THE RIGHT CARE, RIGHT SETTING, AND RIGHT TIME OF HOSPITAL FLOW

March 9, 2017

Dial In: 877.668.4493
Code: 662 657 398

Having Audio Issues?

If you experience any disruptions or other issues with audio during today's WIHI, we ask that you:

- Notify WIHIAdmin through the WebEx chat
- If the problem persists, notify IHI Customer Service at 617.301.4800 or info@ihi.org

Download resources and slides when you log off or next day on IHI.org/WIHI

Dial In: 877.668.4493
Code: 662 657 398

Madge Kaplan

Director of Communications
Institute for Healthcare Improvement

Madge Kaplan, IHI's Director of Communications, is responsible for developing new and innovative means for IHI to communicate the stories, leading examples of change, and policy implications emerging from the world of quality improvement — both in the U.S. and internationally. Prior to joining IHI in July 2004, Ms. Kaplan spent 20 years as a broadcast journalist for public radio – most recently working as a health correspondent for National Public Radio. Ms. Kaplan was the creator and Senior Editor of Marketplace Radio's Health Desk at WGBH in Boston, and was a 1989/99 Kaiser Media Fellow in Health. She has produced numerous documentaries, and her reporting has been recognized by American Women in Radio and Television, Pew Charitable Trusts, American Academy of Nursing and Massachusetts Broadcasters Association.

Pat Rutherford

Institute for Healthcare Improvement

Patricia Rutherford, RN, MS, Vice President, Institute for Healthcare Improvement (IHI), is responsible for developing and testing innovations and new models of care in innovations in patient- and family-centered care; improving access to the right care, in the right place, at the right time; Transforming Care at the Bedside; optimizing care coordination and transitions in care; and clinical office practice redesign (in primary care and specialty practices). She was Project Director for the Transforming Care at the Bedside initiative, funded by the Robert Wood Johnson Foundation, and she served as Co-Investigator for the STate Action on Avoidable Rehospitalizations (STAAR) initiative, funded by the Commonwealth Fund. Her skills include knowledge of process improvement, innovation, and idealized design; coaching clinicians, staff, and senior leaders in organizations on process improvement; and management of all aspects of large-scale performance improvement initiatives.

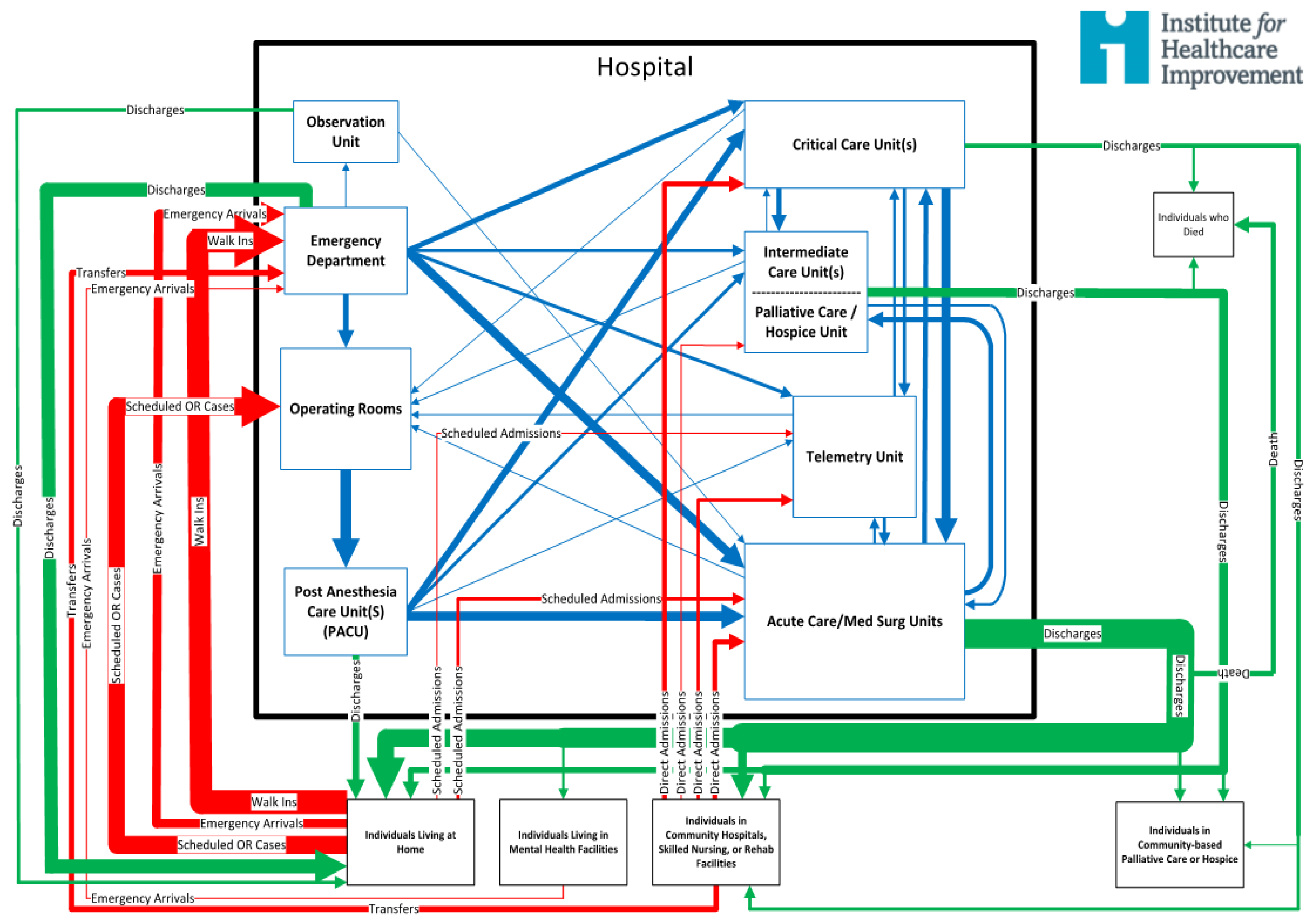
You can reach pat at Prutherford@IHI.org

For resources & slides, visit IHI.org/WIHI

Dial In: 877.668.4493
Code: 662 657 398

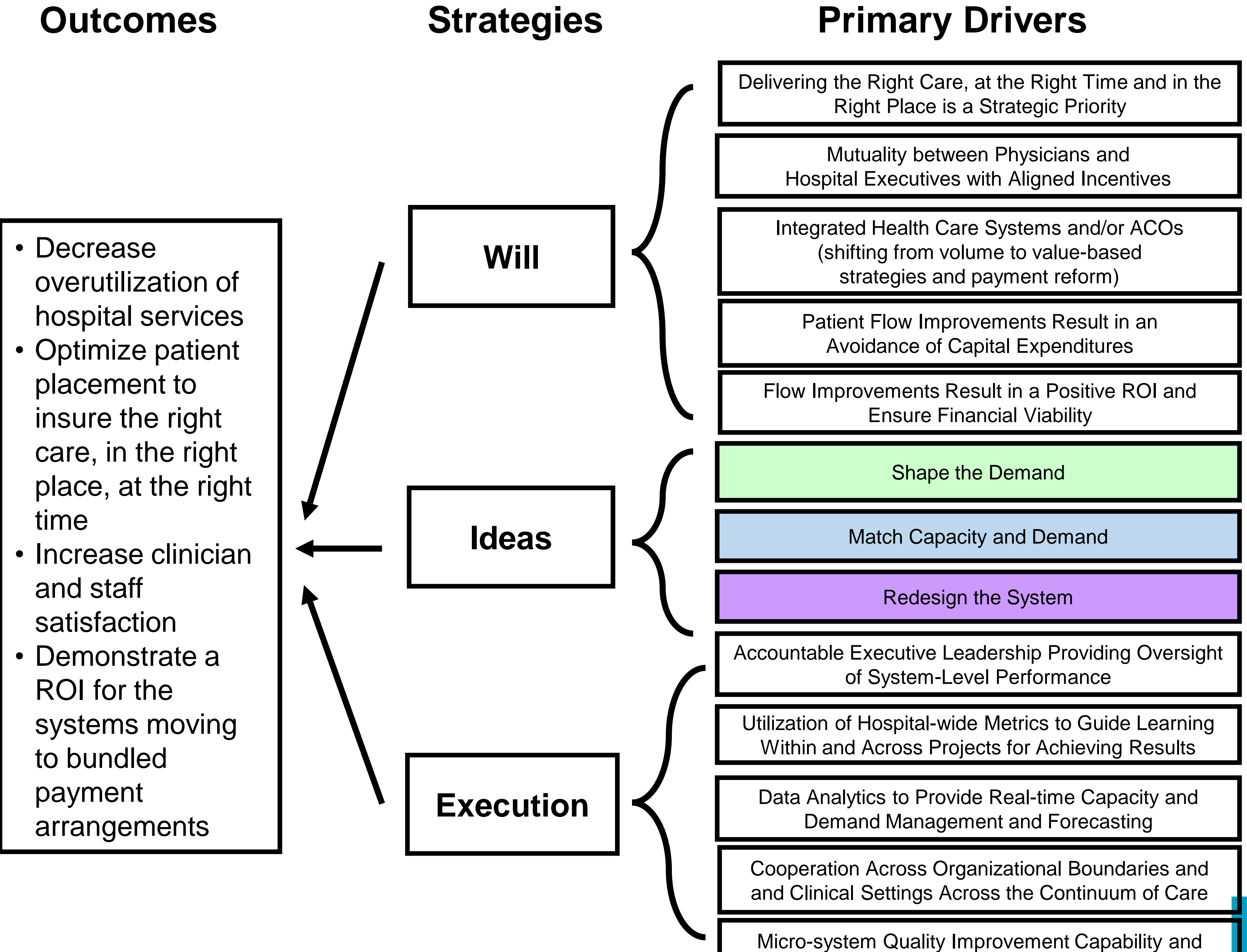
What are your performance goals?

- **Decrease overutilization of hospital services?**
  - Relocate care to more appropriate care settings outside the hospital
  - Decreasing medical errors and harm to patients
  - Manage LOS “outliers”
- **Optimize patient placement to insure the right care, in the right place, at the right time?**
  - Reducing delays in diagnostic testing, treatments, surgery, transfers, discharges, etc.
  - Decrease external diversions
  - Decrease internal diversions (“off-service” patients)
- **Maintain adequate staffing levels to maintain quality and safety?**
- **Increase clinician and staff satisfaction with hospital operations?**
- **Demonstrate a ROI for the hospital or the health system?**
  - Is your goal to have a high utilization of your hospital resources (procedures, beds and staff)? What is the right goal?
  - When do you consider adding more bed capacity?



Institute for Healthcare Improvement
Hospital
Observation Unit
Emergency Department
Operating Rooms
Post Anesthesia Care Unit(S) (PACU)
Critical Care Unit(s)
Intermediate Care Unit(s)
Palliative Care / Hospice Unit
Telemetry Unit
Acute Care/Med Surg Units
Individuals who Died
Individuals Living at Home
Individuals Living in Mental Health Facilities
Individuals in Community Hospitals, Skilled Nursing, or Rehab Facilities
Individuals in Community-based Palliative Care or Hospice
Discharges
Emergency Arrivals
Walk Ins
Transfers
Scheduled OR Cases
Scheduled Admissions
Direct Admissions
Death

Strategies to Achieve System-Wide Hospital Flow



Strategies to Achieve System-Wide Hospital Flow

Building Will

- Delivering the Right Care, at the Right Time and in the Right Place is a Strategic Priority
- Mutuality between Physicians and Hospital Executives with Aligned Incentives
- Integrated Health Care Systems and/or ACOs (shifting from volume to value-based strategies and payment reform)
- Patient Flow Improvements Result in an Avoidance of Capital Expenditures
- Flow Improvements Result in a Positive ROI and Ensure Financial Viability

Strategies to Achieve System-Wide Hospital Flow

Execution

- Accountable Executive Leadership Providing Oversight of System-Level Performance
- Utilization of Hospital-wide Metrics to Guide Learning Within and Across Projects for Achieving Results
- Data Analytics to Provide Real-time Capacity and Demand Management and Forecasting
- Cooperation Across Organizational Boundaries and Clinical Settings Across the Continuum of Care
- Micro-system Quality Improvement Capability and Empowerment of Clinicians and Staff

Ideas: Shape or Reduce Demand

Shape or Reduce Demand

- S1 Relocate care in ICUs in accordance with patients EOL wishes
- S2 Decrease demand for Med/Surg beds by preventing avoidable readmissions
- S3 Relocate low-acuity care in EDs to community-based care settings
- S4 Prevent ED visits and acute care hospital admissions
- S5 Decrease artificial variation in surgical scheduling
- S6 Decrease demand for hospital beds by reducing hospital acquired conditions

Ideas: Match Capacity Demand

Match Capacity and Demand

S7 Data-driven operational management system for hospital-wide patient flow

S8 Real-time demand and capacity management processes

S9 Early recognition of high census and surge planning

Ideas: Redesign the System

Redesign the System

S10 Improve efficiencies, LOS and throughput in the OR, ED, ICUs and Med/Surg Units

S11 Improve efficiencies & coordination of discharge processes

S12 Reducing Length of Stay for Patients with Complex Needs

Portfolio of Projects

	Shape Demand (reduce bed days; reduce low-acuity ED visits; reduce da-of-week census variation)	Match Capacity and Demand (reduce delays in moving patients to appropriate units; ensure patients are admitted to the appropriate unit)	Redesign the System (reduce bed days, reduce LOS; reduce waits and delays)
Hospital (Macro)	Reduce readmissions Reduce admissions for patients with complex needs Proactively shift EOL care to Palliative Care Programs	Hospital-wide oversight system for hospital operations looking at seasonal variation and changes in demand patterns Daily and weekly hospital-wide capacity and demand management Surge planning	Single rooms Seasonal Swing Units Service Line Optimization (frail elders, SNF residents, stroke patients, etc.)
Emergency Dept	Move patients with low acuity needs to community care settings Enroll patients in mental health programs Cooperative agreements with SNFs Cooperative agreements with EMS	Improve predictions of admissions for various units	ED efficiency changes to decrease LOS (for patients being discharged and for patients being admitted) Separate flows in the ED
Critical Care Units	Decrease complications/harm (sepsis) Shift EOL care to Palliative Care Programs	Improve real-time capacity and demand predictions	Decrease LOS (timely consults and procedures; aggressive weaning and ambulation protocols)
Med/Surg Units	Decrease complications/harm Reduce Readmissions Proactively shift EOL care to Palliative Care Programs Cooperative agreements with rehab facilities, SNFs and nursing homes	Improve real-time capacity and demand predictions	Decrease LOS (case management for patients with complex medical and social needs) "Lean" the discharge processes Stagger discharges throughout the day
Operating Rooms	Decrease variation in surgical scheduling Separate flows for scheduled and emergency OR cases	Improve predictions re: transfers to various units	OR efficiency changes to improve throughput

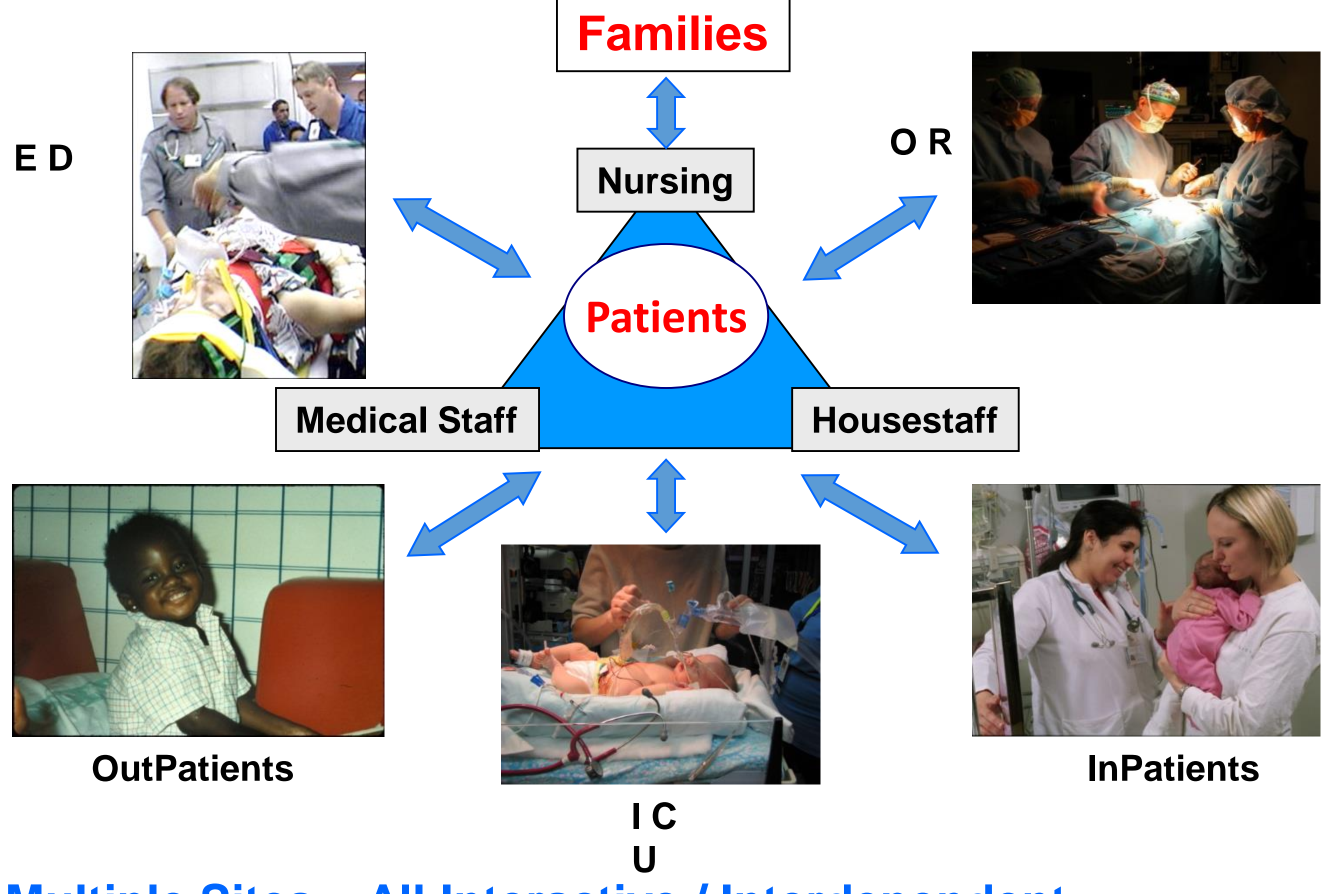
Uma Kotagal

Cincinnati Children's Hospital

Uma R. Kotagal, MBBS, MSc, is the senior executive leader for Cincinnati Children's Population and Community health efforts. In this role, she collaborates internally across teams, and externally with local partners, to improve the health of children in the Greater Cincinnati Region. She also serves a broader role as a Senior Fellow at Cincinnati Children's Hospital Medical Center, where she consults on behalf of and is an ambassador for Cincinnati Children's with other organizations. She formerly served as Senior Vice President for Quality, Safety and Transformation and Executive Director of the James M. Anderson Center for Health Systems Excellence at Cincinnati Children's Hospital Medical Center. As director of the Anderson Center, Dr. Kotagal oversaw the transformation of the health care system in Cincinnati and supported the development of Learning Networks. Dr. Kotagal has also served as director of the neonatal intensive care units at the University Hospital and at Cincinnati Children's. Dr. Kotagal is a Senior Fellow of the Institute for Healthcare Improvement, serves on the Board of Directors of the Ohio Children's Hospital Association, and chairs the Quality Improvement Committee of the Children's Hospital Association. Previously, she served as a member of the advisory committee of the Toronto Patient Safety Center and as an associate editor of *BMJ Quality and Safety*. She is a member of the National Academy of Medicine.

You can reach Uma at uma.kotagal@cchmc.org

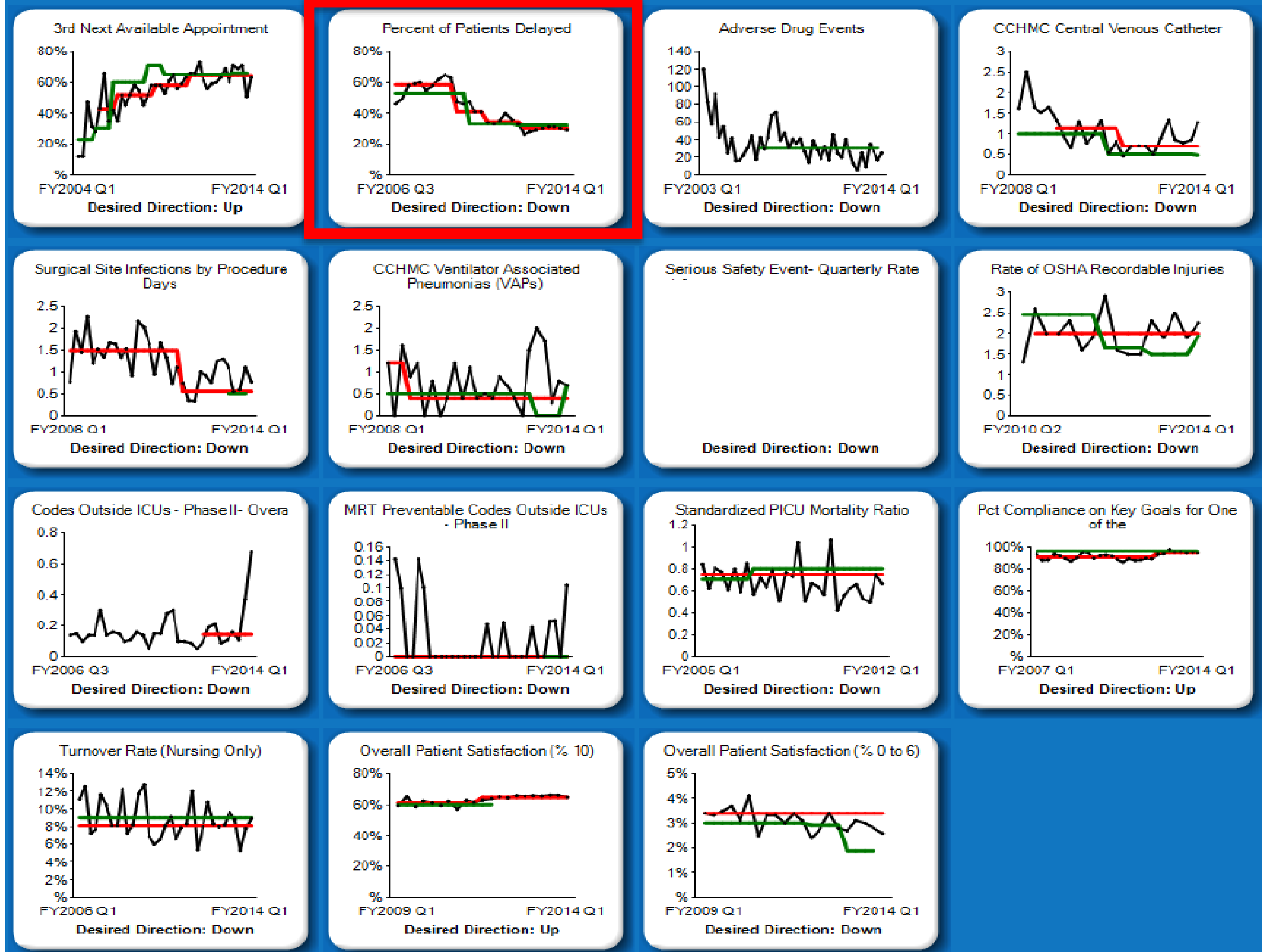
Hospital Flow - Challenge of Team

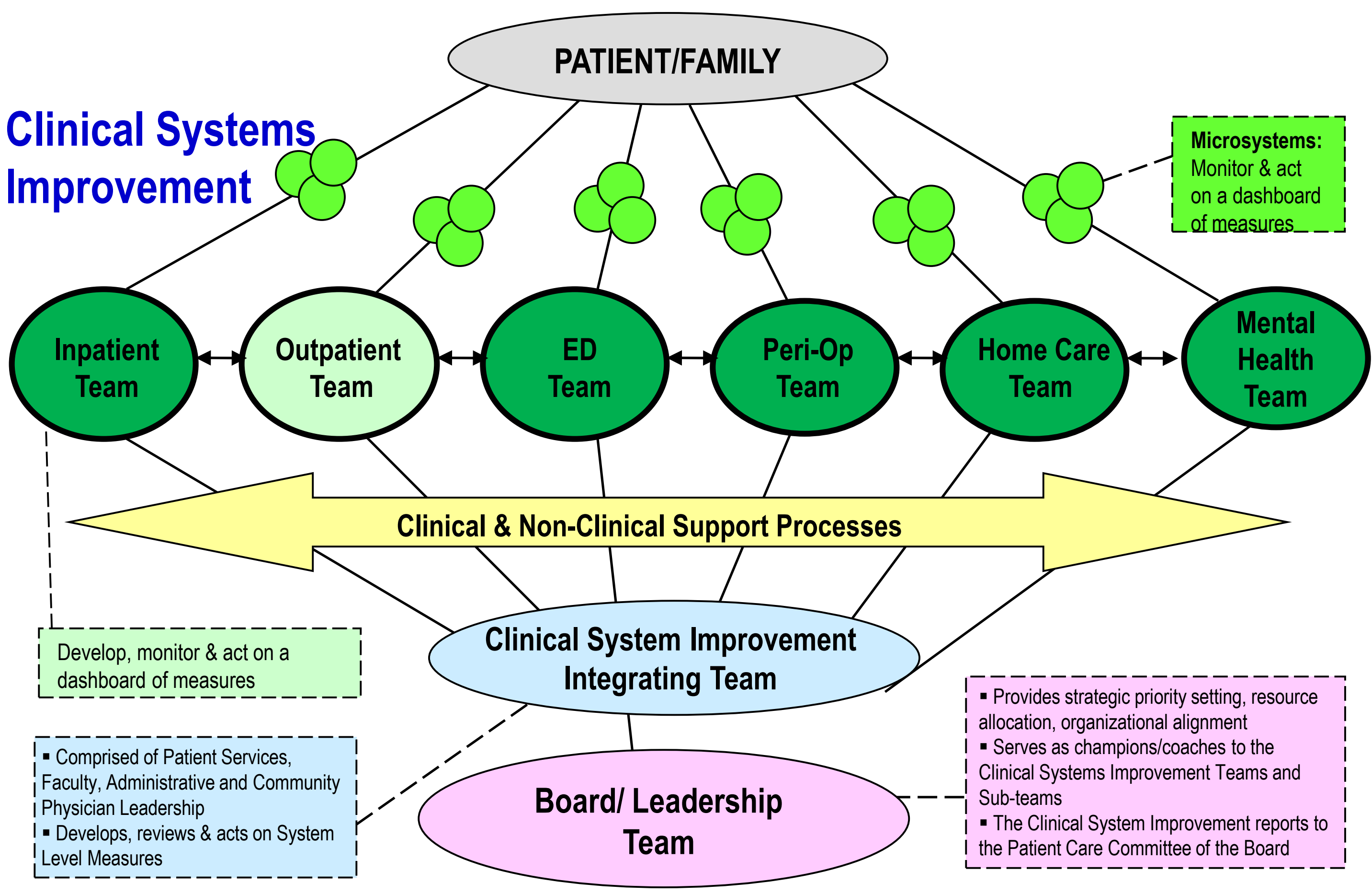


Multiple Sites – All Interactive / Interdependent

System Level Measures

ACCESS, FLOW, PRODUCTIVITY	PATIENT AND EMPLOYEE SAFETY	CLINICAL EXCELLENCE, OUTCOMES	TEAM WELLBEING	PATIENT AND FAMILY EXPERIENCE
3rd next available appointment	Adverse drug events	Codes outside the ICU rate/1,000 days	Staff Satisfaction	Overall Rating: Patient Satisfaction (best possible)
% of patients delayed: ED, PICU, PACU	Bloodstream infection rate	MRT preventable codes outside the ICU	Nursing turnover rate	Patient Satisfaction (0-6)
Touch Time for care givers	Surgical site infection rate	Standardized PICU Mortality Ratio – Expected/ Actual		
	Infection rates: VAP	% use of Evidence-Based Care for eligible patients		
	Serious Safety Events	Clinical and Functional Outcome Improvement		
	OSHA recordable injury rate			


3rd Next Available Appointment
80%
60%
40%
20%
%
FY2004 Q1
FY2014 Q1
Desired Direction: Up
Percent of Patients Delayed
80%
60%
40%
20%
%
FY2006 Q3
FY2014 Q1
Desired Direction: Down
Adverse Drug Events
140
120
100
80
60
40
20
0
FY2003 Q1
FY2014 Q1
Desired Direction: Down
CCHMC Central Venous Catheter
3
2.5
2
1.5
1
0.5
0
FY2008 Q1
FY2014 Q1
Desired Direction: Down
Surgical Site Infections by Procedure Days
2.5
2
1.5
1
0.5
0
FY2006 Q1
FY2014 Q1
Desired Direction: Down
CCHMC Ventilator Associated Pneumonias (VAPs)
2.5
2
1.5
1
0.5
0
FY2008 Q1
FY2014 Q1
Desired Direction: Down
Serious Safety Event- Quarterly Rate
Desired Direction: Down
Rate of OSHA Recordable Injuries
3
2.5
2
1.5
1
0.5
0
FY2010 Q2
FY2014 Q1
Desired Direction: Down
Codes Outside ICUs - Phase II- Overa
0.8
0.6
0.4
0.2
0
FY2006 Q3
FY2014 Q1
Desired Direction: Down
MRT Preventable Codes Outside ICUs - Phase II
0.16
0.14
0.12
0.1
0.08
0.06
0.04
0.02
0
FY2006 Q3
FY2014 Q1
Desired Direction: Down
Standardized PICU Mortality Ratio
1.2
1
0.8
0.6
0.4
0.2
0
FY2005 Q1
FY2012 Q1
Desired Direction: Down
Pct Compliance on Key Goals for One of the
100%
80%
60%
40%
20%
%
FY2007 Q1
FY2014 Q1
Desired Direction: Up
Turnover Rate (Nursing Only)
14%
12%
10%
8%
6%
4%
2%
%
FY2006 Q1
FY2014 Q1
Desired Direction: Down
Overall Patient Satisfaction (% 10)
80%
60%
40%
20%
%
FY2009 Q1
FY2014 Q1
Desired Direction: Up
Overall Patient Satisfaction (% 0 to 6)
5%
4%
3%
2%
1%
%
FY2009 Q1
FY2014 Q1
Desired Direction: Down



PATIENT/FAMILY
Clinical Systems Improvement
Microsystems: Monitor & act on a dashboard of measures
Inpatient Team
Outpatient Team
ED Team
Peri-Op Team
Home Care Team
Mental Health Team
Clinical & Non-Clinical Support Processes
Develop, monitor & act on a dashboard of measures
Clinical System Improvement Integrating Team
▪ Comprised of Patient Services, Faculty, Administrative and Community Physician Leadership
▪ Develops, reviews & acts on System Level Measures
Board/ Leadership Team
▪ Provides strategic priority setting, resource allocation, organizational alignment
▪ Serves as champions/coaches to the Clinical Systems Improvement Teams and Sub-teams
▪ The Clinical System Improvement reports to the Patient Care Committee of the Board

“Flow” as a Safety Initiative

- Prediction → Framework for Safety
- Getting the “Rights” Right
  - Right Diagnosis and Treatment
  - Right Patient in Right Bed – Location
  - Right Nursing Staff and Staffing Expertise
  - Disease Specific Expertise
  - Equipment Expertise

Best Care Model

- Requires ability to “Predict” future needs, and manage present capacity - control variability
- Operations Management techniques to understand and manage variability are the key to success

Somethings to think about that are unique about Flow

- Oversight for Flow Team
- Where to Start
- Capability Building
- Data Analytics
- Project Management

WIHI

A FREE AUDIO PROGRAM FROM IHI

Frederick Ryckman

Cincinnati Children's Hospital

Frederick C. Ryckman, MD has been a practicing surgeon at the University of Cincinnati / Cincinnati Children's Hospital Medical Center since 1984, where he is presently a Professor of Surgery. His interest in operating room management led to a collaboration to re-engineer safety, flow management, and care delivery in the OR at CCHMC. Application of this methodology led to substantial improvements in access, utilization, and safety. He is very interested in how effective teamwork and inter professional partnerships, in the operating rooms and clinical spaces, enhances safety and excellent patient care. In Dr. Ryckman's present role as Senior Vice President – Medical Operations, he's at the crossroads of patient safety, hospital wide patient flow, and daily operations management. He has had the pleasure of being the Surgical Director of solid organ transplantation leading the liver, small intestine, and multi-visceral transplant services since 1985, and has also served as the ACGME Fellowship director for Pediatric Surgery, and the Clinical Director for Pediatric Surgery Division for eight years.

You can reach Dr. Ryckman at Frederick.Ryckman@cchmc.org

Traditional Block

- Reactive System
- Urgent Emergent Cases placed within Block Time as needed
- Elective Case Plan disrupted, prolonged waiting time for elective patients
- Inefficient (Unsafe) Access for Urgent Cases
- Push complex Elective Cases into the late hours
  - Overtime
  - Wrong Team in OR

INITIAL MODEL

TWO CASE SCHEDULING TYPES

SCHEDULED CASES
85-90 % all Cases

EMERGENCIES
10-15 % of all Cases

DAILY SCHEDULE

95 % of all OR time allocated to Doctor Specific Blocks

Emergencies done at end of the day, or forced into slots between scheduled cases.

RESULT

Long Add-On List at the conclusion of the day

Long Waiting Times for parents and children with urgent needs

Often doing complex cases in evening or at night when resources were limited

Not Ideal

Sched | Actual

END OF DAY

?

Block with Urgent Access Assured

INITIAL MODEL

TWO CASE SCHEDULING TYPES

SCHEDULED CASES
85-90 % all Cases

EMERGENCIES
10-15 % of all Cases

DAILY SCHEDULE

95 % of all OR time allocated to Doctor Specific Blocks

Emergencies done at end of the day, or forced into slots between scheduled cases.

RESULT

Long Add-On List at the conclusion of the day

Long Waiting Times for parents and children with urgent needs

Often doing complex cases in evening or at night when resources were limited

OLD
Sched Actual

END OF DAY

?

NEW
Sched. Add-On Work-In

Stratified by Risk/Urgency

A-E List

END OF DAY

- Predictive system
- Urgent Cases in Defined Rooms with Scheduled Teams
- Resources needed can be modeled
- Care based on Urgency / Medical Need

James M. Anderson Center
For
Health Systems Excellence

B-E Case Access - % Successful

Cincinnati Children's Hospital Medical Cente

Add-on Case Access to the OR wi Accepted Time"B-E" Cases MAIN CAMPUS ONLY
System

percent

100%
80%
60%
40%
20%
%

OR Renovation
1 Add-On Room Closed

Aug 2006 (n=265), Oct 2006 (n=254), Dec 2006 (n=211), Feb 2007 (n=150), Apr 2007 (n=243), Jun 2007 (n=239), Aug 2007 (n=323), Oct 2007 (n=259), Dec 2007 (n=231), Feb 2008 (n=200), Apr 2008 (n=274), Jun 2008 (n=162), Aug 2008 (n=288), Oct 2008 (n=115), Dec 2008 (n=206), Feb 2009 (n=155), Apr 2009 (n=206), Jun 2009 (n=194), Aug 2009 (n=241), Oct 2009 (n=166), Dec 2009 (n=253), Feb 2010 (n=198), Apr 2010 (n=218), Jun 2010 (n=191), Aug 2010 (n=191), Oct 2010 (n=209), Dec 2010 (n=268), Feb 2011 (n=139), Apr 2011 (n=189), Jun 2011 (n=206), Aug 2011 (n=183), Oct 2011 (n=259), Dec 2011 (n=184), Feb 2012 (n=165), Apr 2012 (n=279), Jun 2012 (n=280), Aug 2012 (n=195), Oct 2012 (n=249), Dec 2012 (n=207), Feb 2013 (n=169), Apr 2013 (n=187), Jun 2013 (n=195), Aug 2013 (n=329), Oct 2013 (n=322), Dec 2013 (n=162), Feb 2014 (n=200), Apr 2014 (n=115), Jun 2014 (n=132), Aug 2014 (n=218), Oct 2014 (n=91), Dec 2014 (n=85), Feb 2015 (n=59), Apr 2015 (n=89), Jun 2015 (n=135)

CCHMC

Median — Measure Goal — Measure Value

Desired Direction

Last update: 08/07/2015 by: Amy Anneken

“A” Case Access Times – Target 30 Minutes

Cincinnati Children's Hospital Medical Cente

Add-on Case Access to the OR wi Accepted Time("A" Cases MAIN CAMPUS ONLY)
System

Minutes

250
200
150
100
50

Jul 2006 (n=3)
Sep 2006 (n=6)
Nov 2006 (n=16)
Jan 2007 (n=6)
Mar 2007 (n=7)
May 2007 (n=6)
Jul 2007 (n=7)
Sep 2007 (n=3)
Nov 2007 (n=1)
Jan 2008 (n=3)
Mar 2008 (n=3)
May 2008 (n=7)
Oct 2008 (n=2)
Dec 2008 (n=2)
Feb 2009 (n=1)
Apr 2009 (n=2)
Jun 2009 (n=1)
Aug 2009 (n=4)
Oct 2009 (n=3)
Dec 2009 (n=1)
Feb 2010 (n=1)
May 2010 (n=1)
Jul 2010 (n=2)
Sep 2010 (n=4)
Dec 2010 (n=3)
Feb 2011 (n=2)
Apr 2011 (n=3)
Jun 2011 (n=2)
Sep 2011 (n=0)
Nov 2011 (n=3)
Mar 2012 (n=2)
May 2012 (n=2)
Jul 2012 (n=3)
Sep 2012 (n=4)
Nov 2012 (n=3)
Feb 2013 (n=2)
Apr 2013 (n=1)
Jun 2013 (n=3)
Aug 2013 (n=6)
Oct 2013 (n=3)
Dec 2013 (n=1)
Feb 2014 (n=3)
Apr 2014 (n=0)
Jun 2014 (n=2)
Aug 2014 (n=2)
Oct 2014 (n=6)
Dec 2014 (n=1)
Feb 2015 (n=2)
Apr 2015 (n=4)
Jun 2015 (n=1)

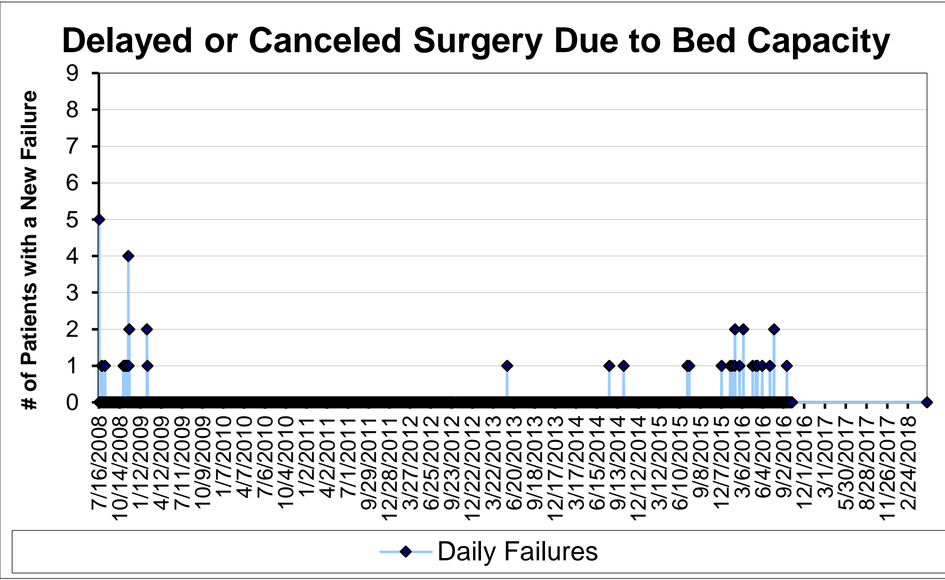
CCHMC

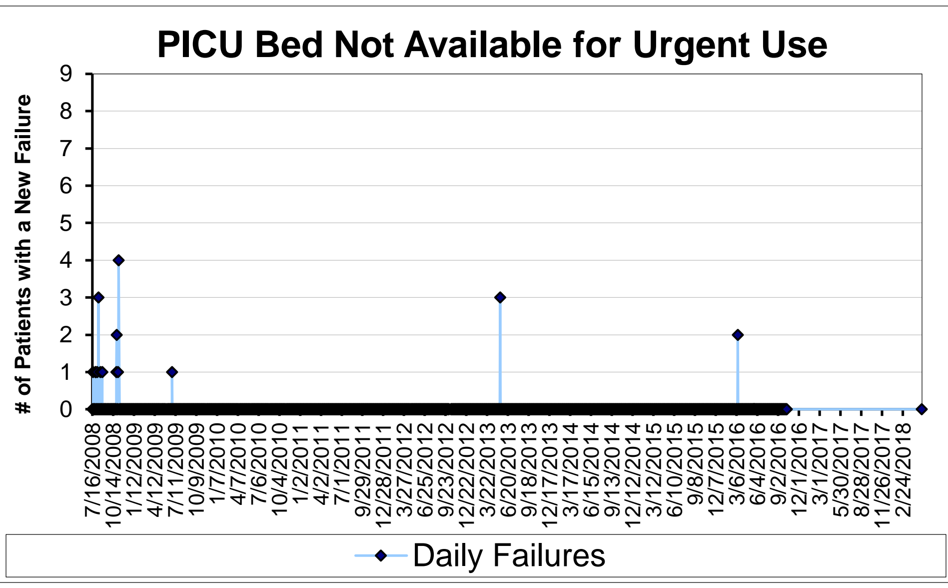
Median
Measure Goal
Measure Value

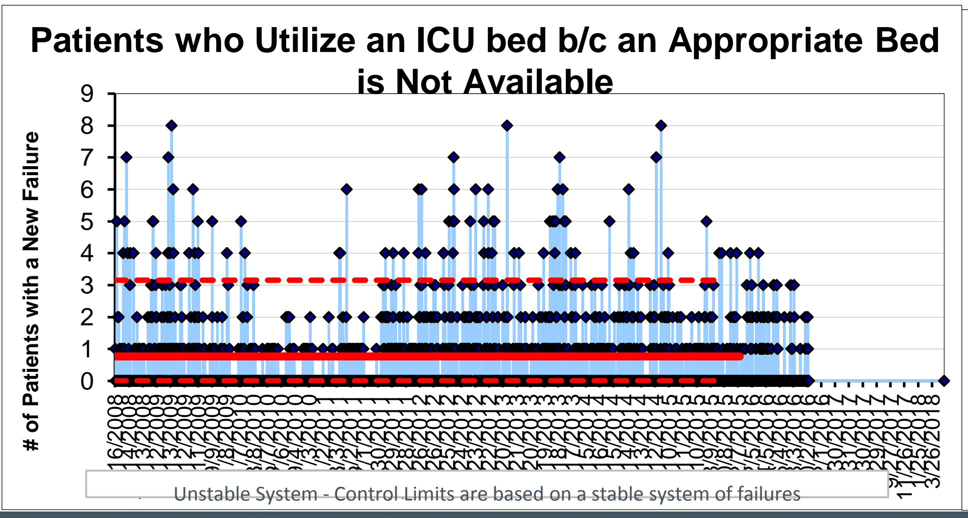
Desired Direction

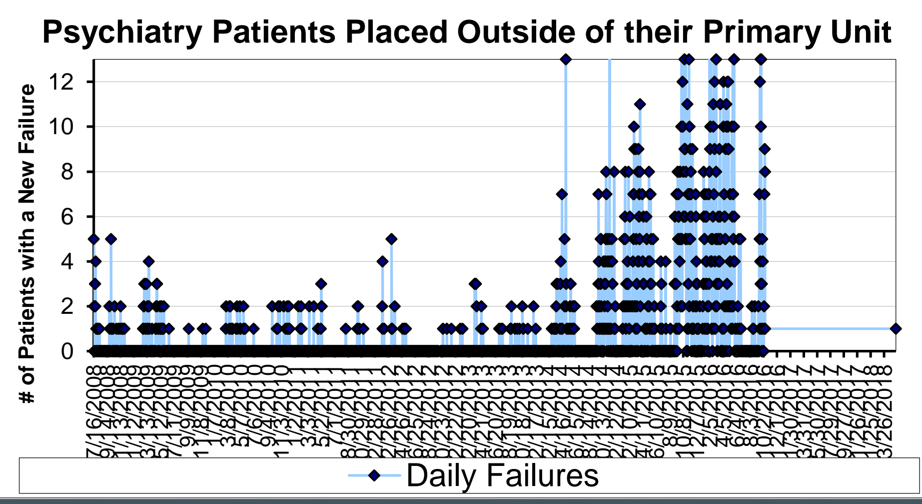
James M. Anderson Center
For
Health Systems Excellence

Critical Flow Failures









Sample Output – Probability of Full Unit

YEAR 2-7 Forecasted PICU Bed Needs - Mid-Range/Most Likely

Bed Needs for PICU - Probability of a Full Unit

20 Replications of a 425 Period (60 Day Warmup) - Mean Probability

POPULATION: Unscheduled Medical/Surgical, BMT, ENT Airway ICU Elective Cases+ OR CAP=3

Models future status
Allows for Safety Considerations
Construct "right size" units

Probability of Unit being Full

PICU BED CAPACITY

■ YEAR 2: Probability of a Full Unit at X Beds ■ YEAR 5: Probability of a Full Unit at X Beds ■ YEAR 7: Probability of Full Unit at X Beds

Staffing Prediction – Proactive Planning

- Data to Front Line Leaders – Updated daily
- Right Staff for the Right Patients
  - Correct Number and Competency
  - Flexible with Changing Environment
  - Prediction of Needs – Be Prepared – Be Resilient

Weekly Census Prediction Report

Last Exec: 10/12/2016 9:56:21 AM

Wednesday 10/12/2016	PICU	HI		NICU	Complex Airway	TCC	CBDI		Medical						Surgical			Overflow
	B5CC	B6HI	A6C	B4	B5CA	A3S	BMT	HemOnc	A4C1	A6N	A6S	A7C1	A7C2	A7NS	A3N	A4N	A4S	Overflow
Total Capacity (# of Beds on Unit)	35	25	17	59	11	24	36	32	12	24	24	11	9	41	22	24	24	
Actual Midnight Census	31	24	17	55	10	23	25	32	11	15	16	10	7	33	17	13	15	0
Predicted Admissions: OR electives	1	0	2	0	10	1	0	0	0	0	0	0	0	3	4	0	4	0
OR add on	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ED	3	0	0	0	1	1	0	0	0	7	6	0	0	6	3	2	3	0
Sleep Study	0	0	0	0	0	0	0	0	0	0	0	0	5	2	0	0	0	0
Direct Admits	0	1	0	1	1	0	0	0	0	2	1	0	0	1	1	2	1	0
EEG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	3	3	0	1	1	1	2	0	1	1	0	1	2	0	1	0	0
Infusions	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	1	0	0
Predicted Discharges	3	1	4	0	3	0	1	3	0	7	7	2	3	8	6	3	3	0
Predicted Demand	34	27	18	56	20	26	25	31	11	18	17	8	10	42	19	16	20	0
Predicted Unit Occupancy	34	25	17	56	11	24	25	31	11	18	17	8	9	41	19	16	20	0

Over Capacity	
Unit	Pts
B6HI	2
A6C	1
B5CA	9
A3S	2
A7C2	1
A7NS	1

Over Capacity	
Services	Pts
PICU	
HI	3
NICU	
Complex Airway	9
TCC	2
CBDI	
Medical	2
Surgical	
Overflow	

Discharge when Medically Ready

All Units

Managing Discharge when Medically Ready

% Discharged within 2 hours of Medically Ready

% Discharged within 2 Hours

Week StartDate (Patients Discharged)

Desired Direction of Change

GOAL — Median — UCL — LCL — % Discharged 2 hrs

Last Updated 9/20/2016 by S. Neogi, James M. Anderson Center for Health Systems Excellence

Upcoming Programs on Flow:

Hospital Flow Professional Development Program

Delivering the right care, in the right setting, at the right time

May 1-4

Cambridge, MA

For more information, visit IHI.org/Hospital-Flow

What You'll Learn

- Make sense of the variety of hospital-wide strategies and approaches needed to deliver the right care, in the right place, at the right time
- Assess the current state of patient flow and identify major opportunities for improvement
- Implement actionable strategies, skills, and data analytics that help ensure that hospital capacity can meet the demands for hospital services — daily, weekly, and seasonally – to:
  - Prevent diversions and overcrowding in EDs
  - Eliminate waits and delays for surgical procedures, treatments, and admissions to inpatient beds
  - Redesign surgical scheduling to improve throughout and to improve patient flow to intensive care units (ICUs) and inpatient units
  - Reduce the need for regular surge plans and excessive overtime
  - Increase the number of patients admitted to the appropriate inpatient unit, based on a patient's clinical condition
  - Utilize case management strategies to reduce the length of stay for "outliers"
  - Decrease inpatient volume by implementing proactive palliative care programs and strategies to reduce readmissions
  - Calculate the return on investment
- Leverage opportunities to collaborate with expert faculty and successful hospital leaders to develop or refine a detailed, customized plan

Find Us at

File Edit View Controls Store Advanced Help

iTunes

care improvement

LIBRARY
Music
Movies
TV Shows
Podcasts
Radio

STORE
iTunes Store
iTunes Match
Ping

SHARED
anderson's Library

GENIUS
Genius

PLAYLISTS
iTunes DJ
90's Music
Classical Music
Music Videos
My Top Rated
Recently Added
Recently Played
Top 25 Most Played
untitled playlist

Music Movies TV Shows App Store Books Podcasts iTunes U Ping Sign In

Subscribe Free

Category: Medicine
Language: English
© 2009 IHI

More From Don Ber...
Website

Links
Report a Concern

Institute for Healthcare Improvement

Description

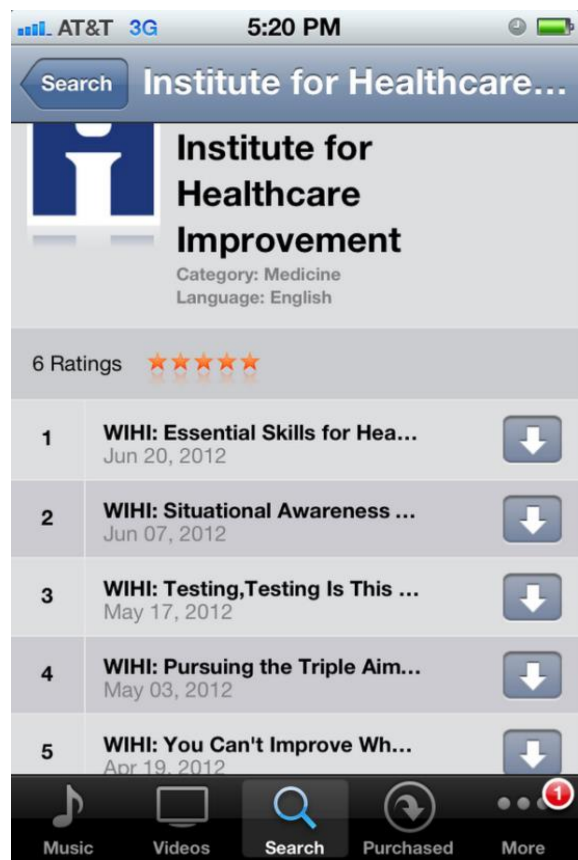
A not-for-profit organization founded in 1991 and based in Cambridge, Massachusetts, the Institute for Healthcare Improvement (IHI) is a reliable source of energy, knowledge, and support for a never-ending campaign to improve health care worldwide. IHI works with health care providers and others to accelerate the measurable and continual progress of health care systems toward safety,... ...More

	Name	Time	Released	Description	Popularity	Price
1	WIHI: Essential Skills for Healt...	1:02:42	6/20/12	WIHI is an exciting new au...		FREE
2	WIHI: Situational Awareness a...	1:00:19	6/7/12	WIHI is an exciting new au...		FREE
3	WIHI: Testing,Testing Is This P...	1:02:06	5/17/12	WIHI is an exciting new au...		FREE
4	WIHI: Pursuing the Triple Aim ...	1:23:04	5/3/12	WIHI is an exciting new au...		FREE
5	WIHI: You Can't Improve What ...	1:00:04	4/19/12	WIHI is an exciting new au...		FREE
6	WIHI: Going, Going, Green Em...	58:59	4/5/12	WIHI is an exciting new au...		FREE
7	WIHI: What Can You Learn in 9...	58:59	3/22/12	WIHI is an exciting new au...		FREE
8	WIHI: Highly Reliable Hospital...	59:32	3/8/12	WIHI is an exciting new au...		FREE
9	WIHI: The Patient Will See You...	1:00:28	2/23/12	WIHI is an exciting new au...		FREE
10	WIHI: The Social Imperative to ...	58:18	2/9/12	WIHI is an exciting new au...		FREE
11	WIHI: Have You Had The Conv...	1:02:53	1/26/12	WIHI is an exciting new au...		FREE
12	WIHI: Removing Barriers to Be...	56:23	1/12/12	WIHI is an exciting new au...		FREE
13	WIHI: Heard at the Forum New...	56:45	12/15/11	WIHI is an exciting new au...		FREE
14	WIHI: Night Talks and Nocturni...	57:29	12/1/11	WIHI is an exciting new au...		FREE
15	WIHI: Health Literacy: New Skil...	57:29	11/17/11	WIHI is an exciting new au...		FREE

Total: 175 Episodes

Listeners also subscribed to

New Directions in Health Care



Thanks to everyone who makes WIHI possible!

Next up on WIHI:

- March 23, 2017
  - What We’re Learning about Patients with Complex Needs
- April 6, 2017
  - Who’s Your Healthcare Proxy?
- April 20, 2017
  - Creating Age-Friendly Health Care Systems