



2011 Northwest Patient Safety Conference

May 19, 2011 – Hilton Seattle Airport & Conference Center

Agenda

- 7:00 **Registration opens** -- Continental Breakfast available; Informal meet & greet with Keynote Speaker James Bagian
- 7:45 **Welcome:** Sharon Eloranta, MD, George W. Merck/IHI Fellow; Chair, Washington Patient Safety Coalition Steering Committee; Medical Director, Quality and Safety Initiatives (Qualis Health, Seattle, WA)
- 7:50 **Opening remarks:** Cathie Furman, RN, MHA, Senior Vice President, Quality and Compliance (Virginia Mason Medical Center, Seattle, WA)
- 8:00 **Keynote presentation** – sponsored by Virginia Mason Medical Center
James Bagian, MD, PE, Veteran NASA Astronaut and Professor, School of Engineering and Medical School (University of Michigan): Patient Safety – It's Not Rocket Science
- 9:30 **Break for Coffee, Networking and Poster Session/Book Sales**
- 10:00 **Keynote presentation** – sponsored by Qualis Health
Michael Leonard, MD, Principal (Pascal Metrics, Inc., Washington, DC): Never Underestimate the Power of Doing Simple Things Well – A systematic approach to safe and reliable care
- 11:00 **Break for Coffee, Networking and Transition to Concurrent Sessions**
- 11:30 **Concurrent Sessions A** – Please choose from the following:

- ❶ Hospital Transition Management: Streamlining the Patient Experience for Better Outcomes – Diane Schultz, RPh, Manager, Medication Safety and Barbara Wood, BSN, MBA, Director, Embedded Care Management Programs (Group Health Cooperative, Seattle, WA)

Hospital Transition Management is a cross-functional improvement process that joins inpatient hospital staff, care management staff, skilled nursing facility staff, clinical pharmacists and other care providers to improve health care quality, reduce avoidable costs during care transitions, and lower readmission rates. Attendees will understand how evidence-based personalized transition management to hospitalized patients will reduce hospital readmissions and improve quality of care; how patient satisfaction is affected by smooth transitions and engaging them in their care; and how medication reconciliation by ambulatory clinical pharmacists post-discharge for patients at high- risk for readmission is associated with statistically significant decreased readmission rates and reduction of potential adverse drug events.

- ❷ Challenges at the Intersection of Patient Safety and Patient Preference – Michael Leonard, MD

Patient preference for treatment and procedures creates additional challenges to improving safety. For example, 'social inductions' prior to 39 weeks gestation are increasingly requested by pregnant women, and raise the chance of neonatal ICU stays; surgical treatment for chronic low back pain is often not supported by evidence: should providers defer to patients' preferences, despite these risks? As we encourage patient activation and empowerment, what is the optimum balance between preference and safety? Dr. Leonard will explore these important issues in a thought-provoking presentation.

⑤ Identifying Vulnerable Populations at Heightened Risk for Medical Error – Elizabeth A. Mattox, RN, MSN, ACNPC, Director of Patient Safety (Veterans Administration Puget Sound Health Care System, Seattle, WA)

This session reviews populations identified as at higher risk for medical error (patients in isolation, with low English proficiency or inadequate health literacy, members of racial and ethnic minorities, and patients at the end of life). The evidence supporting heightened risk will be reviewed. Case studies will be used to illustrate the specific risks. The presentation will also include discussion of practices aimed at reducing the impact of medical error among these specific populations. Ultimately, recognizing higher risk populations allows patient safety professionals to develop targeted, proactive interventions. Attendees will be able to describe specific populations at higher risk for medical error; identify specific practices within their own organization that have the potential to increase risk to vulnerable populations; and learn how to develop proactive interventions for specific at-risk populations based on the information presented.

⑥ Regional Multiple Drug Resistant Organism Prevention Collaboration Pilot Utilizing a Community Partnership – David Birnbaum, PhD, MPH, Healthcare Associated Infections Program Manager (Washington State Department of Health, Olympia, WA)

Qualis Health, in partnership with Washington State Health Department's Healthcare Associated Infections Program, has launched a pilot project at two geographic locations to ensure that best practices in infection control, and in related inter-facility communications, are known and practiced by extended care facilities that transfer patients to and from a major acute care hospital in their region. Session attendees will be able to explain why regional approaches are thought to be the best strategy for containing the emergence of MDROs; describe the range of activities needed in acute and long-term care facilities to contain MDRO; list typical challenges and issues confronting acute and long-term care facilities as they strive to provide continuity of care, smooth transitions, and also prevent transmission of MDRO; and identify a model for forming MDRO prevention collaboratives in their own community.

12:30

Lunch



1:15

Awards Ceremony: Qualis Health Awards of Excellence in Healthcare Quality – Jonathan R. Sugarman, MD, MPH, President & CEO, Qualis Health

Since 2003, Qualis Health has granted the Award of Excellence in Healthcare Quality to outstanding organizations in Washington State. Winners have demonstrated leadership and innovation in improving healthcare practices-reflecting the very best in healthcare quality improvement.

1:45

Transition to Concurrent Sessions

2:00

Concurrent Sessions B – Please choose from the following:

① Qualis Health Awards of Excellence in Healthcare Quality presentations – *Presenters to be announced at lunch!*

Join the top three award recipients to learn more about their challenges and successful strategies in this rapid-fire session, with opportunity for discussion and Q&A.

② Advancing Safety through Every Transition in Care – Nancy E. Skinner, RN-BC, CCM (Riverside Healthcare Consulting, Whitwell, TN)

Gaps in transitions frequently foster potentially preventable negative healthcare outcomes that may compromise the achievement of patient goals and well-being. Recent studies have demonstrated that 1 in 5 patients experiences an untoward event within 30 days of discharge from an acute care facility. This session will explore transitions and coordination of care and demonstrate how a partnership between the healthcare team and patients can contribute to advancing desired healthcare outcomes. Session attendees will be able to detail three strategies that advance patient safety through each transition of care; describe the incidence, severity, and preventability of adverse events affecting patients following transitions between facilities or providers; and cite methods for fostering patient engagement, empowerment and education at each transition of care.

⑤ Turning Data into Useful, Actionable Information – Stephanie Jackson MD, FHM, System Patient Safety Officer, (PeaceHealth, Eugene, OR)

Knowing how to integrate multiple sources of patient safety information can mean the difference between drowning in data and having a lighted path to guide you to your destination. The global trigger tool is a unique and valuable lens on patient safety, but what do we do with all the new information? Learn how one organization has implemented the Institute for Healthcare Improvement Global Trigger Tool and integrated the data with other sources of safety information to drive the safe use of opiates and sedatives in the inpatient population. Session attendees will understand the advantages and limitations of various measures of patient safety; learn how integration of multiple sources of safety information can lead to a focused patient safety initiative; and be able to describe the value of a system approach to serious adverse events and the power of shared stories.

④ Partnering with Patient and Family Advisors to Support Patient Safety – Brandelyn Bergstedt, Coordinator of Patient Family-Centered Care (Seattle Cancer Care Alliance, Seattle, WA)

Partnering with patients, family members and caregivers can increase patient safety, reduce costs and improve clinical outcomes. Participants in this session will learn effective strategies for recruiting and retaining a dynamic group of Patient Family Advisors. The session will include information on interviewing, training and recognizing advisors, different methods of utilizing patients, family members and caregivers in policy and program development and examples of how each has been successful. Common misconceptions about utilizing patient family advisors will be discussed. Participants will learn how to maximize collaboration while avoiding systems breakdown and lack of buy-in. In addition to learning how to include advisors effectively, participants will also learn when including them isn't appropriate. The presenter will cover prep work necessary to begin an advisor program and participants will complete a questionnaire during the presentation to assess their organization's readiness to include advisors and determine their starting point.

3:00 **Break for Coffee and Transition to Closing Plenary**

3:15 **Closing Plenary – Joseph McCannon, Senior Advisor to Dr. Donald Berwick, Administrator, Centers for Medicare and Medicaid Services**

Mr. McCannon will address CMS' priorities for patient safety in the context of the most recent news about federal health care reform, and its implications for stakeholders.

4:15 **Adjourn**

★ Sessions and featured speakers are subject to change due to unexpected circumstances up to and including the day of the event.