



**Concurrent Sessions**  
**Monday, September 15<sup>th</sup> 2008**

4:15 – 5:30 PM

**Lessons from the Other Side of the Fence – Grass is not always Green for Health Plans (501)**

Joyce E Hall, RN CPHQ

Coming from the provider world to the dark side (payers) I found myself shocked at the depth of the quality programs that health plans have. I want to share the insights I have developed over the last 2 years. Health Plans and Providers often find themselves on opposite sides of a fence, in which we need to learn to build gates. Health Plans and Providers have similar goals, similar struggles and similar quality improvement programs but do not often recognize these similarities. The focus of this session is to identify those similarities and build on them to improve member/patient outcomes. Regulatory and Accrediting surveys for the two entities are compared and parallels are drawn. Providers can learn from the electronic submissions that are now required of health plans. Successful collaborations between Health Plans and Providers will be discussed and participants will have an opportunity to explore other possibilities for collaboration.

**How to Powerfully View Data When “Yucky” events are Rare! (Intermediate to Advance) (502)**

Sandra K Murray, MS RD

Standard run or control charts are not accurate when dealing with rare events (falls, needle sticks, infections, other rare errors). Using two newer Control charts, the T and G charts, to track time between or counts between rare events is more appropriate. Learn about this new tool for healthcare.

**The Relationship between Volume and Patient Harm (503)**

Alberta T Pedroja, PhD CPHQ

Attendees will learn how levels of volume relate to patient harm and what steps can be taken to insure patient safety. While it has long been supposed that we make more mistakes when we get busy, we have not been able to quantify the relationship between volume and patient harm so that we know how many patients is unsafe. Furthermore, the likelihood of making a medical mistake appears to increase precipitously, where one more patient in the ED or one more laboring mother can sometimes move the unit into chaos. The study presented here offers a methodology for determining what measures of volume are most predictive of patient harm. These simple calculations provide a rational approach to upward flexing to avoid medical mistakes. Leaders will be able to

develop an early warning system that will increase systems capacity and relieve the pressure caused by high volume.

### **Disruptive Behavior: The New Leadership Imperative (504)**

Paul L Green, MS RN CPHQ

Research from VHA and others shows that conflict and abusive behavior with potentially devastating outcomes happens in highly technical environments, in situations of high stress and among highly educated professionals. Aviation and the military learned this over 20 years ago and developed training scenarios and strategies to improve outcomes in stressful situations. The result has been a drastic decrease in air crashes and fatalities over the last 20 years in this country. These principles have been adapted for healthcare and are proving successful in centers around the country in improving team focus and patient safety. The concepts are so important that they form the basis of JCAHO standards requiring training on team concepts and the 2009 Leadership Standards. These concepts can become a key part of an organization's arsenal to reform culture and create safer and more reliable delivery of high quality care across multiple interventional and service areas.