Hospital Operations Principles Of High Efficiency Health Care Ft Press Operations Management

High Performance Healthcare: Using the Power of Relationships to Achieve Quality, Efficiency and ResilienceBest Care at Lower CostTears in ArizonaMy Hospital ExperienceHealth Care Emergency Management: Principles and PracticeHealth Professions EducationStatistics in a NutshellKeeping Patients SafePreventing Medication ErrorsI'm Going to the HospitalPatient FlowLeading High-Reliability Organizations in HealthcareHospital ReimbursementDying of Health CareTen Strategies of a World-Class Cybersecurity Operations CenterHealthcare Operations ManagementEmergency Department Leadership and ManagementFocused Operations Management for Health Services OrganizationsHandbook of Robotic and Image-Guided SurgeryPrinciples of Disaster Mitigation in Health FacilitiesThe Future of the Public's Health in the 21st CenturyProcess Mining in HealthcarePatient Safety and QualityGuide for All-Hazard Emergency Operations PlanningHospital OperationsVignettes in Patient SafetyFor-Profit Enterprise in Health CarePrinciples and Practice of Cardiothoracic SurgeryHospital OperationsHealth Operations ManagementManaging the UnexpectedApplications of Contemporary Management Approaches in Supply ChainsFive Days at MemorialCrisis Standards of CareHealth Data in the Information AgeTo Err Is HumanManaging the UnexpectedContemporary Leadership ChallengesHospital and Healthcare SecurityThat College Book

High Performance Healthcare: Using the Power of Relationships to Achieve Quality, Efficiency and Resilience

Due to the countless variables that affect revenue and cost, the hospital reimbursement process is by far the most complex of any industry. Requiring only a basic financial background and a working knowledge of accounting, Hospital Reimbursement: Concepts and Principles supplies a clear understanding of the concepts and principles that drive the re

Best Care at Lower Cost

A clear and concise introduction and reference for anyone new to the subject of statistics.

Tears in Arizona

But when Janey learns that the call is from a hospital all the way in Phoenix, Arizona, and a social worker is telling her that her father-in-law is in the hospital, her busy morning suddenly grinds to a halt. Every year, Janey, her husband, William, and

their daughter, Kate, make the trip from Kansas City to Phoenix to visit Jack and Leah Bernett, William's parents, to celebrate a magnificent Christmas holiday. But this trip turns out very differently for this small family. Not long after his father's admission to the hospital, William is shocked to discover that his mother is missing. He decides to rush out to Arizona to find out what has happened to his father and find his missing mother, leaving Janey and Kate to follow him later. Find out what will happen next as one loving family copes with adversity, rallies among themselves, and grows closer in Abby Jacobson's bittersweet and reflective novel, Tears in Arizona.

My Hospital Experience

Social and behavioral science has for decades studied and recognized leadership as a social exchange between leaders and followers. But leadership is rather complex, and as such, it tends to lead to an increased interest within and across different disciplines. This book is an attempt to provide theoretical and empirical framework to better understand leadership challenges in various contexts. The authors cover an array of themes that span from an individual level to an organizational and societal level. In this volume, two sections are presented. The first section based on individual level focuses on different leadership styles and abilities, and the other section provides theories to understand leadership in public administration, in industrial settings and in nonprofit organizations.

Health Care Emergency Management: Principles and Practice

This book is dedicated to improving healthcare through reducing delays experienced by patients. With an interdisciplinary approach, this new edition, divided into five sections, begins by examining healthcare as an integrated system. Chapter 1 provides a hierarchical model of healthcare, rising from departments, to centers, regions and the “macro system.” A new chapter demonstrates how to use simulation to assess the interaction of system components to achieve performance goals, and Chapter 3 provides hands-on methods for developing process models to identify and remove bottlenecks, and for developing facility plans. Section 2 addresses crowding and the consequences of delay. Two new chapters (4 and 5) focus on delays in emergency departments, and Chapter 6 then examines medical outcomes that result from waits for surgeries. Section 3 concentrates on management of demand. Chapter 7 presents breakthrough strategies that use real-time monitoring systems for continuous improvement. Chapter 8 looks at the patient appointment system, particularly through the approach of advanced access. Chapter 9 concentrates on managing waiting lists for surgeries, and Chapter 10 examines triage outside of emergency departments, with a focus on allied health programs Section 4 offers analytical tools and models to support analysis of patient flows. Chapter 11 offers techniques for scheduling staff to match patterns in patient demand. Chapter 12 surveys the literature on simulation modeling, which is widely used for both healthcare design and process improvement. Chapter 13 is new and demonstrates the use of process mapping to represent a complex

regional trauma system. Chapter 14 provides methods for forecasting demand for healthcare on a region-wide basis. Chapter 15 presents queueing theory as a method for modeling waits in healthcare, and Chapter 16 focuses on rapid delivery of medication in the event of a catastrophic event. Section 5 focuses on achieving change. Chapter 17 provides a diagnostic for assessing the state of a hospital and using the state assessment to select improvement strategies. Chapter 18 demonstrates the importance of optimizing care as patients transition from one care setting to the next. Chapter 19 is new and shows how to implement programs that improve patient satisfaction while also improving flow. Chapter 20 illustrates how to evaluate the overall portfolio of patient diagnostic groups to guide system changes, and Chapter 21 provides project management tools to guide the execution of patient flow projects.

Health Professions Education

The Institute of Medicine study Crossing the Quality Chasm (2001) recommended that an interdisciplinary summit be held to further reform of health professions education in order to enhance quality and patient safety. Health Professions Education: A Bridge to Quality is the follow up to that summit, held in June 2002, where 150 participants across disciplines and occupations developed ideas about how to integrate a core set of competencies into health professions education. These core competencies include patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement, and informatics. This book recommends a mix of approaches to health education improvement, including those related to oversight processes, the training environment, research, public reporting, and leadership. Educators, administrators, and health professionals can use this book to help achieve an approach to education that better prepares clinicians to meet both the needs of patients and the requirements of a changing health care system.

Statistics in a Nutshell

Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDS--three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems. To Err Is Human breaks the silence that has surrounded medical errors and their consequence--but not by pointing fingers at caring health care professionals who make honest mistakes. After all, to err is human. Instead, this book sets forth a national agenda--with state and local implications--for reducing medical errors and improving patient safety through the design of a safer health system. This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it, given many patients' expectations that the medical profession always performs perfectly. A careful examination is made of how the surrounding forces of legislation, regulation, and market activity influence the

quality of care provided by health care organizations and then looks at their handling of medical mistakes. Using a detailed case study, the book reviews the current understanding of why these mistakes happen. A key theme is that legitimate liability concerns discourage reporting of errors--which begs the question, "How can we learn from our mistakes?" Balancing regulatory versus market-based initiatives and public versus private efforts, the Institute of Medicine presents wide-ranging recommendations for improving patient safety, in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. To Err Is Human asserts that the problem is not bad people in health care--it is that good people are working in bad systems that need to be made safer. Comprehensive and straightforward, this book offers a clear prescription for raising the level of patient safety in American health care. It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital. This book will be vitally important to federal, state, and local health policy makers and regulators, health professional licensing officials, hospital administrators, medical educators and students, health caregivers, health journalists, patient advocates--as well as patients themselves. First in a series of publications from the Quality of Health Care in America, a project initiated by the Institute of Medicine

Keeping Patients Safe

Meant to aid State & local emergency managers in their efforts to develop & maintain a viable all-hazard emergency operations plan. This guide clarifies the preparedness, response, & short-term recovery planning elements that warrant inclusion in emergency operations plans. It offers the best judgment & recommendations on how to deal with the entire planning process -- from forming a planning team to writing the plan. Specific topics of discussion include: preliminary considerations, the planning process, emergency operations plan format, basic plan content, functional annex content, hazard-unique planning, & linking Federal & State operations.

Preventing Medication Errors

In today's rapidly changing business environment, strong influence of globalization and information technologies drives practitioners and researchers of modern supply chain management, who are interested in applying different contemporary management paradigms and approaches, to supply chain process. This book intends to provide a guide to researchers, graduate students and practitioners by incorporating every aspect of management paradigms into overall supply chain functions such as procurement, warehousing, manufacturing, transportation and disposal. More specifically, this book aims to present recent approaches and ideas including experiences and applications in the field of supply chains, which may give a reference point and useful information for new research and to those allied, affiliated with and peripheral to the field of supply chains and its management.

I'm Going to the Hospital

The anthrax incidents following the 9/11 terrorist attacks put the spotlight on the nationâ€™s public health agencies, placing it under an unprecedented scrutiny that added new dimensions to the complex issues considered in this report. The Future of the Publicâ€™s Health in the 21st Century reaffirms the vision of Healthy People 2010, and outlines a systems approach to assuring the nationâ€™s health in practice, research, and policy. This approach focuses on joining the unique resources and perspectives of diverse sectors and entities and challenges these groups to work in a concerted, strategic way to promote and protect the publicâ€™s health. Focusing on diverse partnerships as the framework for public health, the book discusses: The need for a shift from an individual to a population-based approach in practice, research, policy, and community engagement. The status of the governmental public health infrastructure and what needs to be improved, including its interface with the health care delivery system. The roles nongovernment actors, such as academia, business, local communities and the media can play in creating a healthy nation. Providing an accessible analysis, this book will be important to public health policy-makers and practitioners, business and community leaders, health advocates, educators and journalists.

Patient Flow

Evangelist Uncle Buddie Robinson's hospital experience is the first Western description of "going to heaven," communing with the saints, the angels, and Lord Jesus. He is one of the first Christian ministers to realize that heaven is for real and is our real home.

Leading High-Reliability Organizations in Healthcare

"In Hospital Operations, two leading Operations Management experts and five practicing clinicians demonstrate how to apply new OM advances and metrics to substantially improve any hospital's performance. Replete with examples, Hospital Operations shows how to generate principles-driven breakthrough ideas to systematically improve emergency departments, operating rooms, nursing unites, and diagnostic units." -- Back cover

Hospital Reimbursement

What are the possibilities for process mining in hospitals? In this book the authors provide an answer to this question by presenting a healthcare reference model that outlines all the different classes of data that are potentially available for process mining in healthcare and the relationships between them. Subsequently, based on this reference model, they

explain the application opportunities for process mining in this domain and discuss the various kinds of analyses that can be performed. They focus on organizational healthcare processes rather than medical treatment processes. The combination of event data and process mining techniques allows them to analyze the operational processes within a hospital based on facts, thus providing a solid basis for managing and improving processes within hospitals. To this end, they also explicitly elaborate on data quality issues that are relevant for the data aspects of the healthcare reference model. This book mainly targets advanced professionals involved in areas related to business process management, business intelligence, data mining, and business process redesign for healthcare systems as well as graduate students specializing in healthcare information systems and process analysis.

Dying of Health Care

Since the first edition of Managing the Unexpected was published in 2001, the unexpected has become a growing part of our everyday lives. The unexpected is often dramatic, as with hurricanes or terrorist attacks. But the unexpected can also come in more subtle forms, such as a small organizational lapse that leads to a major blunder, or an unexamined assumption that costs lives in a crisis. Why are some organizations better able than others to maintain function and structure in the face of unanticipated change? Authors Karl Weick and Kathleen Sutcliffe answer this question by pointing to high reliability organizations (HROs), such as emergency rooms in hospitals, flight operations of aircraft carriers, and firefighting units, as models to follow. These organizations have developed ways of acting and styles of learning that enable them to manage the unexpected better than other organizations. Thoroughly revised and updated, the second edition of the groundbreaking book Managing the Unexpected uses HROs as a template for any institution that wants to better organize for high reliability.

Ten Strategies of a World-Class Cybersecurity Operations Center

Today, the debate about our health care system is raging, but it often seems too complex or politically-driven for people to navigate. There has perhaps never been a better time to share with the American public a book that explains the state of our health care in an honest, comprehensive, and relatable way. Dying of Health Care, authored by a primary care physician with nearly 40 years of experience practicing in the U.S. and U.K., provides an easy-to-understand examination of the American health care system's major problems and potential solutions. Dr. Hanna explores the all-important question facing us today: why are Americans paying much more per person for health care than those in other developed nations, but getting much less in terms of quality? Approaching this painful paradox through a clinician's eyes, Dr. Hanna first makes a careful diagnosis and then prescribes an appropriate treatment to heal our ailing system. He shares real-life examples of patients and provides insights into the minds of doctors, including how their decisions influence the costs and outcomes of

treatments. Ultimately, Dr. Hanna exposes how the system harms us - even sometimes kills us - both physically and financially, and he offers innovative solutions that can work to create the quality, affordable system we deserve.

Healthcare Operations Management

Recent research underscores a serious lack of preparedness among hospitals nationwide and a dearth of credible educational programs and resources on hospital emergency preparedness. As the only resource of its kind, Health Care Emergency Management: Principles and Practice specifically addresses hospital and health system preparedness in the face of a large scale disaster or other emergency. Important Notice: The digital edition of this book is missing some of the images or content found in the physical edition.

Emergency Department Leadership and Management

Ten Strategies of a World-Class Cyber Security Operations Center conveys MITRE's accumulated expertise on enterprise-grade computer network defense. It covers ten key qualities of leading Cyber Security Operations Centers (CSOCs), ranging from their structure and organization, to processes that best enable smooth operations, to approaches that extract maximum value from key CSOC technology investments. This book offers perspective and context for key decision points in structuring a CSOC, such as what capabilities to offer, how to architect large-scale data collection and analysis, and how to prepare the CSOC team for agile, threat-based response. If you manage, work in, or are standing up a CSOC, this book is for you. It is also available on MITRE's website, www.mitre.org.

Focused Operations Management for Health Services Organizations

The "I'm Going" series deals with the uncomfortable trips children need to make sometimes: going to the dentist, getting a haircut, the first day of school and other events. In the first volume we meet the little kid who doesn't like to do anything new, but in this story they are facing the frightening reality of having to go to the hospital. Hospitals are no fun for grown-ups, but for kids it can be really strange and scary. "I'm Going to the Hospital" is fun to read, but perfect for the little kid if your life should they ever need to visit a hospital. This book will prepare a child for what a hospital is like and hopefully ease some of those fears in addition to letting them know that what they are feeling is normal.

Handbook of Robotic and Image-Guided Surgery

The Institute of Medicine, Centers for Medicare and Medicaid, The Joint Commission, and other regulatory and accrediting

bodies all agree that hospitals must be transformed into places where each patient receives quality care, every single time. In other words, zero defects. Helping to ensure quality at every level, high-reliability methods offer healthcare leaders the tools they need to achieve this noble goal. Leading High-Reliability Organizations in Healthcare details the attributes and practices that help high-reliability organizations (HROs) excel in the service they provide to their customers. Explaining what it takes to achieve high reliability in healthcare settings, it defines reliability as much more than just being safe, it describes how to measure reliability and paves the way to higher reliability. The book presents proven tools, concepts, and skills that leading healthcare organizations are using to improve safety and quality, including mistake proofing, Lean Six Sigma, and reliability engineering. It details the roles and responsibilities of the two key organizational components involved in achieving high reliability: leadership and the reliability "engineers" who apply reliability methods both technically and socially throughout the healthcare value stream. Rick Morrow, executive in HROs and now System Director of Quality, Safety, and Process Improvement at CHRISTUS Health, one of the largest non-profit healthcare systems, identifies the necessary infrastructure, methods, and analytics required to achieve and sustain higher reliability. He also suggests applications of high reliability concepts that have proven to work well in healthcare settings. The book includes numerous case studies that illustrate success stories of healthcare organizations achieving higher reliability, some achieving zero defects for years. It also contains case studies that examine examples of failures, so you can avoid making the same mistakes.

Principles of Disaster Mitigation in Health Facilities

"[This book is] the most authoritative assessment of the advantages and disadvantages of recent trends toward the commercialization of health care," says Robert Pear of The New York Times. This major study by the Institute of Medicine examines virtually all aspects of for-profit health care in the United States, including the quality and availability of health care, the cost of medical care, access to financial capital, implications for education and research, and the fiduciary role of the physician. In addition to the report, the book contains 15 papers by experts in the field of for-profit health care covering a broad range of topics--from trends in the growth of major investor-owned hospital companies to the ethical issues in for-profit health care. "The report makes a lasting contribution to the health policy literature."--Journal of Health Politics, Policy and Law.

The Future of the Public's Health in the 21st Century

America's health care system has become too complex and costly to continue business as usual. Best Care at Lower Cost explains that inefficiencies, an overwhelming amount of data, and other economic and quality barriers hinder progress in improving health and threaten the nation's economic stability and global competitiveness. According to this report, the

knowledge and tools exist to put the health system on the right course to achieve continuous improvement and better quality care at a lower cost. The costs of the system's current inefficiency underscore the urgent need for a systemwide transformation. About 30 percent of health spending in 2009--roughly $750 billion--was wasted on unnecessary services, excessive administrative costs, fraud, and other problems. Moreover, inefficiencies cause needless suffering. By one estimate, roughly 75,000 deaths might have been averted in 2005 if every state had delivered care at the quality level of the best performing state. This report states that the way health care providers currently train, practice, and learn new information cannot keep pace with the flood of research discoveries and technological advances. About 75 million Americans have more than one chronic condition, requiring coordination among multiple specialists and therapies, which can increase the potential for miscommunication, misdiagnosis, potentially conflicting interventions, and dangerous drug interactions. Best Care at Lower Cost emphasizes that a better use of data is a critical element of a continuously improving health system, such as mobile technologies and electronic health records that offer significant potential to capture and share health data better. In order for this to occur, the National Coordinator for Health Information Technology, IT developers, and standard-setting organizations should ensure that these systems are robust and interoperable. Clinicians and care organizations should fully adopt these technologies, and patients should be encouraged to use tools, such as personal health information portals, to actively engage in their care. This book is a call to action that will guide health care providers; administrators; caregivers; policy makers; health professionals; federal, state, and local government agencies; private and public health organizations; and educational institutions.

Process Mining in Healthcare

Disasters and public health emergencies can stress health care systems to the breaking point and disrupt delivery of vital medical services. During such crises, hospitals and long-term care facilities may be without power; trained staff, ambulances, medical supplies and beds could be in short supply; and alternate care facilities may need to be used. Planning for these situations is necessary to provide the best possible health care during a crisis and, if needed, equitably allocate scarce resources. Crisis Standards of Care: A Toolkit for Indicators and Triggers examines indicators and triggers that guide the implementation of crisis standards of care and provides a discussion toolkit to help stakeholders establish indicators and triggers for their own communities. Together, indicators and triggers help guide operational decision making about providing care during public health and medical emergencies and disasters. Indicators and triggers represent the information and actions taken at specific thresholds that guide incident recognition, response, and recovery. This report discusses indicators and triggers for both a slow onset scenario, such as pandemic influenza, and a no-notice scenario, such as an earthquake. Crisis Standards of Care features discussion toolkits customized to help various stakeholders develop indicators and triggers for their own organizations, agencies, and jurisdictions. The toolkit contains scenarios, key questions, and examples of indicators, triggers, and tactics to help promote discussion. In addition to common elements designed to

facilitate integrated planning, the toolkit contains chapters specifically customized for emergency management, public health, emergency medical services, hospital and acute care, and out-of-hospital care.

Patient Safety and Quality

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nursesâ€™ working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors. The nature of the activities nurses typically perform â€" monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis â€" provides an indispensable resource in detecting and remedying error-producing defects in the U.S. health care system. During the past two decades, substantial changes have been made in the organization and delivery of health care â€" and consequently in the job description and work environment of nurses. As patients are increasingly cared for as outpatients, nurses in hospitals and nursing homes deal with greater severity of illness. Problems in management practices, employee deployment, work and workspace design, and the basic safety culture of health care organizations place patients at further risk. This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety.

Guide for All-Hazard Emergency Operations Planning

Improve your company's ability to avoid or manage crises Managing the Unexpected, Third Edition is a thoroughly revised text that offers an updated look at the groundbreaking ideas explored in the first and second editions. Revised to reflect events emblematic of the unique challenges that organizations have faced in recent years, including bank failures, intelligence failures, quality failures, and other organizational misfortunes, often sparked by organizational actions, this critical book focuses on why some organizations are better able to sustain high performance in the face of unanticipated change. High reliability organizations (HROs), including commercial aviation, emergency rooms, aircraft carrier flight operations, and firefighting units, are looked to as models of exceptional organizational preparedness. This essential text explains the development of unexpected events and guides you in improving your organization for more reliable performance. "Expect the unexpected" is a popular mantra for a reason: it's rooted in experience. Since the dawn of civilization, organizations have been rocked by natural disasters, civil unrest, international conflict, and other unexpected crises that impact their ability to function. Understanding how to maintain function when catastrophe strikes is key to keeping your organization afloat. Explore the many different kinds of unexpected events that your organization may face Consider updated case studies and research Discuss how highly reliable organizations are able to maintain control during

unexpected events Discover tactics that may bolster your organization's ability to face the unexpected with confidence Managing the Unexpected, Third Edition offers updated, valuable content to professionals who want to strengthen the preparedness of their organizations—and confidently face unexpected challenges.

Hospital Operations

A Pulitzer Prize-winning doctor, reporter and author of War Hospital reconstructs five days at Memorial Medical Center after Hurricane Katrina destroyed its generators to reveal how caregivers were forced to make life-and-death decisions without essential resources. Reprint. A best-selling book. On the NYT list of 10 Best Books of 2013.

Vignettes in Patient Safety

This book focuses on problems encountered in areas of high risk for seismic events. It introduces the essential aspects of carrying out vulnerability assessments and applying practical measures to mitigate damage in hospitals addressing structural and nonstructural aspects as well as administrative and internal organization. In a period of only 15 years between 1981 and 1996 93 hospitals and 538 health care centers in Latin America and the Caribbean were damaged as a consequence of natural disasters. The direct cost of these disasters has been enormous; just as devastating has been the social impact of the loss of these critical facilities at a time when they were most needed. For these reasons special consideration must be given to disaster planning for these facilities. Assessing and reducing their vulnerability to natural hazards is indispensable. Principles of Disaster Mitigation in Health Facilities is an updated compilation of various documents on the topic already published by PAHO/WHO. Sections of previous publications have been revised to address the needs of professionals from a variety of disciplines particularly those involved in health facility planning operation and maintenance. Figures and photographs illustrate situations that can increase disaster vulnerability in health facilities. Examples are given of how countries in Latin America have conducted vulnerability assessments and applied specific disaster mitigation measures in their hospitals and health centers.

For-Profit Enterprise in Health Care

Regional health care databases are being established around the country with the goal of providing timely and useful information to policymakers, physicians, and patients. But their emergence is raising important and sometimes controversial questions about the collection, quality, and appropriate use of health care data. Based on experience with databases now in operation and in development, Health Data in the Information Age provides a clear set of guidelines and principles for exploiting the potential benefits of aggregated health data--without jeopardizing confidentiality. A panel of

experts identifies characteristics of emerging health database organizations (HDOs). The committee explores how HDOs can maintain the quality of their data, what policies and practices they should adopt, how they can prepare for linkages with computer-based patient records, and how diverse groups from researchers to health care administrators might use aggregated data. Health Data in the Information Age offers frank analysis and guidelines that will be invaluable to anyone interested in the operation of health care databases.

Principles and Practice of Cardiothoracic Surgery

Handbook of Robotic and Image-Guided Surgery provides state-of-the-art systems and methods for robotic and computer-assisted surgeries. In this masterpiece, contributions of 169 researchers from 19 countries have been gathered to provide 38 chapters. This handbook is 744 pages, includes 659 figures and 61 videos. It also provides basic medical knowledge for engineers and basic engineering principles for surgeons. A key strength of this text is the fusion of engineering, radiology, and surgical principles into one book. A thorough and in-depth handbook on surgical robotics and image-guided surgery which includes both fundamentals and advances in the field A comprehensive reference on robot-assisted laparoscopic, orthopedic, and head-and-neck surgeries Chapters are contributed by worldwide experts from both engineering and surgical backgrounds

Hospital Operations

"This book aims to help healthcare management students and working professionals find ways to improve the delivery of healthcare, even with its complex web of patients, providers, reimbursement systems, physician relations, workforce challenges, and intensive government regulation. Taking an integrated approach, the book puts the tools and techniques of operations improvement in the context of healthcare so that readers learn how to increase the effectiveness and efficiency of tomorrow's healthcare system." -- back of the book

Health Operations Management

Written for a global audience, by an international team, the book provides practical, case-based emergency department leadership skills.

Managing the Unexpected

Hospital and Healthcare Security, Fifth Edition, examines the issues inherent to healthcare and hospital security, including

licensing, regulatory requirements, litigation, and accreditation standards. Building on the solid foundation laid down in the first four editions, the book looks at the changes that have occurred in healthcare security since the last edition was published in 2001. It consists of 25 chapters and presents examples from Canada, the UK, and the United States. It first provides an overview of the healthcare environment, including categories of healthcare, types of hospitals, the nonhospital side of healthcare, and the different stakeholders. It then describes basic healthcare security risks/vulnerabilities and offers tips on security management planning. The book also discusses security department organization and staffing, management and supervision of the security force, training of security personnel, security force deployment and patrol activities, employee involvement and awareness of security issues, implementation of physical security safeguards, parking control and security, and emergency preparedness. Healthcare security practitioners and hospital administrators will find this book invaluable. FEATURES AND BENEFITS: * Practical support for healthcare security professionals, including operationally proven policies, and procedures * Specific assistance in preparing plans and materials tailored to healthcare security programs * Summary tables and sample forms bring together key data, facilitating ROI discussions with administrators and other departments * General principles clearly laid out so readers can apply the industry standards most appropriate to their own environment NEW TO THIS EDITION: * Quick-start section for hospital administrators who need an overview of security issues and best practices

Applications of Contemporary Management Approaches in Supply Chains

Focused Operations Management for Health Services Organizations offers managers and staff the practical knowledge and tools they need to accomplish much more within existing resources. This text identifies common bottlenecks and constraints and focuses on the critical issues and processes faced by managers in the health care field. The book provides tools to significantly improve organizational operations as well as enhance quality and customer satisfaction without increasing the use of physical, human, and financial resources.

Five Days at Memorial

By one estimate, the U.S. wastes $480 billion annually on healthcare expenditures that don’t improve care. Worse, because of faulty systems – not personnel – up to 98,000 people die every year due to preventable medical errors – and that doesn’t count non-terminal events such as hospital-acquired infections. In Hospital Operations, two leading operations management experts and four senior physicians demonstrate how to apply new OM advances to substantially improve any hospital’s operational, clinical, and financial performance. Replete with examples, this bookshows how to diagram hospital flows, trace interconnections, and optimize flows for better performance. Readers will find specific guidance on improving emergency departments, operating rooms, hospital floors, and diagnostic units; and successfully applying metrics. Coverage includes:

reducing ER overcrowding and enhancing patient safety…improving OR scheduling, enhancing organizational learning, and responding to surgeons and other stakeholders… improving bed availability, optimizing nurse schedules, and creating more seamless patient handoffs… reducing lab turnaround time, improving imaging responsiveness, and decreasing lab errors…successfully applying the right metrics for every facet of hospital performance. The authors conclude by previewing the "Hospital of the Future," addressing issues ranging from prevention and self-care to the evolution of technology and evidence-based medicine.

Crisis Standards of Care

In her groundbreaking book The Southwest Airlines Way, Jody Hoffer Gittell revealed the management secrets of the company Fortune magazine called “the most successful airline in history.” Now, the bestselling business author explains how to apply those same principles in one of our nation’s largest, most important, and increasingly complex industries. High Performance Healthcare explains the critical concept of “relational coordination”—coordinating work through shared goals, shared knowledge, and mutual respect. Because of the way healthcare is organized, weak links exist throughout the chain of communication. Gittell clearly demonstrates that relational coordination strengthens those weak links, enabling providers to deliver high quality, efficient care to their patients. Using Gittell’s innovative management methods, you will improve quality, maximize efficiency, and compete more effectively. High Performance Healthcare walks you step by step through the process of: Identifying weak areas of relational coordination within your organization Transforming work practices that are creating barriers to relational coordination Building a high performance work system to foster consistent relational coordination across all disciplines The book includes case studies illustrating how some healthcare organizations are already transforming themselves using Gittell’s proven tools. It concludes by identifying industry-level obstacles to high performance healthcare and showing how individual organizations and their leaders can support sweeping change at the highest levels. Policy changes and increased access to care will not alone answer the healthcare industry’s problems. Timely, accurate, problem-solving communication that crosses all organizational boundaries is a powerful response to business as usual. High Performance Healthcare explains exactly how to achieve this crucial dynamic, providing a long-awaited cure to an industry in crisis.

Health Data in the Information Age

In high school, everyone's talking about college. What to do. Where to go. Why it's important. Classes are given on it. Books are written about it. But details get left out. Every year, college graduates learn this the hard way as they step into adulthood. I was one of them. After earning a four-year degree, I went through two of the worst years of my life. Not that my situation is unique. I am a part of a generation that was told to go to college first and sort out the details later. Most of

us did. We chased the promise of a big shiny future, and we ended up being chased by the mistakes of our past. That's not to say we completely regretted going. This book isn't a list of privileged millennial complaints. It's a collection of wisdom gained in less than pleasant ways. It's a story of hardship, failure, victory, and perseverance. It's all of the things we wish someone had told us. And it takes place before college, in college, after college, and without college. This is the wild, painful, awkward, hilarious, depressing, & beautiful journey from youth to maturity. This is the college book that no one ever gave us.

To Err Is Human

"Nurses play a vital role in improving the safety and quality of patient car -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)."--Online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk.

Managing the Unexpected

In 1996 the Institute of Medicine launched the Quality Chasm Series, a series of reports focused on assessing and improving the nationâ€™s quality of health care. Preventing Medication Errors is the newest volume in the series. Responding to the key messages in earlier volumes of the seriesâ€"To Err Is Human (2000), Crossing the Quality Chasm (2001), and Patient Safety (2004)â€"this book sets forth an agenda for improving the safety of medication use. It begins by providing an overview of the system for drug development, regulation, distribution, and use. Preventing Medication Errors also examines the peer-reviewed literature on the incidence and the cost of medication errors and the effectiveness of error prevention strategies. Presenting data that will foster the reduction of medication errors, the book provides action agendas detailing the measures needed to improve the safety of medication use in both the short- and long-term. Patients, primary health care providers, health care organizations, purchasers of group health care, legislators, and those affiliated with providing medications and medication- related products and services will benefit from this guide to reducing medication errors.

Contemporary Leadership Challenges

Featuring a number of case studies and a theoretical framework, this textbook leads the reader across geographical

boundaries and through the logical steps in health operations management. The authors explore its development as a tool for monitoring and controlling the use of valuable resources.

Hospital and Healthcare Security

Over the past two decades, the healthcare community increasingly recognized the importance and the impact of medical errors on patient safety and clinical outcomes. Medical and surgical errors continue to contribute to unnecessary and potentially preventable morbidity and/or mortality, affecting both ambulatory and hospital settings. The spectrum of contributing variables-ranging from minor errors that subsequently escalate to poor communication to lapses in appropriate protocols and processes (just to name a few)-is extensive, and solutions are only recently being described. As such, there is a growing body of research and experiences that can help provide an organized framework-based upon the best practices and evidence-based medical principles-for hospitals and clinics to foster patient safety culture and to develop institutional patient safety champions. Based upon the tremendous interest in the first volume of our Vignettes in Patient Safety series, this second volume follows a similar vignette-based model. Each chapter outlines a realistic case scenario designed to closely approximate experiences and clinical patterns that medical and surgical practitioners can easily relate to. Vignette presentations are then followed by an evidence-based overview of pertinent patient safety literature, relevant clinical evidence, and the formulation of preventive strategies and potential solutions that may be applicable to each corresponding scenario. Throughout the Vignettes in Patient Safety cycle, emphasis is placed on the identification and remediation of team-based and organizational factors associated with patient safety events. The second volume of the Vignettes in Patient Safety begins with an overview of recent high-impact studies in the area of patient safety. Subsequent chapters discuss a broad range of topics, including retained surgical items, wrong site procedures, disruptive healthcare workers, interhospital transfers, risks of emergency department overcrowding, dangers of inadequate handoff communication, and the association between provider fatigue and medical errors. By outlining some of the current best practices, structured experiences, and evidence-based recommendations, the authors and editors hope to provide our readers with new and significant insights into making healthcare safer for patients around the world.

That College Book

The field of cardiothoracic surgery continues to evolve at a rapidly expanding rate. New technologies are under constant development and as patients present with more advanced pathophysiology and complex comorbidities, management becomes more dependent on multi-disciplinary Teams. While there are a variety of innovative and high-profile topics that dominate the literature and the interests of clinicians, sometimes is it the basics both in terms of acute and sometimes unusual problems that often challenge cardiothoracic surgeons on a day to day basis. The goal of Principles and Practice of

Cardiothoracic Surgery is to hopefully highlight the current state of the art management of these problems.