

IHI's Hospital Flow Professional Development Program

Pat Rutherford

VP, Institute for Healthcare Improvement



November 4-8, 2019
Boston, MA

Have Questions?

2

The screenshot displays a Zoom meeting window. The main area shows a presentation slide from the Institute for Healthcare Improvement (IHI). The slide title is "IHI's Hospital Flow Professional Development Program" by Pat Rutherford, VP at IHI. The event dates are November 4-8, 2019, in Boston, MA. A chat panel is open on the right side of the window, titled "Chat". Inside the chat panel, a blue box contains the text "This is the chat panel". At the bottom of the Zoom window, there is a toolbar with several icons. A blue speech bubble icon is highlighted with a callout box that says "1. Click chat bubble if panel does not appear automatically". To its right is a red "X" icon. Another callout box points to the chat area, saying "2. Type your question here and send to everyone". Below the chat panel, there is a text input field with the placeholder "Type your chat message here" and a "To:" dropdown menu set to "Everyone".

Institute for Healthcare Improvement

Informational Call
September 4, 2019

IHI's Hospital Flow Professional Development Program
Pat Rutherford
VP, Institute for Healthcare Improvement

November 4-8, 2019
Boston, MA

Chat

This is the chat panel

To: Everyone

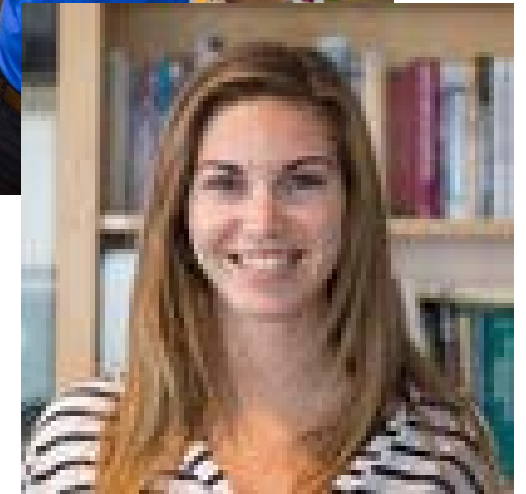
Type your chat message here

1. Click chat bubble if panel does not appear automatically

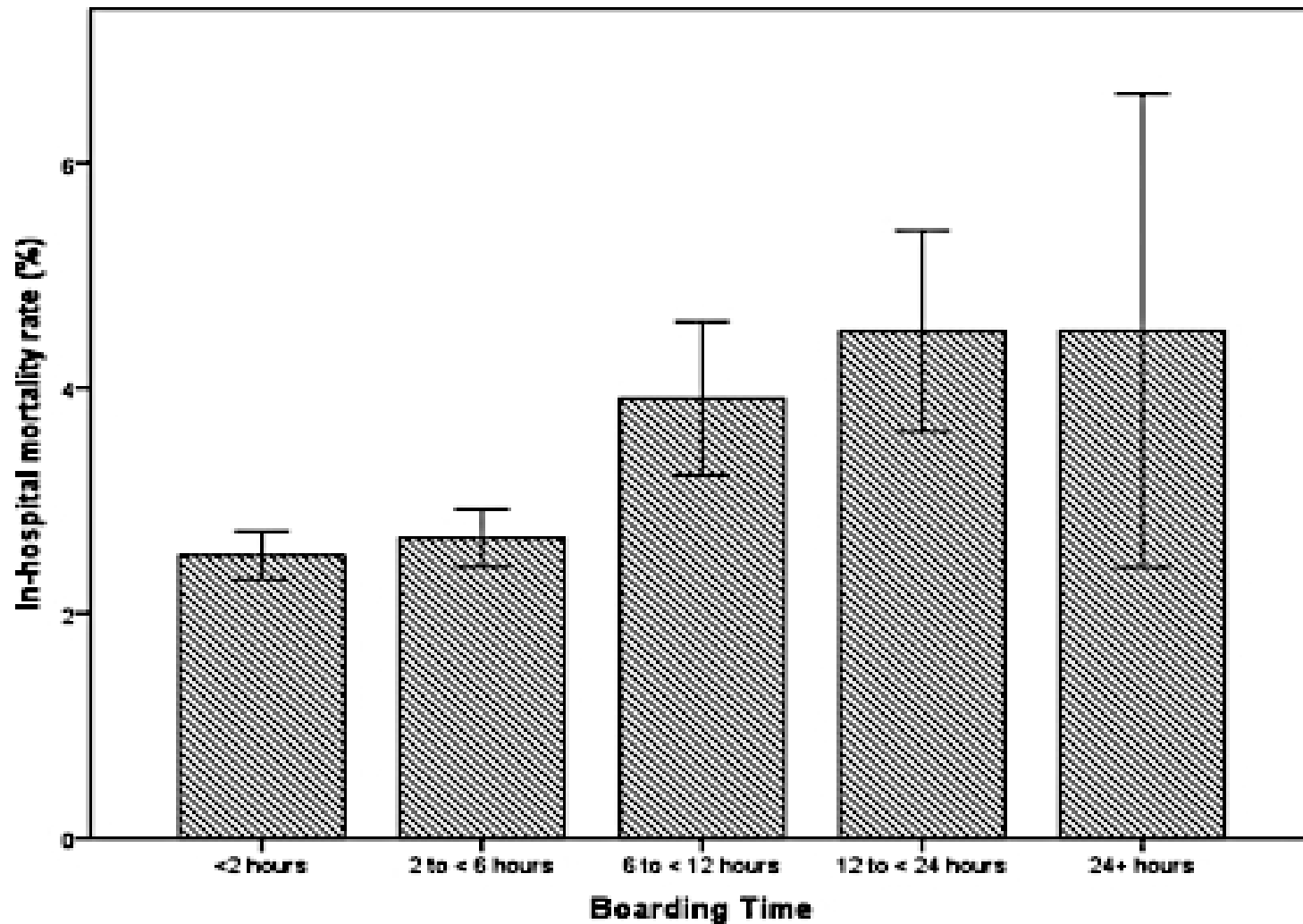
2. Type your question here and send to everyone



Why Hospital Flow Is Key to Patient Safety



ED Boarding and Mortality



Singer, A. J., Thode Jr, H. C., Viccellio, P. and Pines, J. M. (2011), The Association Between Length of Emergency Department Boarding and Mortality. *Academic Emergency Medicine*, 18: 1324–1329.



ICU Transfer Delay and Hospital Mortality

- Observational cohort study on medical-surgical wards at 5 hospitals to investigate the impact of delayed ICU transfer.
- A total of 3789 patients met the critical eCART threshold before ICU transfer, and the median time to ICU transfer was 5.4 hours.
 - Delayed transfer (>6 hours) occurred in 46% of patients (n = 1734) and was associated with increased mortality compared to patients transferred early (33.2% vs 24.5%, $P < 0.001$).
 - In patients who survived to discharge, delayed transfer was associated with longer hospital length of stay (median 13 vs 11 days, $P < 0.001$)
- Delayed ICU transfer is associated with increased hospital length of stay and mortality. Use of an evidence-based early warning score, such as eCART, could lead to timely ICU transfer and reduced preventable death.



The Problem and the Opportunity

Addressing vexing issues of patient flow in hospitals is essential to ensure safe, high quality, patient-centered care. Failure to provide the “right care, in the right place, at the right time” puts patients at risk for sub-optimal care.

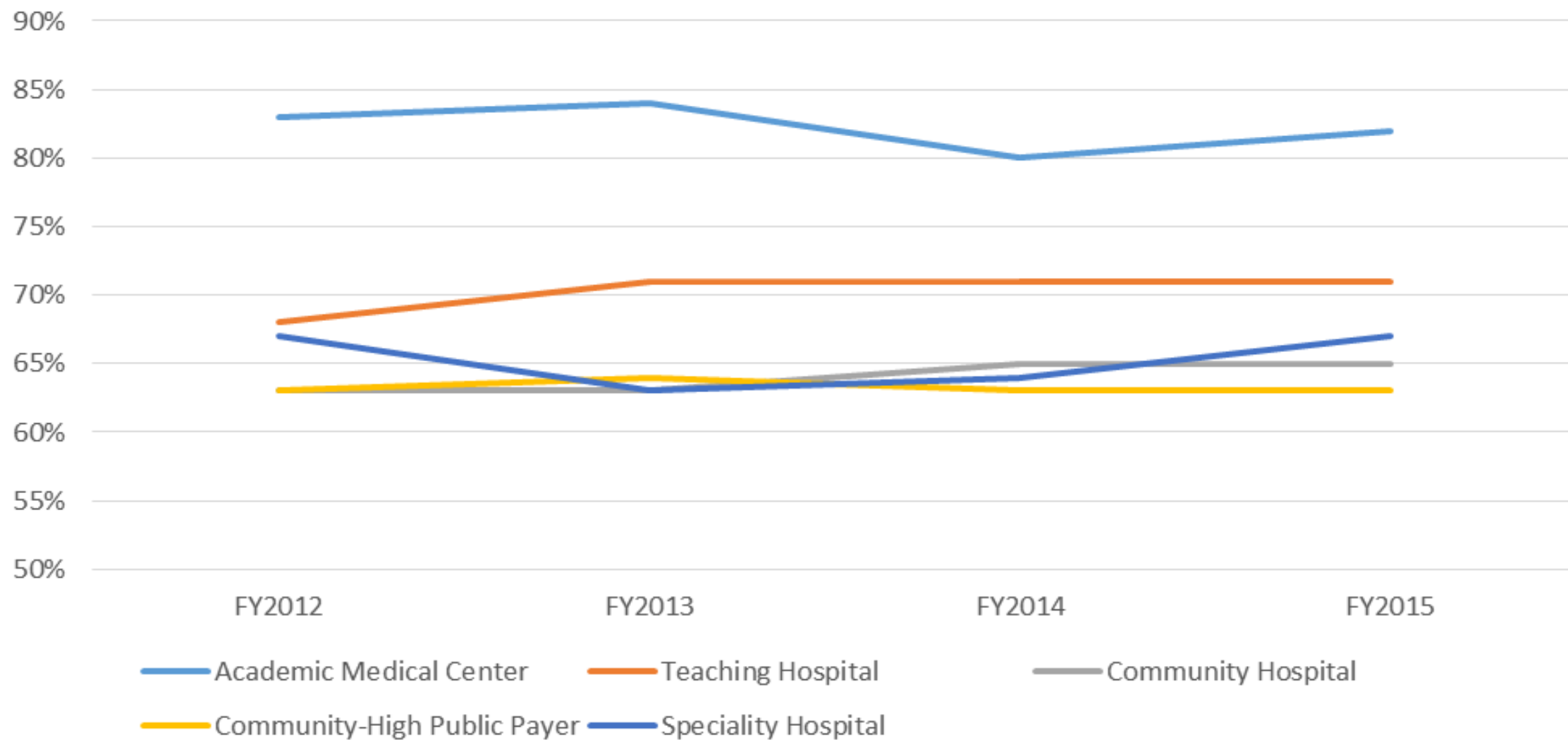
Poorly managed hospital flow also adds to the already taxing burden on clinicians and staff and diverts their attention from clinical care. Improving hospital flow is critical lever for increasing value -- for patients, clinicians and health care systems.



What would success in achieving hospital-wide flow look like at your hospital or health system?



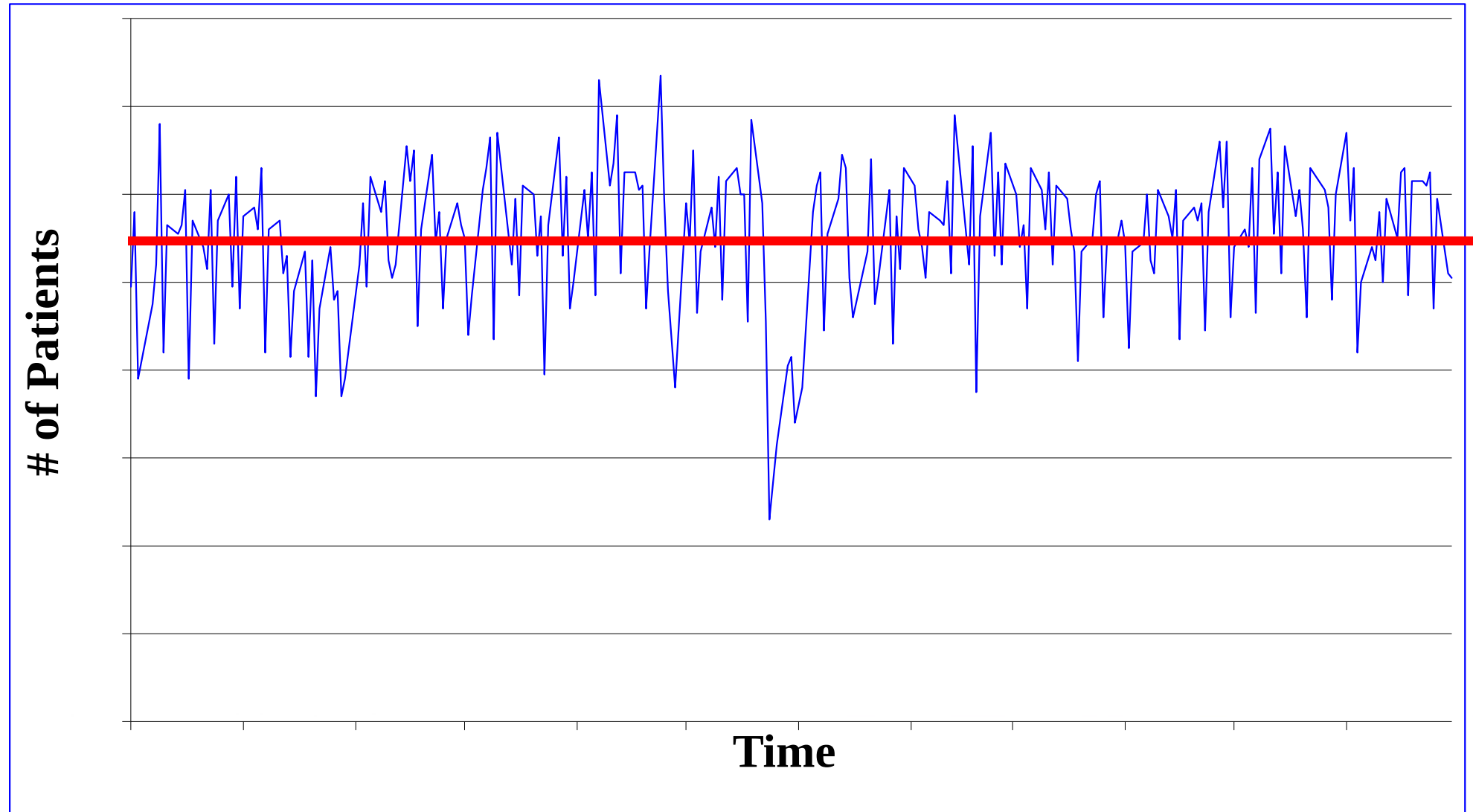
Median Occupancy Rates by Cohort



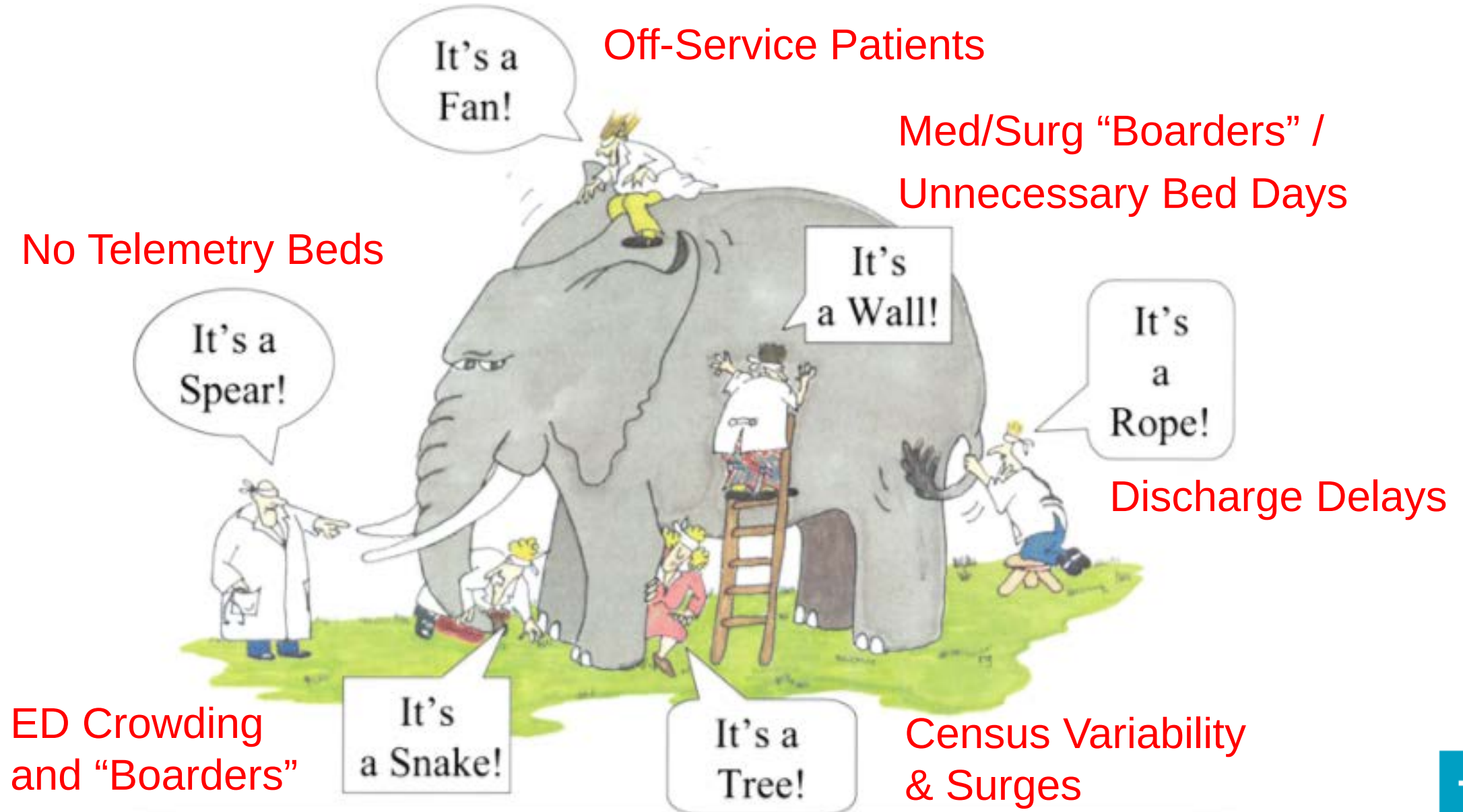
Source: Massachusetts Hospital Profiles, Data Through Fiscal Years 2012-2015, Center for Health Information and Analysis



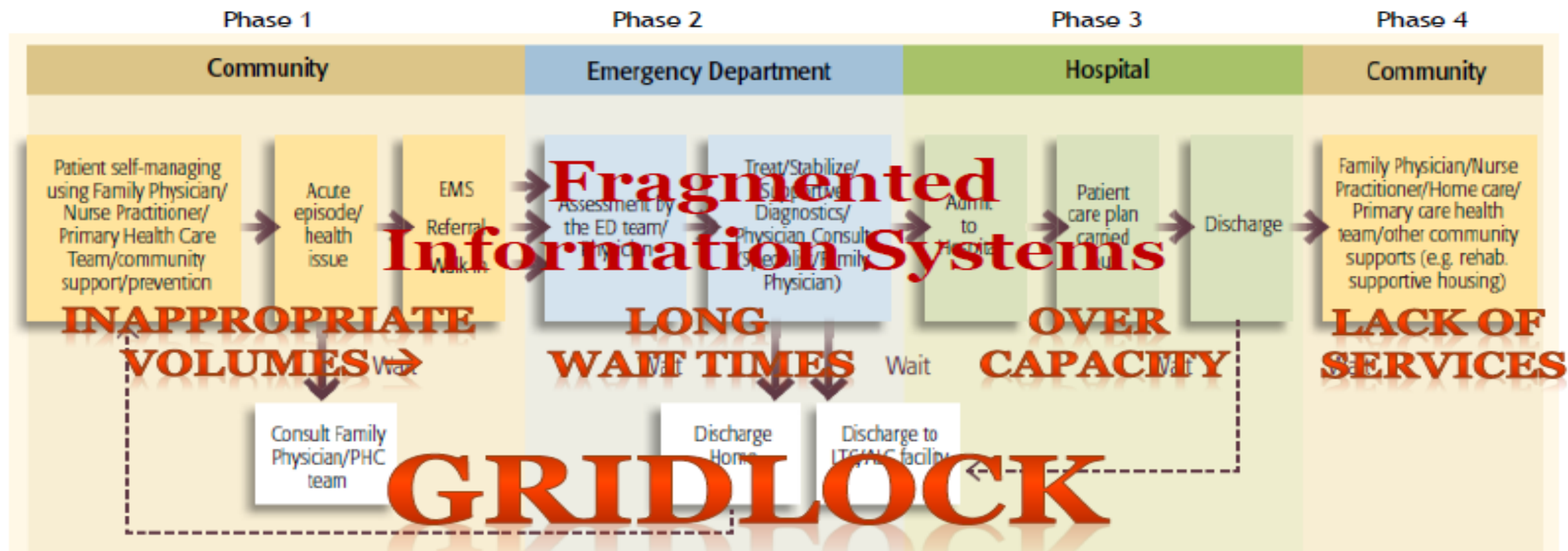
Average Occupancy Rates (at hospital or unit level) and the Day-to-Day Realities of Managing Patient Flow

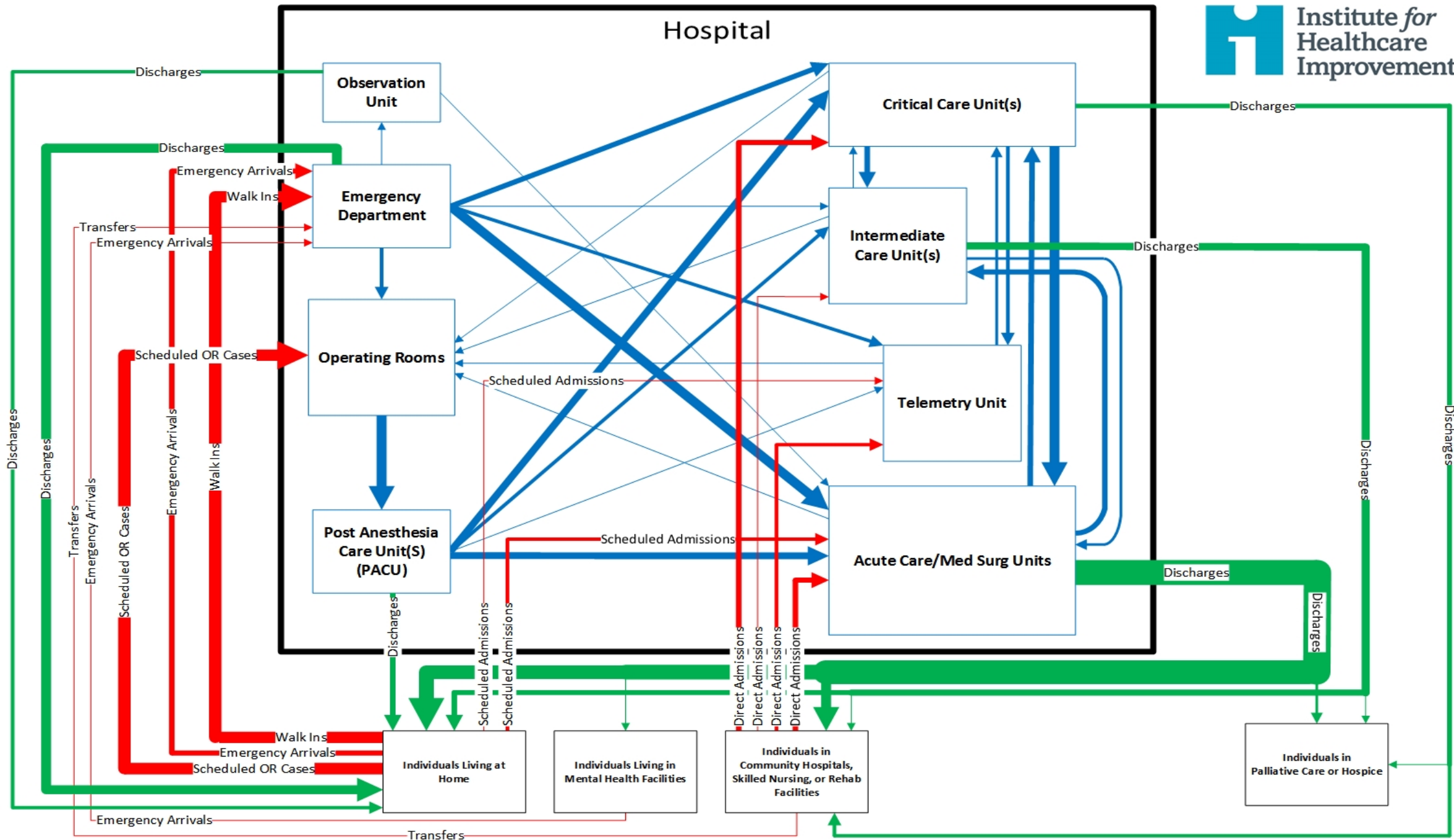


System-wide View of Patient Flow of Helps to Avoid Isolated Perspectives and Flow Projects



Wait Times in the Emergency Department - It's a System Problem







Six Ways Not to Improve Patient Flow: A Qualitative Study

- Narrowly focused initiatives reflected a decentralized system and the lack of a coherent system-level strategy for patient flow
- Well-established principles exist for improving timeliness and efficiency -- assess capacity and demand, ascertain and address the causes of variation and streamline care processes.
- Improving efficiencies in isolated areas will not lead to improved hospital-wide patient flow (need to focus on the greatest system constraint and scrutinize how different sub-systems throughout the hospital impact each other)
- Move beyond a proliferation of piecemeal initiatives to a coherent strategy of identifying the greatest constraints, and after the greatest constraint has been addressed move to the next constraint in the system.
- Without a system perspective to inform improvement efforts, the most promising initiatives may become just another dismal entry in 'The How-Not-To Guide' to patient flow



Success is Possible!

- Based on AHA data, overall nationwide hospital inpatient occupancy was 67.8% (AHA 1991–2011); range was from 33.6% to 74%)
- Once managed efficiently, US hospitals, on average, could achieve an 80–90 percent bed occupancy rate—without adding beds at capital costs of approximately \$1 million per bed.
- As a result of “smoothing” the scheduling of elective surgeries, improving discharge efficiencies, use of advanced data analytics and other interventions to improve flow at CCHMC, the hospital’s quality of care improved even as the occupancy rate grew from 76 percent to 91 percent. Hospital officials also report improved overall safety for patients and reduction in stress on the doctors and nurses who treat them.



Guiding the Flock: Simple Rules to Improve Hospital-wide Patient Flow



Guiding the Flock: Three Simple Rules to Improve Hospital-wide Patient Flow. Lloyd Provost and Pat Rutherford, IHI blog post Aug. 7, 2018



Simple Rules to Improve Hospital-wide Patient Flow

We propose the adoption of these three simple rules for governing complex systems for achieving hospital-wide patient flow.

Right Care, Right Place: Patients are placed on the appropriate clinical unit alongside the clinical team with disease- or condition-specific expertise.

Right Time: There should be no delay greater than two hours in patient progression from one hospital unit or clinical area to another, based on clinical readiness criteria. For example, patients should be transferred within two hours from the ED to an inpatient unit, within one hour from a PACU to a surgical unit, and discharge to home or community care within two hours.

Operational Capacity: Teams should ensure each unit or clinical area has operational capacity at the beginning of each day. For example, a unit should have one or two beds available and staffed at 7:00 AM based on patient demand patterns.



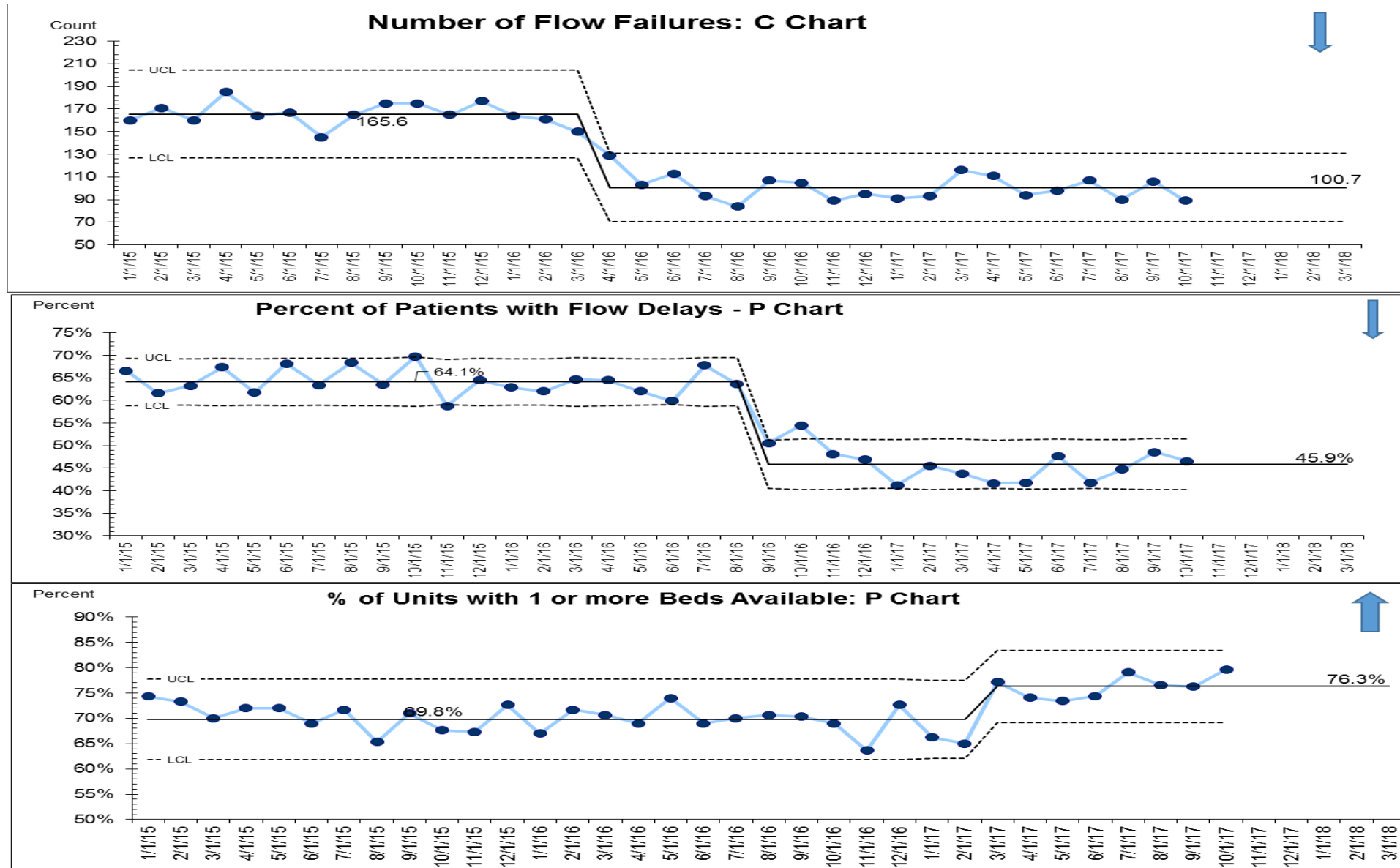
Simple Rules to Improve Hospital-wide Patient Flow

These simple rules are not intended for judgement or accountability. Rather, they can **form the basis for a hospital-wide flow philosophy that unites all staff and departments to a common purpose**. They can provide the basis for daily flow huddles to manage safe and timely patient progression throughout the hospital.

The hospital flow oversight team should create a **hospital-wide learning system to understand failure** to achieve these simple rules and develop approaches to **mitigate flow failures and flow delays**.



Simple Rules to Improve Hospital-wide Patient Flow



IHI's Framework and Strategies for Achieving Hospital-wide Patient Flow



Achieving Hospital-wide Patient Flow

The Right Care, in the Right Place, at the Right Time



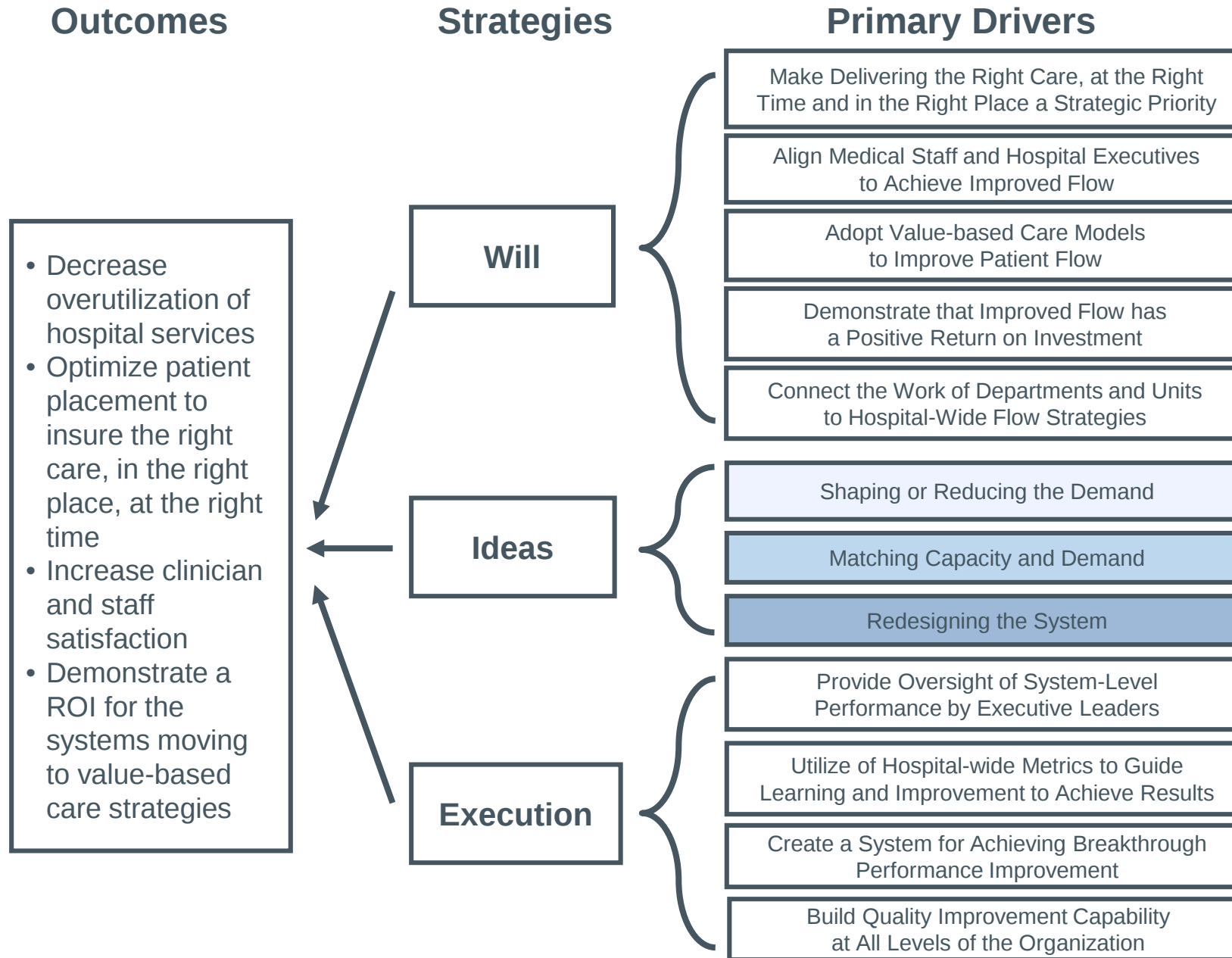
AN IHI RESOURCE

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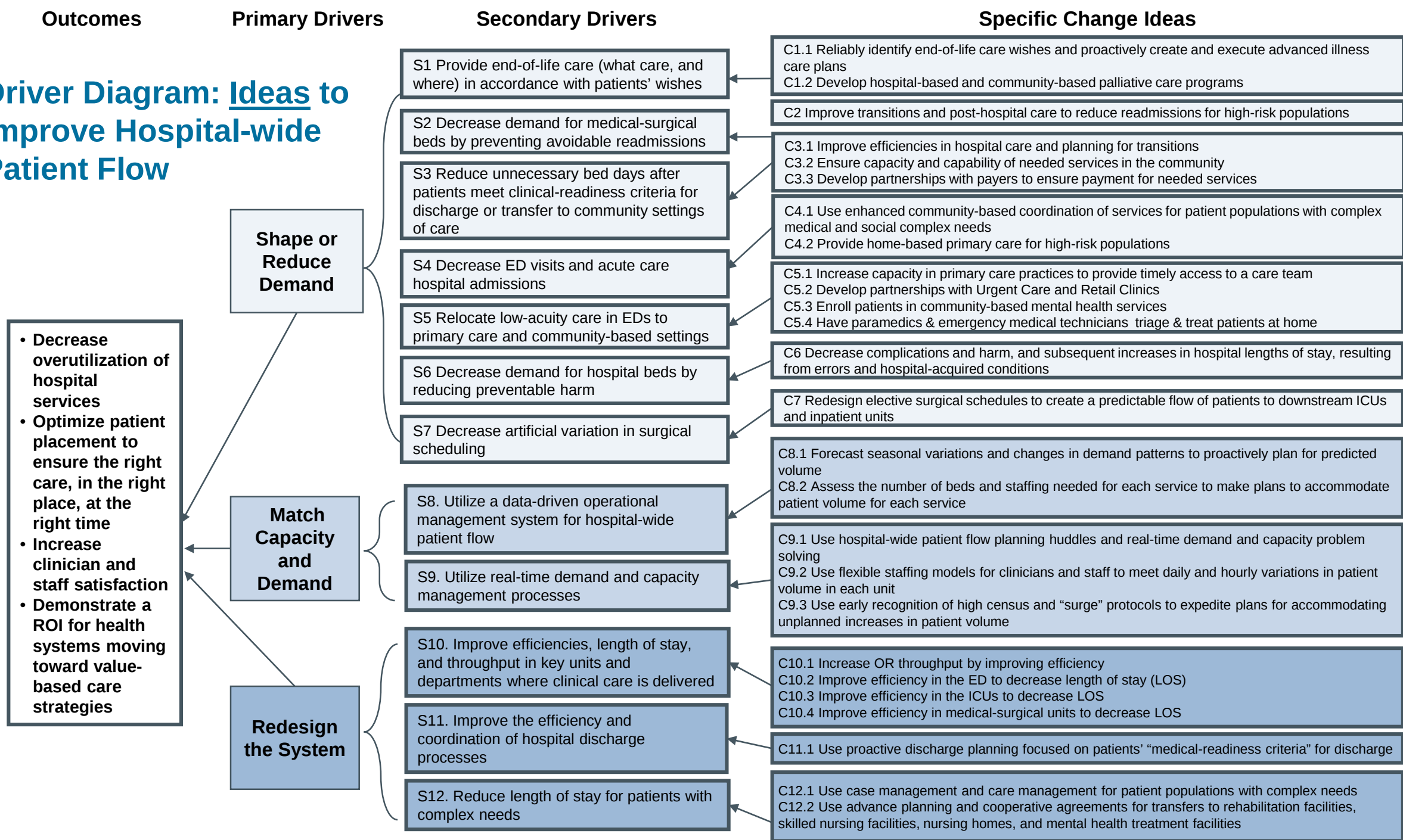
How to Cite This Paper: Rutherford PA, Frowst LP, Kotagal UR, Luther E, Anderson A. Achieving Hospital-wide Patient Flow. IHI White Paper, Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017. (Available at www.ihi.org)

http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Hospital-wide-Patient-Flow.aspx?utm_source=ihi&utm_campaign=Flow-WP&utm_medium=rotating-feature-2

Strategies to Achieve System-Wide Hospital Flow



Driver Diagram: Ideas to Improve Hospital-wide Patient Flow



Shape or Reduce Demand



Changing the Cultural Norm

the conversation project

A national campaign encouraging everyone to have a conversation about their wishes for end-of-life care

conversation ready

Collaboration to ensure health care systems are ready to receive and honor wishes for end of life care



The New York Times



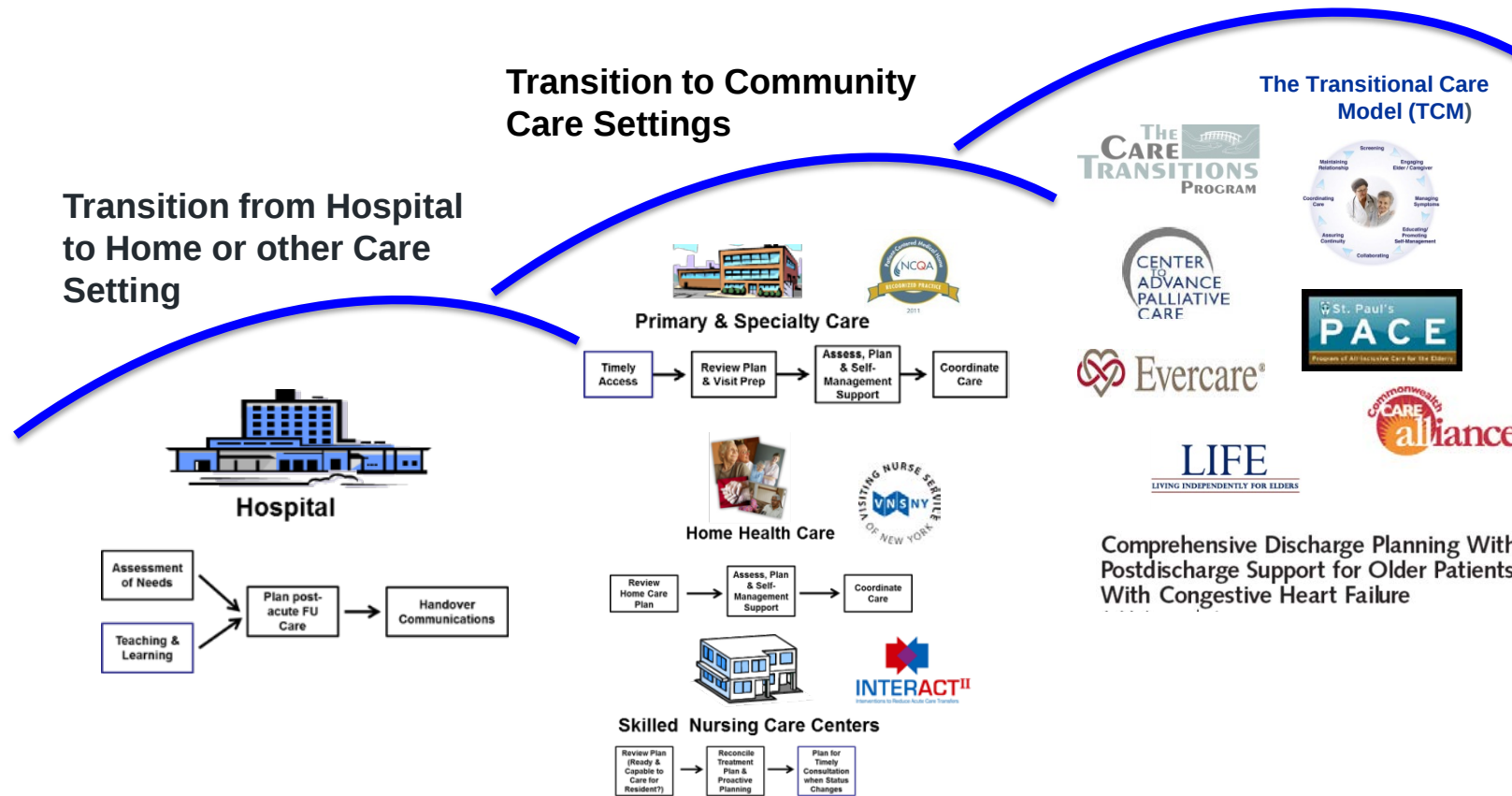
Advanced Illness Planning : Respecting Choices

Respecting Choices controls the per capita cost of care

	Per capita cost of care		
	La Crosse Wisconsin	Statewide Wisconsin	National Average
Reduces unwanted hospitalizations—percent hospitalized at least once during last six months of life ²⁹	59.5% (below 10th percentile)	67.5%	71.5%
Reduces costs of care in last two years of life due to elimination of unwanted treatment ²⁹	\$48,771	\$67,443	\$79,337
Decreases hospital care intensity in last two years of life ²⁹	0.49 (half the national average)	0.72	1.00
Reduces inpatient days in last two years of life ²⁹	10.0 days (below 10th percentile)	13.2 days	16.7 days
Reduces hospital deaths ²⁹	20.4%	20.9%	25.0%
Reduces percent of decedents seeing 10 or more different physicians during last six months of life ²⁹	22.7% (well below 10th percentile)	31.0%	42.0%
Reduces percent of decedents spending seven or more days in ICU/CCU during last six months of life ²⁹	3.8% (well below 10th percentile)	6.8%	15.2%
Reduces percent of decedents admitted to ICU/CCU in which death occurred ²⁹	9.5% (well below 10th percentile)	13.1%	18.5%

Reduces healthcare costs: for each dollar spent on ACP the cost of healthcare is reduced by \$2. The ROI is \$1 for every dollar spent.^{12,30}

Alternative or Supplemental Care for High-Risk Patients



Key Design Elements

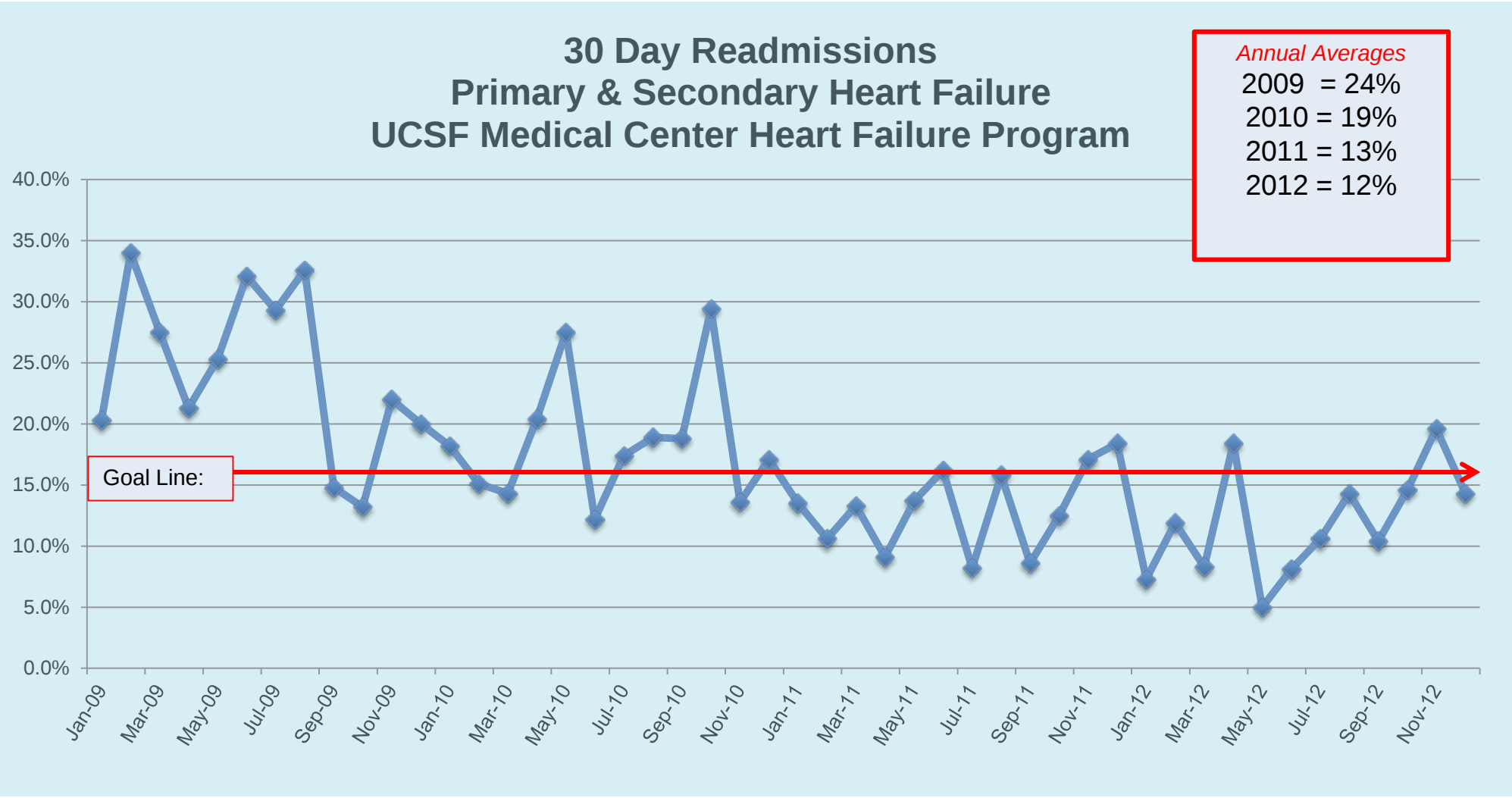
Patient and Family Engagement

Cross-Continuum Team Collaboration

Health Information Exchange and Shared Care Plans



30 Day Readmissions: Primary & Secondary Heart Failure 65+



Unnecessary Bed Days

- HOSPITAL CARE: Delays in hospital care and transitions out of the hospital
 - Consults, results of tests, imaging and procedures
 - Comprehensive assessments for post-acute care needs, interdisciplinary and patient/family planning, decision-making and/or transitions out of hospital to community-based care
- COMMUNITY-BASED CARE AND SERVICES: Lack of availability for needed services (lack of capacity or capability in the community settings of care)
 - Palliative Care and Hospice (hospital, community or home)
 - Community Hospital, LTACs, Skilled Nursing Facilities, Rehabilitation Facilities and Long-Term Care
 - Psychiatric and Mental Health services and/or facilities
 - Home Health Care services
 - Community services (housing, meals, transportation, etc.)
- POLICY AND PAYMENT: Lack of eligibility and/or payment for needed services



Alternative Level of Care: Canada's Hospital Beds, the Evidence and Options

“Current activity-based funding policies’ singular focus on hospitals, without commensurate changes in post-acute care, jeopardizes the viability of these policies by exacerbating pressures on bottlenecks in the system. We have discussed three policy options – building more, integrated care and financial incentives – that offer potential solutions. These are not intended to be presented as either/or options; given the complexity of the problem, a solution may well involve a combination of all three.

These three options address how policy makers might alleviate current ALC. However, this paper does not address the complementary issue of reducing “future” ALC (such as by expanding primary care, improving the continuity of care and reducing avoidable hospital admissions), a topic that requires further linkages between community and secondary care providers.”

Atrius Health ACO: Reducing ED Visits & Admissions

Utilization of emergency rooms, hospitals and drugs tends to be lower than average:

- With Medicaid, demonstrated 39% fewer admits/1000 on hospital (medical) admissions and 37% fewer Emergency Room visits/1000 as compared with the health plan's network.
- With Medicare Advantage, demonstrated 12% fewer Emergency Room visits/1000 and 5% fewer SNF admits/1000 as compared with the plan's network.
- For a commercial PPO product, 30-day readmission rate that is half of the plan's network rate, and 25% fewer Emergency Room visits/1000.
- For a commercial HMO, demonstrated 8% fewer inpatient admits/1000 and 9.5% less Rx scripts/1000.



Reducing Non-Urgent Emergency ED Services

- Extend hours in Primary Care
- Independence at Home (home-based primary care)
- Use of Telemedicine in Emergency Departments
- Urgent Care Centers (many now part of health care systems)
- Retail Clinics
- Paramedics and Emergency Medical Services managing non-emergency calls*
- Community Health Workers connecting frequent ED users with community-based services*
- Coordinated, Intensive Medical, Social, and Behavioral Health Services*



Clostridium difficile Infection Rates in Hospitals

Many hospitals acknowledge that *C. diff* infections are a widespread problem, especially as the CDC estimates that 94 percent of cases occur in hospitals. *C. diff* infections [increase patient length of stay](#) by more than 55 percent and may increase the cost of their care by 40 percent or more. More worrying, 500,000 patients are infected annually and 29,000 patients die each year from the drug-resistant superbug, so [researchers are focused](#) on finding potential treatments.

Two solutions for hospitals to cut down on the infection risk: make sure staff follow [hand-hygiene protocols](#) and [establish antibiotic stewardship](#) programs.



“Level-loading” Electively-Scheduled Surgical Cases

- By smoothing the inherent peaks-and valleys of patient flow, and eliminating the artificial variability, that unnecessarily impair patient flow, hospitals can improve patient safety and quality while simultaneously reducing hospital waste and cost.
- CCHMC: scheduling of “itineraries” for patients having surgical procedures
 - Redesign elective surgical schedules to create a predictable flow of patients to downstream ICUs and inpatient units.
 - Simultaneously schedule OR suite rooms and ICU beds (based on predicted length of stay).



Match Capacity and Demand



Scenario Planning

BASELINE SCENARIO

Question: What will our capacity look like at the end of FY2016?

Answer:

- Budgeted growth of **883 additional discharges** at **BIDMC** in FY16
- Expect **370 incremental discharges** (in first year of **MetroWest Medical Center** deal)
 - 6.4 day average LOS expected
- **Closing 14 Obs beds** at **BIDMC**
- Opening **43 new Med/Surg beds** at **BIDMC** by June 2016 (net addition of 29 beds)

USING THE SCENARIO PLANNING TOOL

WHAT DOES THE FUTURE BED CAPACITY LOOK LIKE BY CLINICAL AREA?

WHAT ARE THE IMPLICATIONS IN TERMS OF CAPACITY PLANNING?

1 Observe Current State

	Beds	Usable Beds	Average Occupancy Rate	% of Time in Red Zone
Critical Care	77	77	82.1%	65.3%
Med/Surg	441	417	92.9%	96.5%
Observation	32	32	39.1%	0.0%
Med/Surg & Obs	473	449	89.0%	81.3%

2 Describe a Future Scenario

Additional expected discharges per year	370
Avg LOS (days) of additional discharges [current = 4.1]	6.4
Critical Care beds added (+) or removed (-)	0
Med/Surg beds added (+) or removed (-)	43
Observation beds added (+) or removed (-)	-14
Budgeted increase (+) or decrease (-) in discharges	626
Organic % growth (+) or decline (-) in discharges	0.4%

3 Understand Future State

	Beds	Usable Beds	Average Occupancy Rate	% of Time in Red Zone
Critical Care	77	77	84.8%	81.2%
Med/Surg	484	457	87.4%	71.0%
Observation	18	18	71.7%	12.2%
Med/Surg & Obs	502	475	86.8%	66.2%



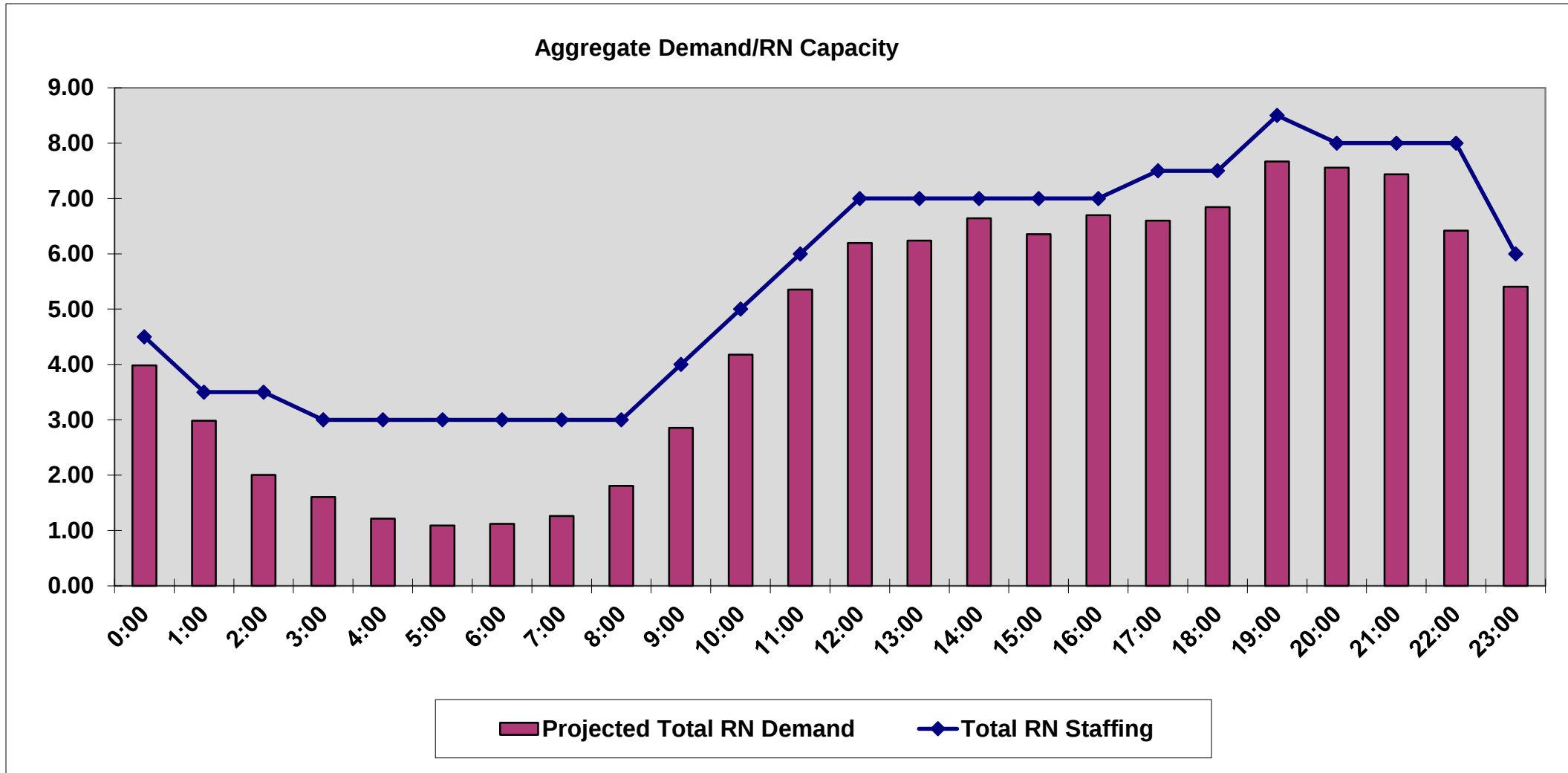
Beth Israel Deaconess
Medical Center



HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

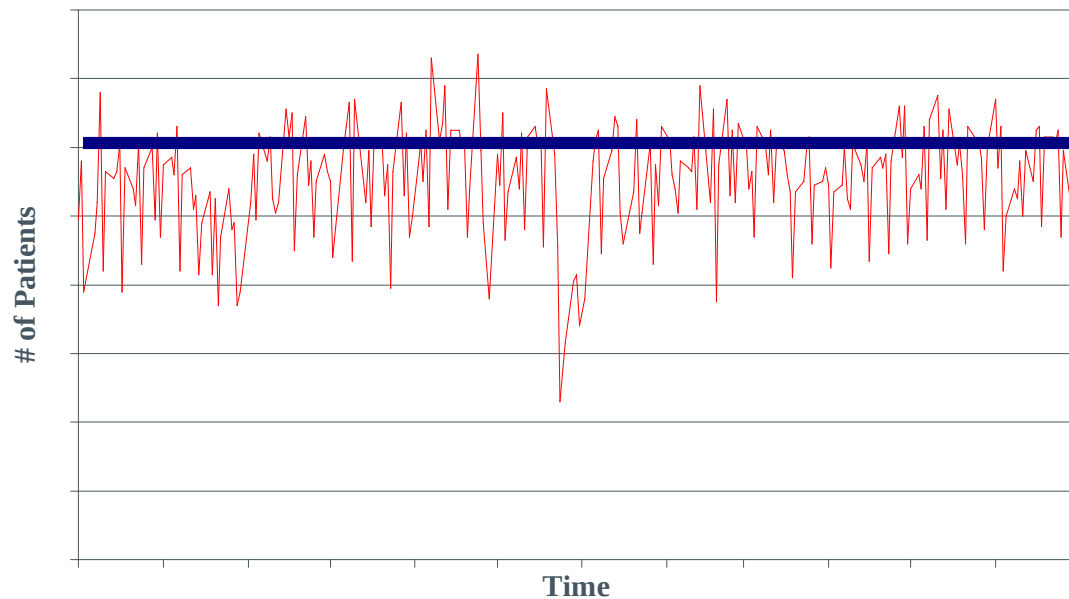


RN Capacity for Predicted ED Demand

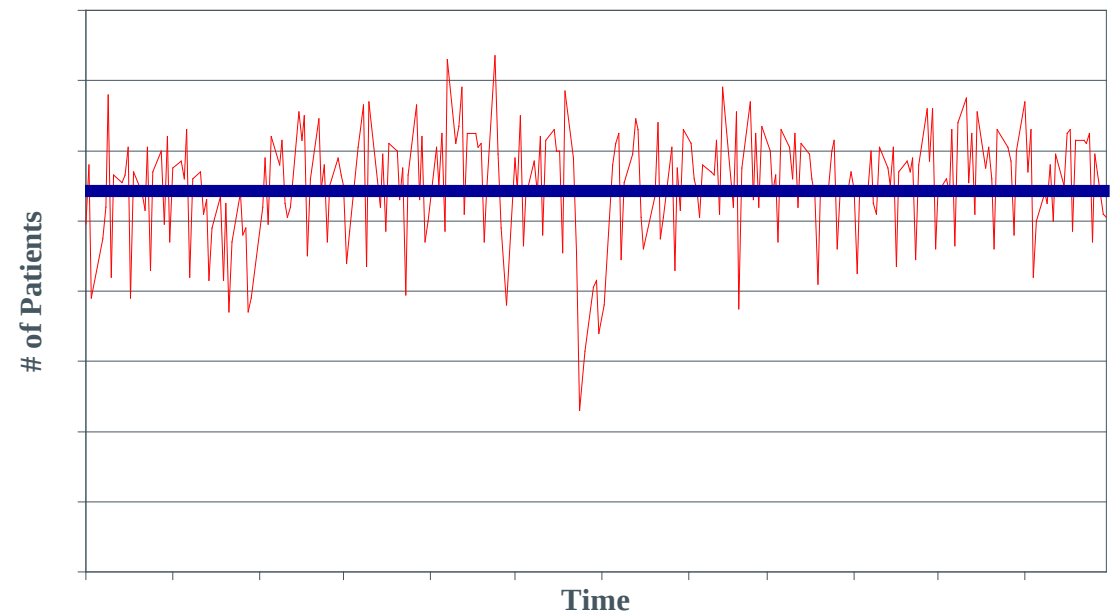


Demand/Capacity Management

What nurse staffing is needed to consistently provide safe and quality care?



Staffing for >95% census/occupancy



Staffing for > average census/occupancy

Why should nurse leaders be “champions” for improving hospital-wide patient flow?

- “Failing to achieve hospital-wide patient flow — the right care, in the right place, at the right time — puts patients at risk for suboptimal care and potential harm. It also increases the burden on clinicians and hospital staff and can accelerate burnout.” *
- Some of the challenges in providing adequate nurse staffing to meet the fluctuating demands of patient census, acuity and complexity can be simultaneously alleviated by the implementation of strategies to improve the safe and timely patient progression throughout the hospital.
 - √ Decreasing census variability due to elective surgical scheduling
 - √ Ensuring adequate bed capacity for various clinical services which require specialized nursing skills and competencies to care the clinical and psychosocial needs of specific patient populations.
 - √ Increasing nurses’ time in value-added care to ensure safe and effective care of patients
 - √ Using advanced data analytics to match capacity (beds and staffing) and long-term, short-term and real-time patient demand



Real-Time Demand and Capacity (RTDC) Management Processes

Four Steps of Real-Time Demand Capacity Management

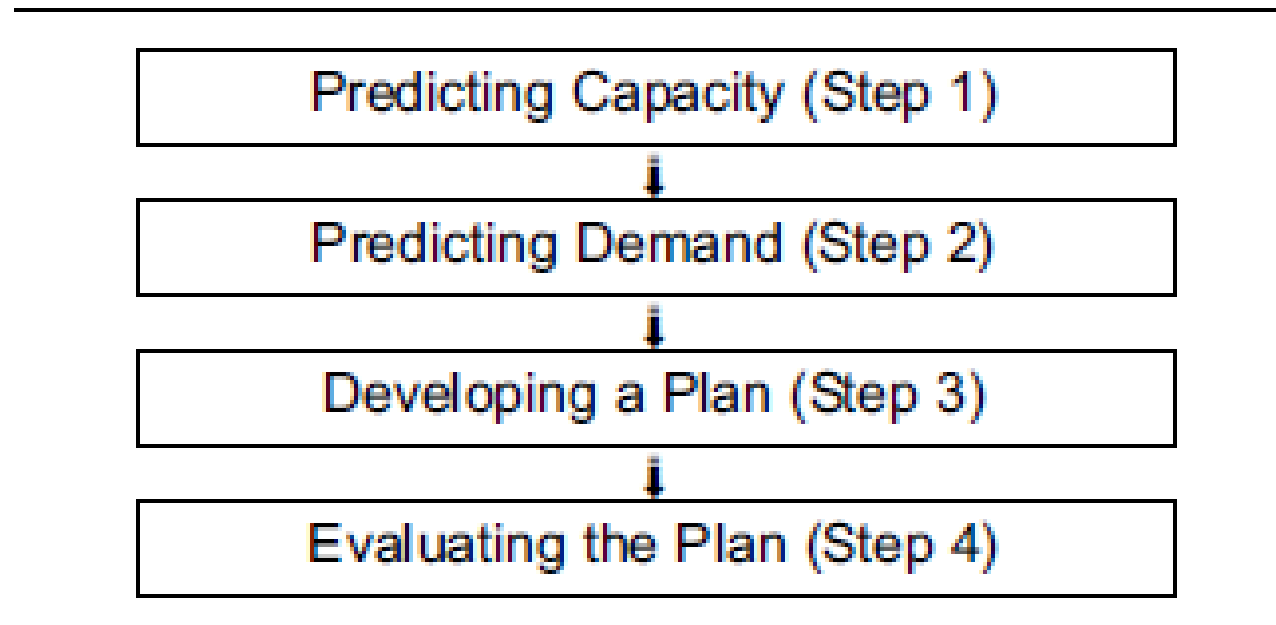
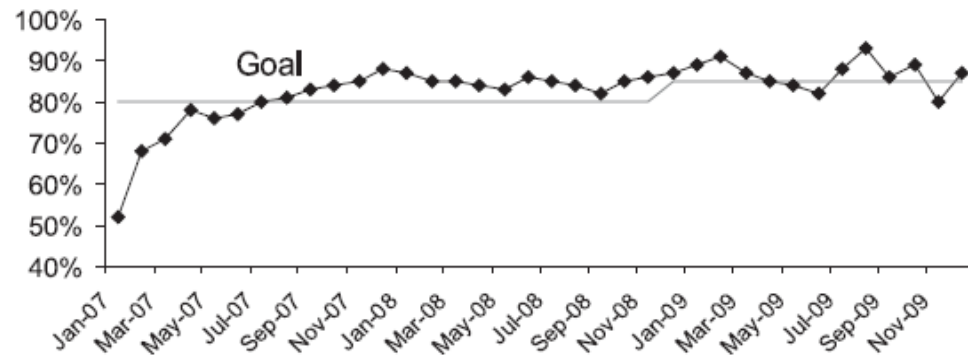


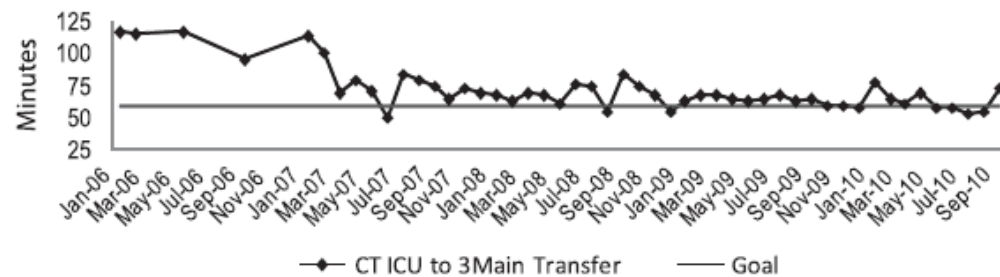
Figure 1. The four steps of real-time demand capacity management are depicted.

Results at UPMC

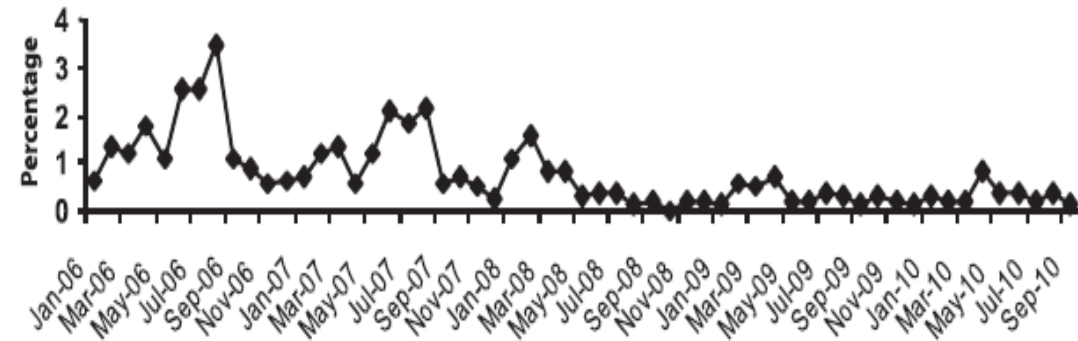
**Monthly Accuracy of Discharge Predictions,
January 2007–November 2009**



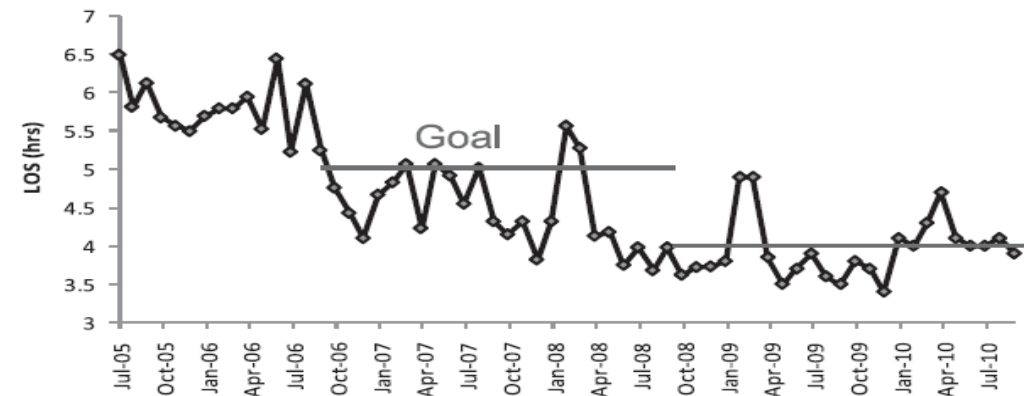
**Cardiothoracic (CT) ICU to 3 Main Transfer Time,
January 2006–September 2010**



**Percentage of Patients Who Left Without Being Seen
(LWBS), January 2006–September 2010**



**Emergency Department (ED) Median Length of Stay
(LOS) for Admitted Patients, July 2005–July 2010**



Surge Planning

Green Reflects an optimally functioning system, a state of equilibrium, homeostasis. Staff describe it as, a good day.

Yellow Reflects the state of early triggers which identifies and allows the system to initiate early interventions.

Orange Reflects escalating demand without readily available capacity. In this state aggressive action required to avoid system overload and ultimate gridlock.

Red Reflects a state of gridlock as a result of system overload. The system should respond by using its organizational Disaster Plan.

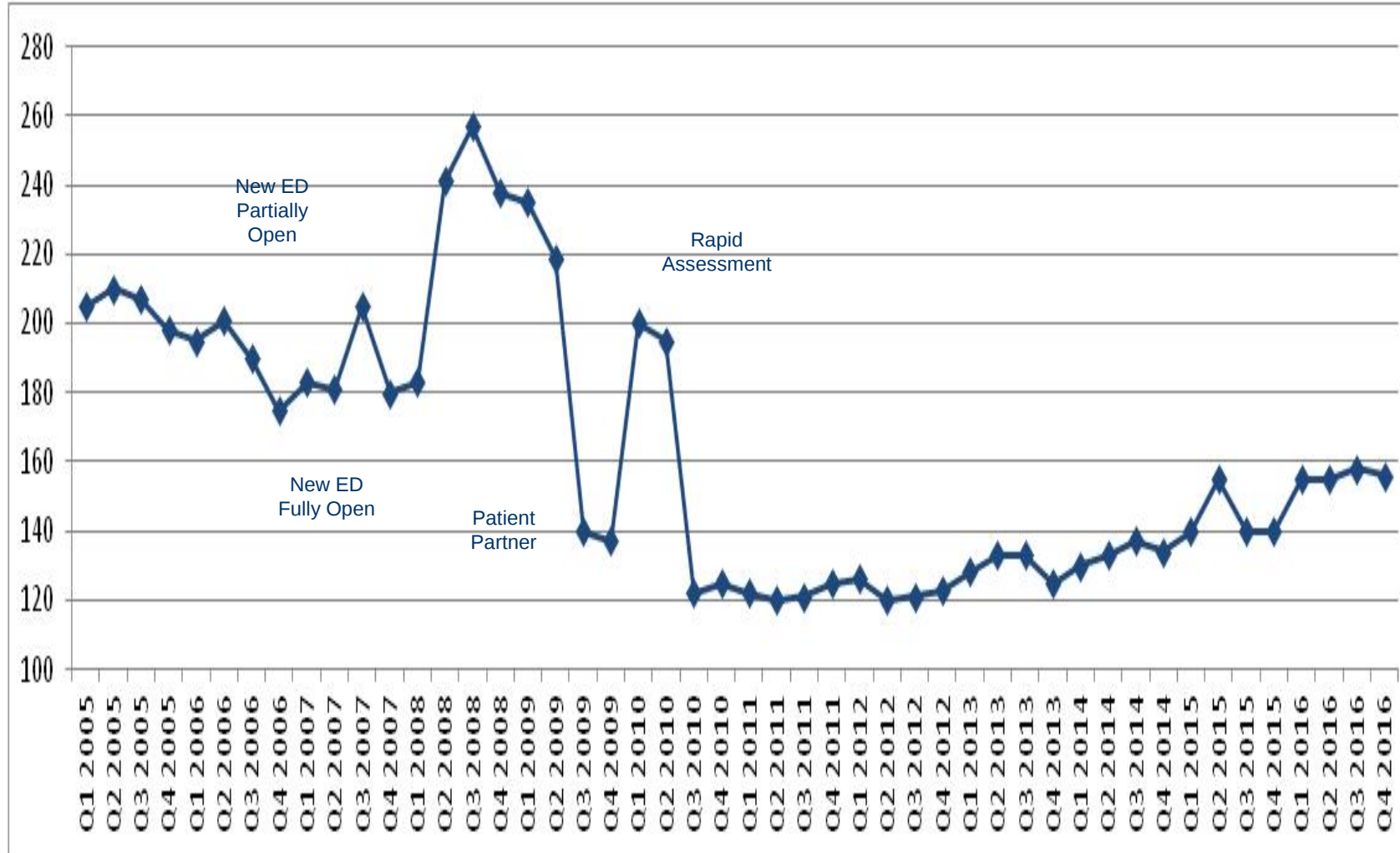
	Green	Yellow	Orange	Red
Census				
Acuity				
Other				
Staff				



Redesign the System



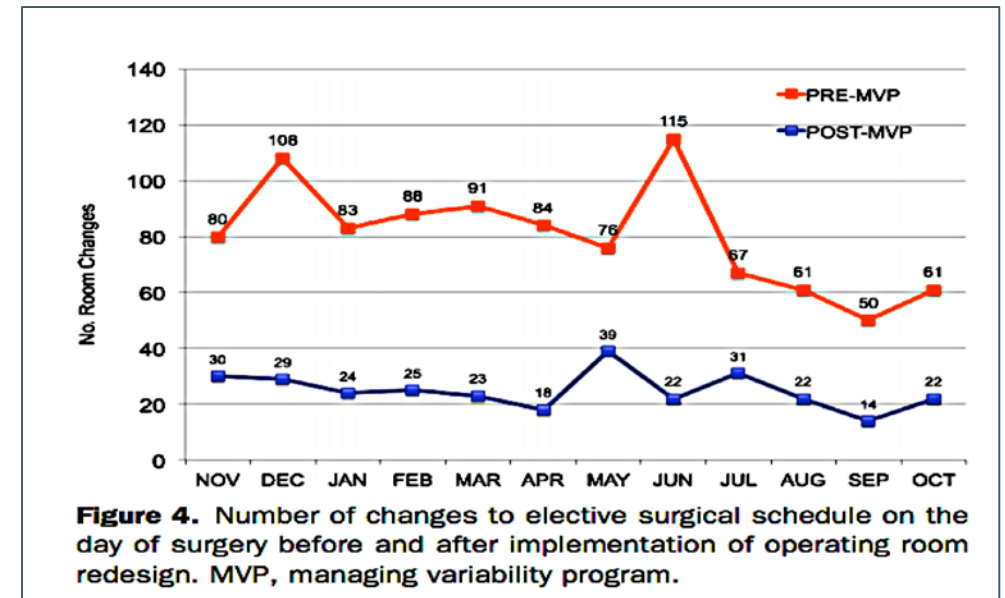
ED Median Total Length of Stay (min)



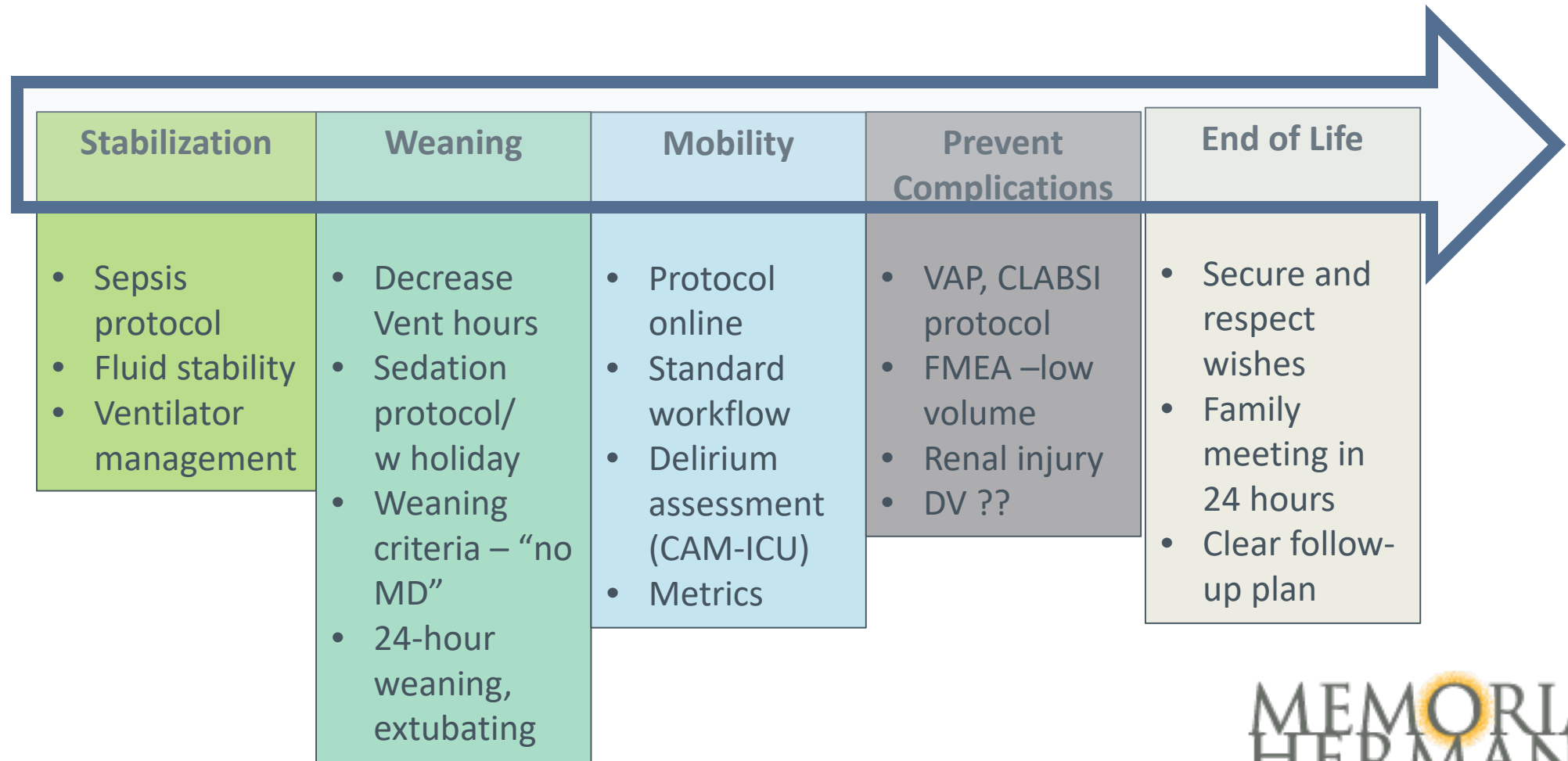
Separate Flows for Elective and Non-Elective Surgical Cases

Mayo Clinic Florida

- Surgical volume and surgical minutes increased by 4% and 5%, respectively;
- Prime time use increased by 5%;
- Overtime staffing decreased by 27%;
- Day-to-day variability decreased by 20%;
- The number of elective schedule same day changes decreased by 70%;
- Staff turnover rate decreased by 41%. Net operating income and margin improved by 38% and 28%, respectively



Foundational Elements for ICU Efficiencies and Patient Flow



MEMORIAL
HERMANN



Standardizing Multidisciplinary Rounds

Old Model

Resident or other provider presented case and any updates; other input contributed ad hoc:

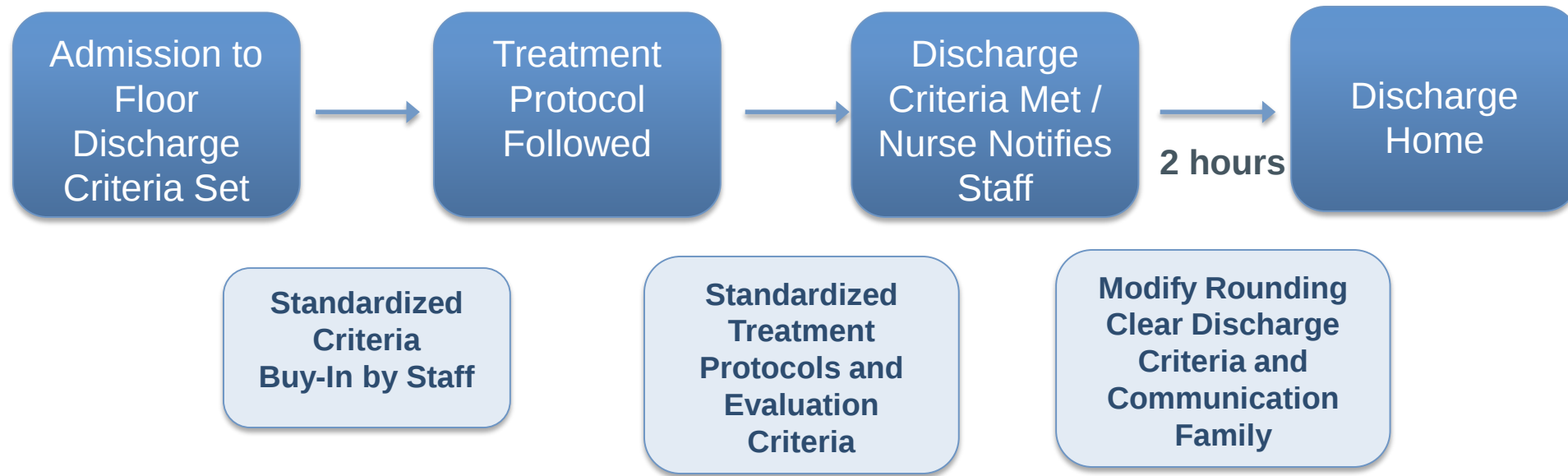
- *Less experienced nurses often felt uncomfortable jumping in unless resident remembered to ask*
- *Residents unclear on contribution*

Patient Progression Model

Case Manager facilitates discussion prompting each discipline for input on standard, defined elements

- *Created clear expectations for participation and care is planned more collaboratively*

Discharging Patients when Medically-ready



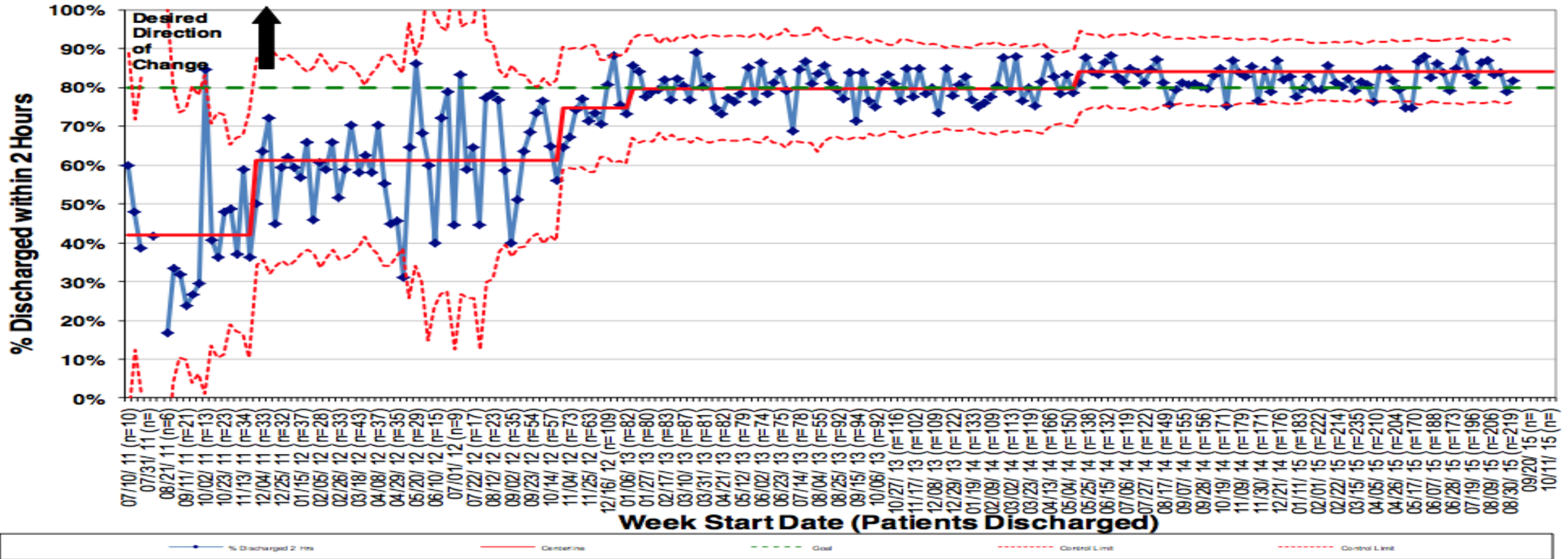
- Medical-readiness criteria for discharge established at admission
- Nurse at bedside notifies service when medical discharge criteria are met
- Discharge from hospital with 2 hours (> 2 hours = discharge delay)
- Review length of stay and readmissions as balancing measures

Discharging Patients when Medically-ready



Managing Discharge when Medically Ready % Discharged within 2 Hours of Medically Ready

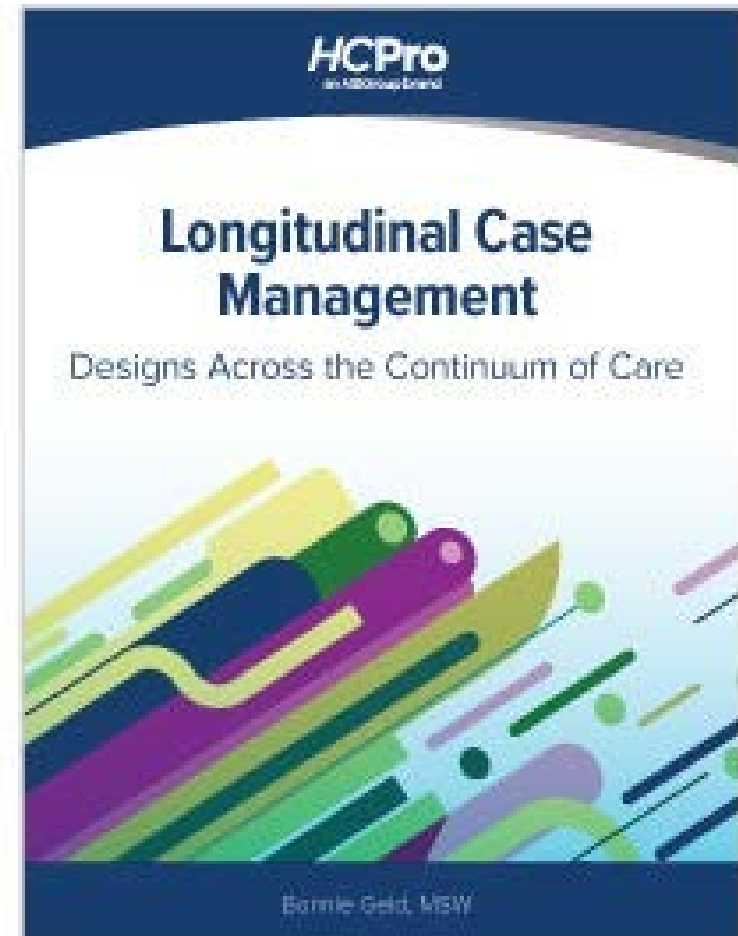
Includes patients on A6C, A6N, A6S, LA1W, B5CA, A3N, A4N, and A6S



Moving Beyond Traditional Case Management Approaches

Inpatient Practices

- Discharge Planning
- Interdisciplinary Rounds
- LOS Rounds (weekly)
- Escalation
- Emergency Department Case Management/Social Work
- Payment deals with post acute providers
- Consolidation of Inpatient Case Management and Social Work that resulted in parallel play



Driver Diagram: Ideas to Improve Hospital-wide Patient Flow

- **Decrease overutilization of hospital services**
- **Optimize patient placement to ensure the right care, in the right place, at the right time**
- **Increase clinician and staff satisfaction**
- **Demonstrate a ROI for health systems moving toward value-based care strategies**

Shape or Reduce Demand

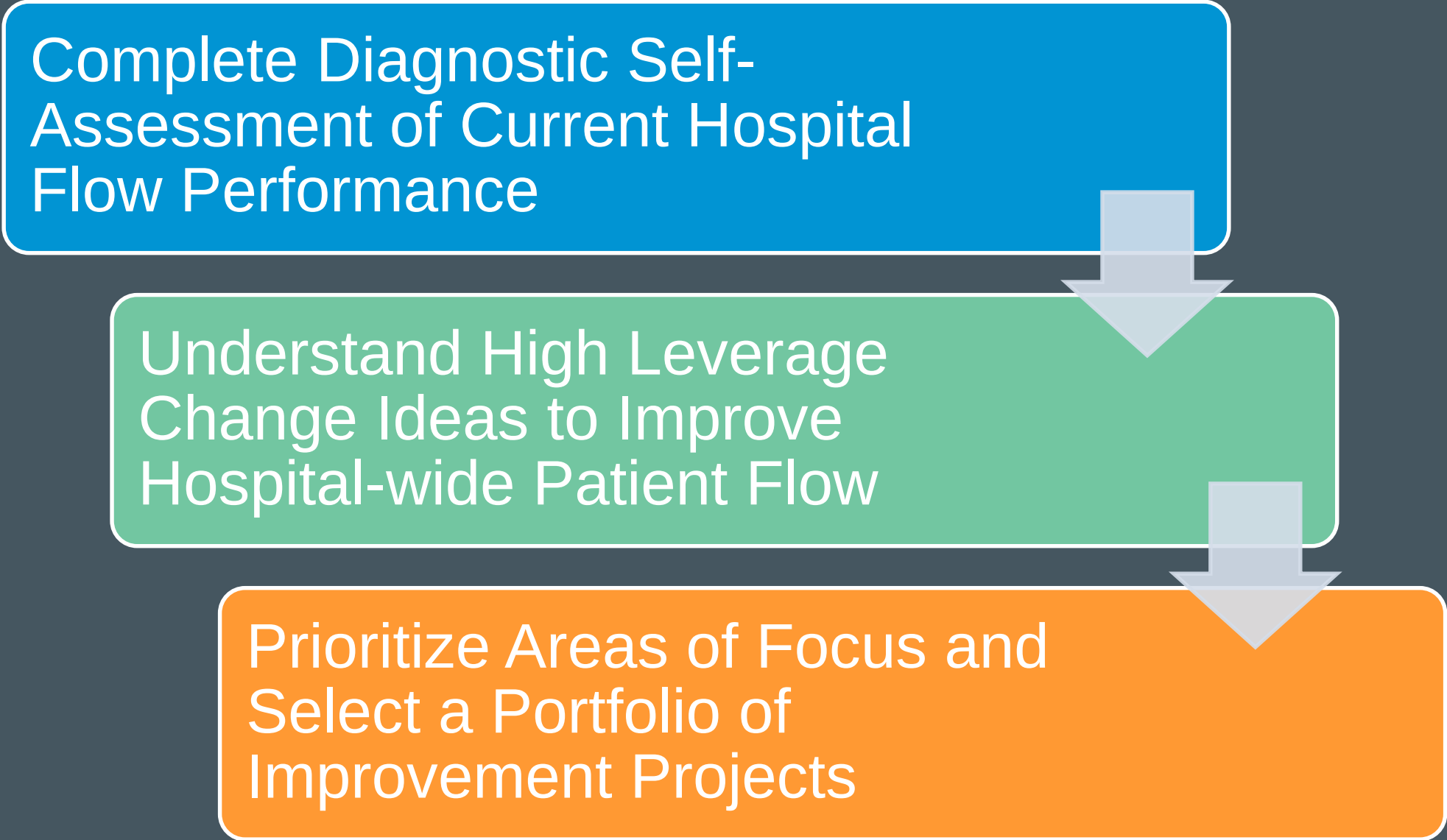
Match Capacity and Demand

Redesign the System

- Primary Drivers**
- S1 Provide end-of-life care (what care, and where) in accordance with patients' wishes
 - S2 Decrease demand for medical-surgical beds by preventing avoidable readmissions
 - S3 Reduce unnecessary bed days after patients meet clinical-readiness criteria for discharge or transfer to community settings of care
 - S4 Decrease ED visits and acute care hospital admissions
 - S5 Relocate low-acuity care in EDs to primary care and community-based settings
 - S6 Decrease demand for hospital beds by reducing preventable harm
 - S7 Decrease artificial variation in surgical scheduling
 - S8. Utilize a data-driven operational management system for hospital-wide patient flow
 - S9. Utilize real-time demand and capacity management processes
 - S10. Improve efficiencies, length of stay, and throughput in key units and departments where clinical care is delivered
 - S11. Improve the efficiency and coordination of hospital discharge processes
 - S12. Reduce length of stay for patients with complex needs

- Specific Change Ideas**
- C1.1 Reliably identify end-of-life care wishes and proactively create and execute advanced illness care plans
 - C1.2 Develop hospital-based and community-based palliative care programs
 - C2 Improve transitions and post-hospital care to reduce readmissions for high-risk populations
 - C3.1 Improve efficiencies in hospital care and planning for transitions
 - C3.2 Ensure capacity and capability of needed services in the community
 - C3.3 Develop partnerships with payers to ensure payment for needed services
 - C4.1 Use enhanced community-based coordination of services for patient populations with complex medical and social complex needs
 - C4.2 Provide home-based primary care for high-risk populations
 - C5.1 Increase capacity in primary care practices to provide timely access to a care team
 - C5.2 Develop partnerships with Urgent Care and Retail Clinics
 - C5.3 Enroll patients in community-based mental health services
 - C5.4 Have paramedics & emergency medical technicians triage & treat patients at home
 - C6 Decrease complications and harm, and subsequent increases in hospital lengths of stay, resulting from errors and hospital-acquired conditions
 - C7 Redesign elective surgical schedules to create a predictable flow of patients to downstream ICUs and inpatient units
 - C8.1 Forecast seasonal variations and changes in demand patterns to proactively plan for predicted volume
 - C8.2 Assess the number of beds and staffing needed for each service to make plans to accommodate patient volume for each service
 - C9.1 Use hospital-wide patient flow planning huddles and real-time demand and capacity problem solving
 - C9.2 Use flexible staffing models for clinicians and staff to meet daily and hourly variations in patient volume in each unit
 - C9.3 Use early recognition of high census and "surge" protocols to expedite plans for accommodating unplanned increases in patient volume
 - C10.1 Increase OR throughput by improving efficiency
 - C10.2 Improve efficiency in the ED to decrease length of stay (LOS)
 - C10.3 Improve efficiency in the ICUs to decrease LOS
 - C10.4 Improve efficiency in medical-surgical units to decrease LOS
 - C11.1 Use proactive discharge planning focused on patients' "medical-readiness criteria" for discharge
 - C12.1 Use case management and care management for patient populations with complex needs
 - C12.2 Use advance planning and cooperative agreements for transfers to rehabilitation facilities, skilled nursing facilities, nursing homes, and mental health treatment facilities

Complete Diagnostic Self-
Assessment of Current Hospital
Flow Performance



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graph TD; A[Complete Diagnostic Self-Assessment of Current Hospital Flow Performance] --> B[Understand High Leverage Change Ideas to Improve Hospital-wide Patient Flow]; B --> C[Prioritize Areas of Focus and Select a Portfolio of Improvement Projects];
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Understand High Leverage
Change Ideas to Improve
Hospital-wide Patient Flow

Prioritize Areas of Focus and
Select a Portfolio of
Improvement Projects



Hospital Flow Professional Development Program

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



IHI's Hospital Flow Professional Development Program

is designed for a team or individuals who are tasked with hospital operations, throughput, and ensuring optimal patient flow in the acute care hospital.

- 5-day intensive shared learning and capability building
- 20 leading health care expert faculty presenters
- Leverage opportunities to collaborate with expert faculty and successful hospital leaders to develop or refine a detailed, customized action plan

November 4-8, 2019 | Boston, MA



Hospital Flow Professional Development Program



More information at ihi.org/hospital-flow

Achieving Hospital-wide Flow: Right Care, Right Place, Right Time

November 4-8, 2019 | Boston, MA

Participants will learn from:

- Expert faculty
- Case study presenters
- Other program participants

Participants will have opportunities to engage in:

- Pre-assessment of current hospital-wide flow performance
- Working sessions with team members
- Exchange of ideas with other program participants & faculty
- Ad hoc faculty coaching



Hospital Flow Professional Development Program



Who should attend?

This program is designed for teams who are responsible for implementing and maintaining operational efficiencies, throughput, and optimizing patient flow in acute care hospitals.

While individual participants will gain value from this professional development program, IHI strongly recommends that hospitals and health care systems consider sending teams of 4 to 8 leaders to this program.

Recommended Team Members:

CEOs, COOs, Chief Nurse Executives, Surgeons and Medical Directors, Nursing Directors, Service Line Leaders, Financial Analysts, Quality Improvement Leaders

More information at ihi.org/hospital-flow



Have Questions?

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The screenshot displays a Zoom meeting window. The main area shows a presentation slide from the Institute for Healthcare Improvement (IHI). The slide title is "IHI's Hospital Flow Professional Development Program" by Pat Rutherford, VP at IHI. The event dates are November 4-8, 2019, in Boston, MA. A chat panel is open on the right side of the window, titled "Chat". Inside the chat panel, a blue box contains the text "This is the chat panel". At the bottom of the Zoom window, there is a toolbar with several icons. A blue speech bubble icon is highlighted with a callout box that says "1. Click chat bubble if panel does not appear automatically". To its right is a red "X" icon. Another callout box points to the chat input area at the bottom right, stating "2. Type your question here and send to everyone". The input area has a "To:" dropdown menu set to "Everyone" and a text field with the placeholder "Type your chat message here".

Institute for Healthcare Improvement

Informational Call
September 4, 2019

IHI's Hospital Flow Professional Development Program
Pat Rutherford
VP, Institute for Healthcare Improvement

November 4-8, 2019
Boston, MA

Chat

This is the chat panel

To: Everyone

Type your chat message here

1. Click chat bubble if panel does not appear automatically

2. Type your question here and send to everyone



Thank you!

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Please reach out to krowbotham@ihi.org with any questions about the program

