The New Diagnostic Team — Doctors, NPs, PAs, Nurses and…THE PATIENT
Mark Graber, M.D., FACP, senior fellow, president and founder of Society to Improve Diagnosis in Medicine, Stony Brook, NY
This session will discuss the new recommendations from the Institute of Medicine report “Improving Diagnosis in Health Care” on working as a diagnostic team. The role that patients and nursing staff can play will be emphasized. Pathology and radiology have drifted away from the team and need to be brought back. The role that the electronic medical record plays in advancing and hindering teamwork and diagnosis will be reviewed.

#2 Lessons Learned from a Traumatic Event
Joy Plamann, MBA, RN, BC, vice president of operations, CentraCare Health, chief nursing officer, St. Cloud Hospital, St. Cloud, MN
Hospitals have been places of healing, but in recent years have also been identified as places of risk, with the incidence of violent episodes increasing across the state of Minnesota. Learn from the experience of one hospital about proactive interventions to mitigate the risks of violence as well as strategies to implement after an active threat event has taken place.

#3 Patient-Instigated Parkinson’s Medication Improvement Project: A Success Story
Ron Kitzmann, RPH, MBA, director, pharmacy, Park Nicollet Methodist Hospital, St. Louis Park, MN; Joan Gardner, RN, BSN, nurse clinician, Park Nicollet Methodist Hospital, St. Louis Park, MN; V. Ross Collins, Minneapolis, MN
The Patient-Family Advisory Committee suggested a project to improve timeliness and accuracy of administration of levodopa starting in the emergency department and going through the system. Clinic and hospital nursing, pharmacy, emergency department and medical staff representatives collaborated to make improvements. Hear about the multiple strategies implemented to continue improvement.

#4 Transcending Burnout: SurTHRIVING in Changing Times
Linda Shell, DNP, MA, RN, corporate director, education, Volunteers of America, Eden Prairie, MN
Health care is ever-changing and filled with challenges and chaos, often resulting in depression, lost work and burnout. Research indicates when SurTHRIVE skills are increased, one not only survives in changing environments, but can SurTHRIVE, resulting in increased work performance, job satisfaction and improved outcomes. This workshop discusses the concept of SurTHRIVE skills and provides practical tips.

12:10 – 1:10 p.m.  
Lunch
Breaking Sessions

#5 Promoting Health Through Happiness — Community Resiliency
Corey L. Martin, M.D., director of medical affairs, Buffalo Hospital, Buffalo, MN
A first-of-its-kind study was recently launched in two communities, Buffalo and Monticello, to help raise the level of happiness and resiliency. This study will focus on how resiliency can be learned and how it affects the overall health efforts in each community. This program will focus on both the collaboration of the two communities and the results of the program as it tries to boost the overall mental and physical health of their communities.

#6 Moving Patient Safety Forward through Measurement
Jennifer Lundblad, Ph.D., president and CEO, Stratis Health, Minneapolis, MN
Patient safety is consistently a high priority for health care delivery organizations and for patients and families. However, hospital safety measures currently reported at state and national levels don't provide a comprehensive picture for patients or hospitals. The Hospital Quality Reporting Steering Committee has developed a patient safety composite measure. Engage in a lively discussion about using measurement to advance patient safety.

#7 When EHRs Cause Patient Harm: Lessons from Malpractice
Trish Lugtu, B.S., CPHIMS, CHP, associate director, research, MMIC, Minneapolis, MN
Electronic healthcare records (EHRs) significantly improve patient safety and quality and occasionally cause harm. This session focuses on the high severity patient harm that results directly from EHR factors. Learn about EHR-related factors through malpractice data and case studies; explore barriers that contribute to breakdowns and a simplified approach for effectively reducing risk of related harm.

#8 Embrace Your Googling Patients
Andrew Olson, M.D., FACP, FAAP, assistant professor, director, sub-internship in Critical Care Clerkship, University of Minnesota Medical School, Minneapolis, MN
Because patients and families have unprecedented access to health information, health care providers must adapt to helping patients process and refine this information instead of simply providing information. This session will focus on strategies to expand the diagnostic team to include patients and families to improve the health care process.

2:15 – 2:40 p.m. Break

2:40 – 4 p.m. General Session: Diagnostic Error in Medicine — The Next Imperative for Patient Safety
Mark Graber, M.D., FACP, senior fellow, president and founder of Society to Improve Diagnosis in Medicine, Stony Brook, NY
Diagnostic error may be the largest unaddressed problem in patient safety today, in all health care settings. Graber will review findings from the Institute of Medicine report “Improving Diagnosis in Health Care” on the incidence and etiology of the problem, and steps that clinicians, patients and health care organizations could take to begin addressing the problem.

Friday, Oct. 28

8:30 – 9:45 a.m. General Session: Communication Essentials for Patient- and Family-Centered Care
Dorothy Sisneros, M.S., MBA, partner, senior vice president, client services, Language of Caring, Phoenix, AZ
We cannot engage patients and families and provide truly patient- and family-centered care without patient- and family-centered communication. Our communication needs to extend beyond the tasks and activities at hand to solicit, honor and address patients’ preferences, needs and concerns. Sisneros will define patient- and family-centered communication, describe essential skills and identify strategies for helping employees, patient and family advisors and physicians strengthen their skills and apply them to build trusting relationships, reduce patient and family anxiety and strengthen emotional support.

10 – 11 a.m. Breakout Sessions

#9 Teaming Up to Prevent Biological Specimen Handling Errors
Susan Noaker, Ph.D., LP LLC, project manager, surgical services, Fairview Health Services, Minneapolis, MN
and Deborah Axmacher, RN, MSN, MBA, CNOR, director-perioperative and endoscopy services, Fairview Health Services, Minneapolis, MN
A system network team redesigned processes to reduce errors in the management of biological specimens in the operating room. A failure modes and effects analysis assessed risk at each process step. The new procedures resulted in a 70 percent decrease in the risk of specimen mismanagement. Fairview Health Services received a National Patient Safety Foundation award for this work. Learn how they tackled this important initiative.
#10 Evidence-Based Care Delivery: Development and Diffusion of Systemwide Best Practices
Anna Kleckner, MPH, Ph.D., evidence-based practice consultant, and Tiffany Grandchamp, implementation practice consultant, Allina Health, Minneapolis, MN
Allina Health has established an evidence-based care delivery system to support clinical guideline development, communication, implementation and monitoring. There are three components: the Allina Health Evidence-Based Decision-Making Model, the Allina Health Diffusion Model and an evidence-based care delivery dashboard for tracking multiple outcomes. Two systemwide best practice efforts will be featured.

#11 Strengthening Community Partnerships: Post-Discharge Firefighter Visits
Steve Koering, fire chief, St. Louis Park Fire Department, St. Louis Park, MN, and Linda Bauermeister, MAL, BSN, RN, senior director of home care, hospice and population health, Park Nicollet, St. Louis Park, MN
Learn how emergency medical technicians from the St. Louis Park Fire Department and the care integration team at Park Nicollet Methodist Hospital collaborated to develop procedures and outcome metrics to improve the transition from hospital to home. The program has resulted in reduced hospital readmissions, improved outcomes and high patient satisfaction.

#12 Improving Provider/Patient Relationships and Diagnostic Quality Through Deliberative Patient Engagement
Kyle Bozentko, executive director, The Jefferson Center, St. Paul, MN
The Jefferson Center has conducted research on reducing diagnostic error and improving patient/provider communication through deliberative patient engagement to generate patient-centered strategies and recommendations for improving diagnostic quality. Explore steps providers and care systems can take to implement recommendations in their care settings, incentives encouraging adoption of these recommendations and additional opportunities to expand patient engagement in safety efforts.

11 – 11:15 a.m.
Break

11:15 a.m. – 12:15 p.m.
Breakout Sessions

#13 Using Clinical and Cultural Change Interventions to Reduce CAUTI
Susan Klammer, MPH, quality/patient safety project coordinator, Minnesota Hospital Association, St. Paul, MN, and Stacie Urbanick, MSN, RN, director of nursing, Essentia Health-St. Mary’s Oak Crossing, Detroit Lakes, MN
Long-term care organizations achieved a significant reduction in CAUTI through implementing the AHRQ Safety Program for Long-Term Care: CAUTI. Learn about the program and hear how a participating facility used the framework and toolkit to shift culture and reduce or eliminate CAUTI.

#14 Respecting Ourselves and Our Patients: Improving Patient Safety by Improved Handling of Violent Patients
Timothy Morgenthaler, M.D., chief patient safety officer, professor of medicine, Mayo Clinic, Rochester, MN
Health care workers experience the most nonfatal workplace violence compared to other professions. Recent studies suggest that 20-40 percent of physicians and 20-80 percent of nurses will experience episodes of violence initiated by patients, families or visitors over their career. Learn how the Mayo Clinic Violent Patient Handling Program is designed to respect both staff and patient safety.

#15 Exploring Patient and Family Engagement Across Minnesota
Catherine Schramm, MHA, project consultant, Minnesota Alliance for Patient Safety, Minneapolis, MN
Visit the newest tools and resources to advance patient/resident/client and family engagement across care settings in Minnesota. Explore the new local, virtual community designed to support and advance patient and family engagement to improve safety and care quality. Experience stories of tried and true practices and challenges encountered by organizations and those they served.

#16 Designing for Medication Safety
Steve Meisel, Pharm.D., CPPS, director of patient safety, Fairview Health Services, Minneapolis, MN
Medication safety is a high priority, but often confounded by ambiguous definitions and the lack of a standard national metric. Safety improvement efforts are often taken in reaction to internal and external events. In this session, learn how one health system established a conceptual framework and organizational model for approaching medication safety. Measures of success will be explained and reviewed.

12:15 – 1:15 p.m. Lunch
Breakout Sessions

#17 Using LEAN A3 Problem-Solving as a Proactive Process to Improve Patient Safety
Michael Goleski, RT (R), MBA, CPHQ, radiology manager; Raegan Sipe, BSN, RN, CEN, clinical care supervisor, and Jean Kohs, R.Ph., CPHQ, Hennepin County Medical Center, Minneapolis, MN
The patient safety team at Hennepin County Medical Center implemented a successful Good Catch Recognition Program to encourage near-miss safety event reporting by frontline staff. The team addressed near-miss events using LEAN A3 methodology. This session details an effective A3 project that significantly reduced the risk for medication errors in the emergency department.

#18 Living Safely in the Community: Children and Adults with Mental Illness
Sue Abderholden, MPH, executive director, and Donna Fox, director of adult programming and suicide prevention, National Alliance on Mental Illness Minnesota, St. Paul, MN
In this session you will learn about the best practices for discharge planning for children and adults with mental illnesses. Explore how to engage families in creating safe spaces and crisis plans. Learn about means restriction.

#19 Addressing the Opioid Crisis through Evidence-Based Pain Assessment and Management
Audrey Hansen, BSN, M.A., PMP, project manager, health care consultant, Institute for Clinical System Improvement, Minneapolis, MN, and Joseph Bianco, M.D., family medicine/primary care, Essential Health – Ely Clinic, Ely, MN
Learn about the new Institute for Clinical Systems Improvement guideline for improving acute and chronic pain management, including opioids. This guideline focuses on involving patients to improve functioning, enhance quality of life and decrease pain. Hear about an effective chronic pain management program that provides safe and respectful management of opioids for chronic pain.

#20 Partnering with Patients in Strategic Organizational Safety Work
Catherine Schramm, MHA, project consultant, Minnesota Alliance of Patient Safety, Minneapolis, MN and Lisa Juliar, patient advisor, Minnesota Hospital Association, St. Paul, MN
Partnering with patients, residents and families for the safest care is one of the eight National Patient Safety Foundation recommendations. Learn from experienced organizations about ways to deepen partnerships with patients and residents in the strategic work to advance patient safety.

2:15 – 2:30 p.m. Break

2:30 – 3:30 p.m. Closing Keynote Session: Joy in Partnerships: Patients and Teams
Barbara Balik, RN, Ed.D., speaker, partner, Aefina Partners, Albuquerque, NM
Team members in all roles can achieve joy in work and energized partnerships with patients. Safe care, healthy care environments and joy in work come through thriving partnerships. Learn about transformational leadership practices that contribute to thriving partnerships that are vital for achieving joyful, patient-centered care environments.

3:30 p.m. Closing Remarks and Adjourn
Conference Information

About the conference
“Partnering for Safer Care” is the eighth statewide conference sponsored by the Minnesota Alliance for Patient Safety (MAPS) since 2002. The 2016 MAPS Conference will disseminate leading edge practices, provide knowledge on critical topics in safe care and facilitate creative and solution-oriented dialogue about how to make health care sustainably and measurably safer in Minnesota.

Objectives
- Recognize trends in safe care to improve safety across health care settings;
- Provide strategies and actions for establishing and maintaining a culture of safety;
- Demonstrate how organizations have successfully measured the outcomes of their patient safety improvement initiatives;
- Provide creative and solution-oriented initiatives to make health care safer and more sustainable everywhere;
- Explore opportunities to improve engagement between patients, residents, families and providers for safe care everywhere.

Who Should Attend
Health care professionals, quality and safety leaders, managers, educators, patients involved in facility committees or advisory groups and others interested in patient safety across all health care settings.

Registration
Registration information about the patient safety conference can be found at www.mnpatientsafety.org

You may register for this program in any of the following ways:
- By mail: download the registration form at http://www.mnpatientsafety.org/Events/2016-Conference and mail to:
  MAPS Conference
  c/o Minnesota Hospital Association
  2550 University Ave. W., Ste. 350-S
  Saint Paul, MN 55114-1900
- By fax: (651) 659-1477
- Online: visit http://www.mnhospitals.org, click on “Calendar of Events” and login to register.

Registration Fee
(Does not include lodging accommodations)
- Before Sept. 11, 2016
  - $310 MAPS members
  - $360 Non-members
  - $75 Patient or Resident Volunteer Advisors per day
- After Sept. 11, 2016
  - $395 All attendees
  - $75 Patient or Resident Volunteer Advisors per day
- On-site
  - $500 All attendees

The fee reflects the cost of program development, administration, promotion, faculty expenses, lunch and break items. MAPS reserves the right to cancel or reschedule due to an insufficient number of registrants or other unforeseen circumstances. Registration will be accepted on a first-received basis. Registration fees, less a $25 cancellation fee, are refundable if notice is received five working days prior to the program date. Registrants unable to attend may send one alternate. “No-show” registrations will be billed. Space is limited!

Special Needs
If you have any special needs that we can accommodate for this program, please contact MHA’s Education Department at (651) 641-1121 prior to the event.

Accommodations
To make reservations, please call the Marriott Northwest directly at (800) 441-6422 or (763) 536- 8300. Please indicate that you are attending the MAPS Conference when making overnight accommodations. Room rate: $139 standard suite.

Continuing Education Opportunities
- Nurses Contact Hours: This activity has been designed to meet the Minnesota Board of Nursing continuing education requirements. A total of up to 12.7 contact hours will be awarded to those attending this educational activity. However, the nurse is responsible for determining whether this activity meets the requirements for acceptable continuing education. (Day One: 6.4; Day Two: 6.3).
- Pharmacists: 10.5 contact hours have been applied for through the Minnesota Board of Pharmacy. Pharmacists must complete a CEU and program evaluation form at the conclusion of the conference. Official certificates of continuing education will be mailed to attendees after the program. (Day One: 5.25; Day Two: 5.25).
- Long-Term Care Administrators: 10.5 Continuing Education Units have been applied for through the Minnesota Board of Examiners for Nursing Home Administrators. (Day One: 5.25; Day Two: 5.25).
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Care Providers of Minnesota
Please indicate which breakout sessions you will be attending (check one per time slot)

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☐ #2 Lessons Learned from a Traumatic Event
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☐ #20 Partnering with Patients in Strategic Organizational Safety Work

Method of Payment

☐ Check made payable to MAPS enclosed ☐ VISA ☐ MasterCard ☐ American Express

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