**2019 DSHS Healthcare Safety Conference**

**"Protection Through Prevention"**

***Agenda, Session Descriptions and Learning Objectives***

**Wednesday, August 28, 2019**

**11:00 am – 12:00 pm** Registration and Check-in

**12:00 am – 12:10 pm** Welcome

**General Sessions:**

**12:10 pm – 1:10 pm** ***"ESRD BSIs and Hospitalizations",*** Dany Anchia, BSN, RN, CDN, Clinical Quality Manager, ESRD Network of Texas, Inc.

*The bloodstream infections (BSI) and long-term catheter (LTC) quality improvement activities (QIAs) are aimed at reducing bloodstream infections and long-term catheter rates within the ESRD Network of Texas dialysis facilities with the highest BSI rates. Improvement in these two areas of focus will be obtained by observation audits, utilization of CDC Core Interventions, development of quality improvement processes, data monitoring, monthly reporting, and ongoing patient engagement activities. The ESRD Network of Texas has also been directed by the Centers for Medicare and Medicaid Services (CMS) to collaborate with 10% of the outpatient dialysis facilities within the state of Texas. The goal of this pilot project is to achieve a 2%-point decrease in the average rate of overall hospitalizations and a 10% relative decrease in ESRD-related hospitalizations.*

Upon completion of this event, participants should be able to:

- Verbalize common infections and hospitalization causes related to dialysis patients.
- Describe and apply initiatives and interventions that the ESRD Network is utilizing to help ESRD facilities reduce BSIs and hospitalizations.

**1:15 pm – 2:15 pm** ***"How Safe is the Patient's Journey Through the HealthCare Maze?",*** Cheri Lattimer, RN, BSN, Executive Director National Transitions of Care Coalition

*The importance of positive care transitions and a safe patient journey is an essential aspect of health care quality and patient safety. As providers of care, we often focus on improving transitions from the hospital to the next level of care. Yet, every change a patient makes in their care options; a PCP referral to a specialist, a skilled nursing facility transition to home, an Emergency room visit with return to home, or any medication change is a transition interaction. These interactions need the support of a collaborative care team to ensure that care coordination, patient-centered engagement, education, medication reconciliation and management plus information transfer occur each time. This commitment of understanding the needs and barriers to providing excellent quality transitions is not an option but a mandate for changes in process and provider behavior to improve the patients' journey across the continuum.*

Upon completion of this event, participants should be able to:

- Relate to the gaps and barriers to a safe patient journey.
- Discuss 7 key elements for improving transitions and care coordination for patients and family caregivers.

**2:15 pm – 2:30 pm** Break

**2:30 pm – 3:30 pm** ***"Lessons Learned from the Frontline: C. auris in NY and Beyond",*** Belinda Ostrowsky, MD, MPH, Field Medical Officer, NY, Division of Healthcare Quality Promotion (DHQP), CDC

*Candida auris is a globally emerging multi-drug resistant yeast. New York State (NYS) first detected C. auris in July 2016 and has continued to be a highly affected area in the U.S. This pathogen is problematic due to difficulty with identification, potential to develop resistance to multiple classes of antifungal medications, and extensive transmission within healthcare facilities. C. auris colonization is also likely a risk factor for infection and can be a factor in transmission to other patients. This session will review these challenges, as well as infection, prevention and control, cleaning, and other measures to address C. auris. Practical strategies and lessons learned from the experience in NYS will be shared.*

Upon completion of this event, participants should be able to:

- Upon completion of this event, participants should be able to:
- Describe why C. auris is an emerging multi drug resistant threat (including challenges to identification, resistance profiles, ability to spread in healthcare facilities and current epidemiology).
- Describe infection prevention and control, cleaning and other management recommendations for addressing C. auris.

**3:35 pm – 4:35 pm** ***"HAI-lights from the Field",*** Anna Nutt, MPH, CIC; Susana Baumann, MPH, CIC; Bobbiejean Garcia MPH, CIC, FAPIC; Thi Dang, MPH, CHES, CIC, FAPIC; Gretchen Rodriguez, MPH, CIC; Melba Zambrano, MSN-IC, RN, CIC

*This presentation will be a lightning session covering some of the interesting investigations that occurred in the last year. Topics will include infections related to medical devices, contaminated products, medical tourism, and blood transfusions.*

Upon completion of this event, participants should be able to:

- Describe noteworthy healthcare-associated infection investigations in Texas.
- Discuss outbreak control measures, evidence-based infection control practices, and the patient notification process.

## Thursday, August 29, 2019

**7:00 am – 8:00 am** Registration and Check-in

**8:00 am – 8:15 am** Welcome

**General Sessions:**

**8:15 am – 9:15 am** ***"KEEPING PATIENTS SAFE---ONE AT A TIME",*** Eunice Halverson, MA, CPPS, Center for Patient Safety

*How do you keep your patients safe? How do you rate the patient safety culture at your organization – punitive, blame free or somewhere in between? Each participant will be invited to complete a self-evaluation matrix to rate your culture from reactive to highly reliable. This TED-style presentation will offer practical steps you can implement to positively impact your patient safety culture by improving your event reporting process and*

*clearly defining patient safety metrics. Learn how to redesign your care processes so they become consistently more reliable.*

Upon completion of this event, participants should be able to:

- Identify actions to improve patient safety culture in your work environment.t
- Apply system design improvements to your daily processes to achieve high reliability.

**9:15 am – 9:30 am** Break

**9:30 am – 10:30 am *"Patient Notification of Infection Control Breaches and HAI Outbreaks",*** CDR Kiran M. Perkins, MD, MPH, Lead, Response Team, Division of Healthcare Quality Promotion (DHQP), CDC

*Deciding if, when, and how to notify patients about infection control breaches or healthcare-related outbreak investigations can be challenging. Public health agencies play a critical role in helping assess communication needs under these circumstances. This presentation will help the participant consider reasons for when and why patient notification should be considered and conducted.*

Upon completion of this event, participants should be able to:

- Describe what constitutes patient notification and describe different types of patient notifications.
- Identify situations where patient notification should be considered.

**10:30 am – 10:45 am** Break

**10:45 am – 11:45 am *"OR to CSD Best Practices for Sterilization in Health Care Facilities",*** Bob Marrs, CRCST, CIS, CHL, VP of Organizational Development, Beyond Clean

*Approximately 27 million surgical procedures are performed in the United States each year, with up to 5% resulting in surgical site infections (SSIs). While advances have been made in infection control practices, surgical site infections are associated with substantial morbidity and mortality. It is estimated that approximately half of SSIs are deemed preventable using evidence-based strategies. You will find this session to be a complete and concise description of best practices in cleaning, transport, receipt, decontamination, assembly, sterilization, storage and distribution of surgical instruments and devices including discussion of device manufacturer's IFUs and common errors in OR and CSDs.*

Upon completion of this event, participants should be able to

- Describe reprocessing best practice workflows in cleaning, transport, receipt, decontamination, assembly, sterilization, storage and distribution.
- Describe implementation strategies for best practices.

**11:45 am – 1:00 pm** Lunch on you own

**1:00 pm – 1:30 pm *"Poster Presentations"***

**Concurrent Sessions:**

**1:30 pm – 2:30 pm *"Requirements and Rules for Operating a Licensed and Certified Ambulatory Surgery Center",*** Randy Moten, NCI, Zone Manager-San Antonio, Texas, Health Care Quality Section Zone 3, Texas Health and Human Services Commission

*All Ambulatory Surgery Centers (ASCs) in Texas must comply with Texas Administrative Code Title 25, Chapter 135 Ambulatory Surgical Centers. Those ASCs that are certified by CMS must comply with 42CFR 416. This presentation will review the operating requirements for both licensed and certified ambulatory surgery centers in Texas. The Federal Conditions of Coverage and the minimum standards for a licensed ASC will be compared. Common Patient Safety Program and National Safety Program survey deficiencies will be identified.*

Upon completion of this event, participants should be able to:

- Identify current Conditions of Coverage (Certification).
- Identify current minimum standards for a licensed ASC.

**1:30 pm – 2:30 pm *"Basics of Potable Water Systems: The Interplay of Mechanical, Operational and Chemical Challenges",*** Michael Castro, MPH, Western Hemisphere Product Manager of Healthcare Water Portfolio, Pall Medical

*In-premise water distribution systems can develop biofilm within a few days, even when the influent water meets drinking water criteria. Biofilms host bacteria, amoeba, algae and other microorganisms, which can be released under the force of water flow and subsequently travel to the points of use, i.e. showers and faucets. Biofilm provides a protective environment from chemical and thermal disinfectants and is extremely difficult to eradicate, once established. However, biofilms can contain opportunistic waterborne pathogens, which are potentially harmful for immunocompromised people, including Legionella pneumophila, Pseudomonas aeruginosa, among others and have been shown to be a major cause of severe infections, including pneumonia, in high-risk patient populations. This session will describe a multi-barrier approach to reduce risks.*

Upon completion of this event, participants should be able to:

- Identify exposure routes and amplification conditions as well as conditions which may increase the risk of water as a source of Healthcare Acquired Infections.
- Raise objections and identify infection prevention concerns associated with the mechanical, operational & chemical challenges with in-premise water systems.

**2:35 pm – 3:35 pm *"Water Management, Environmental Sampling and Outbreak Investigation",*** Michael Castro, MPH, Western Hemisphere Product Manager of Healthcare Water Portfolio, Pall Medical

*United States healthcare facilities are required to have a Water Management Program (WMP) to address the risks from growth and spread of opportunistic waterborne pathogens. Developing a plan requires input from a cross-functional team. A collaborative relationship between clinical and facility management stakeholders is critical. Without bringing together experience, evidence-based medicine and engineering solutions, the WMT may not achieve sustainable results. Environmental water sampling and outbreak investigation will be described.*

Upon completion of this event, participants should be able to:

- Identify practical steps required for the development of an effective Water Management Team and Water Management Plan for the clinical environment.
- Correctly identify and respond to a waterborne outbreak.

**2:35 pm – 3:35 pm *"Medication Safety Solutions: Technology and Systems Approach",*** Randy Martin, PharmD, BCCCP, CPPS, Associate Dean for Clinical Affairs & Assoc. Professor, UNT System College of Pharmacy; Associate Chief of Pharmacy, UNT Health; Senior Fellow, SaferCare Texas

*This session will introduce and examine medication safety technology and system solutions used in a variety of healthcare settings. This session will also explore new challenges created by new and established technologies. Upon completion of the session, learners should be more familiar with medication safety solutions and new medication safety challenges that have recently emerged.*

**3:35 pm – 3:50 pm** Break

**3:50 pm – 4:50 pm *"VIM-CRPA in West Texas",*** Gillian Blackwell, BSN, RN, CIC, HAI Epidemiologist, Texas Department of State Health Services

*This presentation will walk you through the largest cluster of VIM-CRPA in the United States. From the discovery of the carbapenemase in West Texas, to the response which included a CDC team deployed to assist, and finally to the development of the multi-facility containment strategy – "West Texas gives VIM the B.O.O.T."*

Upon completion of this event, participants should be able to:

- Describe the cases of VIM-CRPA in West Texas.
- Summarize the containment strategy used to slow the spread of VIM-CRPA.

**Friday Morning, August 30, 2019**

**7:00 am – 7:30 am** Registration and Check-in

**Concurrent Sessions:**

**7:30 am – 8:30 am *"Strategies for Mitigating Risks in the Environment of Care: A Look into the Future",*** J. Hudson Garrett Jr., PhD, MSN, MPH, MBA, FNP-BC, IP-BC, PLNC, AS-BC, VA-BC, FACDONA, FAAPM, FNAP, Assistant Professor of Medicine, Division of Infectious Diseases, University of Louisville School of Medicine

*This interactive session will review the role of the Clinical Environment of Care in the transmission of Healthcare Associated Infections. The program will also discuss core and adjunctive approaches and technologies that will address risks associated with the clinical environment of care. Finally, the session will provide healthcare professionals with a framework to address the threat of emergent pathogens and future challenges associated with disinfection and the clinical environment of care.*

Upon completion of this event, participants should be able to:

- Identify core and adjunctive approaches and technologies that serve to address risks associated with the clinical environment of care.
- Describe strategies to foster an interprofessional approach to integrating an environment of care program into the infection control program.
- Explore the impact of emerging pathogens, the changing healthcare environment, and healthcare interventions of the future and their impact across the healthcare continuum of care.

**7:30 am – 8:30 am *"Human Factors Engineering and Patient Safety: A Worksystem Framework for Protection Through Prevention Part 1: Introduction, Methodology & Overview",*** Adam Probst, PhD, MS, CPPS, Director of Human Factors Clinical Operations, Office of Patient Safety, Baylor Scott & White Health

*Human factors engineering is the application of psychological and physiological principles to the design of products, processes, and systems. The goal in healthcare is to reduce human error, increase productivity, and enhance safety and comfort. Given the complexity of healthcare work systems and processes, human factors engineering must be increasingly employed to improve patient safety. This session will describe the history, science, and key principles that can be used to improve clinical worksystems and improve patient safety. Case studies will be presented for discussion.*

Upon completion of this event, participants should be able to:

- State the brief history of human factors application to healthcare quality and safety.
- State key human factors principles related to patient safety.
- Give an example of an error related to human factors.

**8:35 am – 9:35 am** ***"Human Factors Engineering and Patient Safety: A Worksystem Framework for Protection Through Prevention" Part 2: Application",*** Adam Probst, PhD, MS, CPPS, Director of Human Factors Clinical Operations, Office of Patient Safety, Baylor Scott & White Health

*This interactive presentation will dig deeper into human factors principles and a clinical worksystem improvement framework to analyze errors in various case studies. A human factors intervention 'flip chart' will be utilized and a Patient Safety First 'How to Guide' will be demonstrated for implementing human factors in healthcare as a framework for improving patient safety.*

Upon completion of this event, participants should be able to:

- Apply human factors principles and framework to analyze human errors/use error Vs useR error.
- Apply a human factors clinical worksystem improvement framework:
    - Human factors engineering techniques and methodologies that can be utilized to identify errors and barriers to safe patient care
    - Patient Safety First 'How to Guide' for implementing human factors in healthcare as a framework for discussion

**8:35 am – 9:35 am** ***"Good Drugs and Bad Bugs: Antimicrobial Stewardship and Resistant Pathogens in Post-Acute and Long-Term Care Settings",*** Robin L. P. Jump, MD, PhD, Long-Term Care Infectious Disease Service Team Leader, Geriatric Research Education and Clinical Center, Louis Stokes Cleveland Veterans Affairs Medical Center, Cleveland, Ohio

*Antibiotic overuse contributes to the prevalence of multi-drug resistant organisms. Infection prevention and control as well as antimicrobial stewardship are key measures to combat these pathogens. Healthcare personnel working in post-acute and long-term care settings face distinct challenges for implementing contact precautions and improving antibiotic use. This session will review general principles and recent evidence to help people working in PALTC settings address these challenges.*

Upon completion of this event, participants should be able to:

- Discuss implementation of contact precautions for multi-drug resistant organisms (MDROs) in long-term care settings, balancing risks and benefits
- Review general principles of antibiotic stewardship and its importance in post-acute and long-term care (PALTC) settings.

**9:35 am – 9:50 am** Break

**9:50 am – 10:20 am *"Creutzfeldt–Jakob Disease (CJD) Infection Prevention",***
Rachael Straver, DVM, MPH, HCID/Prion Team Lead Epidemiologist, Emerging & Acute Infectious Disease Branch, Texas Department of State Health Services
*This presentation will address risk factors for exposure and infection prevention education concerning prion diseases/Creutzfeldt-Jacob disease (CJD) in healthcare settings.*

Upon completion of this event, participants should be able to:
- Describe CJD exposure risk factors.
- Describe CJD infection prevention.

**10:20 am – 10:50 am *"DSHS Healthcare Safety Status Update",*** Jennifer Vinyard, MPH, CIC, Epidemiologist, Healthcare Safety Data Team Lead and Vickie Gillespie, BSN, RN, CIC, Public Health Specialist, Texas Department of State Health Services.

*This year marks the return of Healthcare Safety data reporting after the Hurricane Harvey reporting suspension in 2017 and 2018. During this time, several changes to reporting have occurred or are underway. The goal of this presentation is to describe changes implemented for the 2019 reports to reflect updates to the National Healthcare Safety Network (NHSN) data analyses as well as describe 2019 legislative changes to the Healthcare Safety Reporting mandate to align reporting requirements with the Centers for Medicare and Medicaid Services Healthcare Associated Infections (HAI) reporting mandates. The phase in schedule and important dates will be provided. In addition, preliminary results of PAE reporting will be shared and "Is This Reportable?" PAE case scenarios will be presented.*

Upon completion of this event, participants should be able to:
- Describe changes to the Healthcare Associated Infection Reporting Requirements.
- Identify the key reporting dates for phasing in reporting changes.
- State if presented adverse events are required to be reported.

**9:50 am – 10:50 am *"Infection Prevention and Control in LTC Facilities: Quality Monitoring Program Activities and Current Regulations",*** Sharilyn Mead RN, Nurse IV-NFQR and QMP Development, Quality Monitoring Program/Program Development and Innovation, Medicaid & Chip Services, Texas Health & Human Services Commission

*This presentation will provide an overview of the HHS Quality Monitoring Program and its activities related to infection prevention and control (IPC), including the development and implementation of an evidence-based best practice IPC focus area for nursing facilities. In addition, the presentation will review current state and federal regulations related to IPC in nursing facilities, assisted living and ICF/IID.*

Upon completion of this event, participants should be able to:
- Describe the function of the HHS Quality Monitoring Program, and its resources related to infection prevention and control (IPC).
- Describe the state and federal regulations related to infection prevention and control for LTC facilities.

**General Session:**

**10:55 am – 11:55 am *"Drop the Ball: Epic Failure Leads to Epic Breakthrough",***
Devin Henderson, CPS

*Devin has learned that failure isn't a dead end, it's just a fork in the road (like when he got X'd by Mel B and booted off America's Got Talent). Learn how taking risks, "dropping the ball", picking up the ball, and repeating that process makes you a winner…and may the fork be with you. This presentation will outline step step-by-step strategies for accomplishing goals and using failure to your advantage.*

Upon completion of this event, participants should be able to:

- Identify step-by-step strategies for accomplishing goals.
- Enhance their ability to use failure to their advantage.

**11:55 am – 12:00 pm** Final Comments and Instructions