Readmission/ ADE/ VTE Peer-to-Peer Learning Session

2:15 p.m. Friday, September 7, 2012
Sharon Burnett and Jeanne Naeger
Missouri Hospital Association

Overview of Session

• Welcome and overview of session activities
• Hospital sharing and peer-to-peer learning
  › CoxHealth
  › Phelps County Regional Medical Center
  › Boone Hospital Center
  › Citizen’s Memorial Healthcare
• Hospital self assessment of opportunities for improvement using OATS tool
• Facilitated discussion to support participants in the planning of immediate next steps and tests of change
• What’s next — review of upcoming activities and learning opportunities
READMISSIONS: Closing the Gaps to Improve Patient Care

Becky Watts, R.N., BSN
Administrative Director, Cardiovascular Services, CoxHealth
Springfield, Missouri

About CoxHealth

- Three hospital system with 783 licensed beds
- 57 physician clinics
- 22 counties served
- 2011 all cause readmission rate 11%
  - Hospitalist Program
  - Physician Performance Based Incentives
  - Evidenced based care i.e. Get With The Guidelines (GWTG) – Heart Failure (HF)
What Did We Test?

- Readmission Risk Orderable: 8/27/12
- Discharge Call Center Pilot: 8/1/12

What Do We Plan to Test?

- Consistent method to identify patients readmitted within 30 days
- Standardized HF Order sets
- PCP identification/notification of pt upon admission/discharge
- Nurse Risk Stratification Tool
What Do We Plan to Test?

- Education
  - Heart Failure Survival Kit
  - Standardized HF education across the continuum
- Pharmacy Technician
  - Medication Reconciliation in ED
  - Discharge Medication Service expansion to additional units

What Have We Learned So Far?

Importance of:

- High level committee incorporating executive leadership
- Collaborate with teams to avoid duplication
  - Readmission Subgroups: 3
  - Additional existing groups: 4
- Support from frontline to executive level
- IT essential to the team
- Map readmission continuum and address gaps
What Were Our Barriers?

- Computer Technology
- Absence of key subject matter expert – Chief Medical Information Officer
- Identification of readmitted patients upon admission
- Discharge medication list
  - No area for medication indication on nursing discharge medication list (Depart in EMR)
  - Complicated for patients
How Did We Overcome These Barriers?

- Invited Chief Medical Information Officer to Committee Meetings
  - Clinic and hospital patient flow
  - Chronic patient care treatment and long term needs
  - Flow of EMR information
- Exploring options
  - Identification of readmitted patients upon admission
  - Improved medication education

What Can We Teach From Our Journey?

- Establish subgroups/work groups for focus areas
- Collaboration among teams
- Key team members - add as identified
- Leverage IT platforms
- Standardize communication throughout the continuum
Aim:
Reduce 30-Day All Cause readmission rate by 20% by Dec. 31, 2013.

Why is this project important?
- Improve patient care and outcomes.
- Create more efficient processes and enhance collaboration.
- Increase inpatient bed capacity for new admissions.

Aim Statement

Changes being Tested, Implemented or Spread

**T:** Readmission Risk Hospitalist Orderable Pilot.

**T:** Discharge Call Center Pilot.

**T:** Pharmacy Tech Discharge Medication Service.

Run Charts

**CoxHealth Readmission Rate Within 30 Days (All Cause)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan - Dec 2011</td>
<td>19.9%</td>
</tr>
<tr>
<td>Jan - April 2012</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

**HF Discharge Appointments Scheduled and Documented Prior to Discharge**

<table>
<thead>
<tr>
<th>Year</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan - Dec 2011</td>
<td>60%</td>
</tr>
<tr>
<td>Jan - April 2012</td>
<td>80%</td>
</tr>
</tbody>
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Lessons Learned

- High level committee incorporating executive leadership.
- Collaborate with teams to avoid duplication.
- Additional existing groups: 4.
- Support frontline to executive level.
- Map readmission continuum and address gaps.

Recommendations and Next Steps

- Develop consistent method to identify patients readmitted within 30 days.
- Standardize HF order sets, PCCM notification of pt upon admission/discharge, HF education across the continuum.
- Implement Nurse Risk Stratification Tool, Heart Failure Survival Kit, Pharmacy Tech Med Rec in ED, Pharmacy Tech Discharge Med Service to additional units.

Team Members

Dan Sontheimer, MD (Adm. Leader), Becky Watts (Leader), Brenda Reith/Lisa Willis (P.I. Facilitators, Data Entry), Representatives: Hospitalist, Cardiologist, Chief Medical Information Officer, Pharmacist, Dietician, Nurse Managers, Oxford HHC, CF, SW, NP, Ambulatory Facilitator (Mandy Stanley), IT, Cardiac Rehab, FOC, Regional Services and Clinical Educators.

Feel Free to Contact Us:

Becky Watts
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CoxHealth
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417-269-7178
Decreasing Readmissions by Decreasing ED Utilization

Linde Merrow RN, MS
Administrative Director Clinical Quality & Measurement
Phelps County Regional Medical Center

About Us

- Phelps County Regional Medical Center, located in Rolla, is one of Missouri’s leading referral centers, serving over 200,000 residents in South Central Missouri.
- PCRMC is a non-tax supported, county-owned 242 bed hospital. It has more than 1,500 employees, 100 plus physicians and a five member elected board.
- PCRMC is a HIMSS Stage 6 designated hospital.
What Did We Test?

- Individuals with non-emergent pain related symptoms were impacting a rural busy emergency department which led to overcrowding, long waiting room times and misuse of resources.
- Some of these patients actually presented to the ED 3-4 times per day.
- ED Care Managers implemented multiple interventions to assist patients to utilize the appropriate level of care.

What Have We Learned So Far?

- Reasons for non-emergent pain related services:
  - Headache/Migraine
  - Dental Pain
  - Abdominal Pain-chronic
  - Back Pain-chronic
  - Extremity Pain- chronic
  - Drug Withdrawal
  - Alcohol Intoxication
- Addressing the ED readmission patterns requires:
  - Intensive Care Management follow-up, especially at the beginning of the process
  - Consistency from ED physicians, nurses, care managers, and PCP
  - Education of options available, importance of lifestyle changes, differences of emergency services and outpatient services, & importance of PCP
  - Coordination of individual's needs through appropriate community resources
ED Utilization by Group 1

What Were Our Barriers?

- Identifying individuals that presented to the ED frequently for non-emergent issues.
- Communicating to ED physicians, nurses, and care managers the individuals that presented to the ED frequently for non-emergent issues.
- Finding drug/alcohol treatment facilities for the individuals.
- Finding psychiatric providers for the individuals.
- Having individuals want to participate in their healthcare and treatment plan, especially at the beginning.
How Did We Overcome These Barriers?

• Communication
• Education
• Accountability
• Consistency
• Holistic Approach

What Can We Teach From Our Journey?

• Educate healthcare providers (hospital & community) on any process changes.
• Use electronic methods to track and communicate process changes.
• Intensive use of resources at the beginning of process change.
• Building ongoing relationships and trust with individuals/families helps the process changes.
• We found that the majority of individuals wanted to participate in their healthcare and treatment plan.
Feel Free to Contact Us:

- Kim Woodson MSW  ED Care Manager  573-458-7610
- Barb Adair RN, BSN  ED Care Manager  573-458-7684
- Linde Merrow RN, MS  Administrative Director CQM  573-458-7676

ADE: Reducing Hypoglycemia

Cheryl Eady, MSN, RN, NE-BC, CPHQ
Boone Hospital Center
Columbia, Missouri
Boone Hospital Center

- 394-bed full service hospital, Columbia, MO
- Regional referral center providing services to people in 26 mid-MO counties.
- Excel in Cardiology, Neurology, Surgical, and Obstetrical service lines.
- 24 hour Level II Emergency Department with hospital-based ambulance service and helipad for incoming emergency air transports.
- 2000 staff and 350 physicians work at Boone.
- Magnet Hospital
- Affiliated with BJC Healthcare.

Project Title: ADE: Hypoglycemia  Date: August 25, 2012 (July actions)
Hospital Name: Boone Hospital Center  State: Missouri
Executive Sponsors: Dr. Jerry Kennett, CMO & Dr. Mary Beck, CNO
Director Champion; Cheryl Eady
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Aim Statement
Reduce incidence of severe hypoglycemia (BG 15-39 mg/dl) in adult inpatient population at BHC 50% by 12/31/2013.

This project is important because hypoglycemia is the most common complication of insulin therapy and severe hypoglycemia accounts for 80% of the ADEs observed by BJC surveillance technology.

Run Charts
Printed diabetic review reports not useful to patient care nurse, but are to Outcome Coordinators.
POC + SSI + Meal Coordination is not easy to achieve.

Recommendations and Next Steps
- Change Novolog (Insulin Aspart) times on MAR to align with meals.
- Coordinate timing POC BG + Novolog + meal.
- Implement ED early warning alert of high risk patients.
- Sulfonylurea alerts to be generated electronically real-time.
- Intranet Diabetes Management site

Lessons Learned
- Printed diabetic review reports not useful to patient care nurse, but are to Outcome Coordinators.
- POC + SSI + Meal Coordination is not easy to achieve.

Team Members
- C. Barnes, Quality Coord.
- K. Vogt, Clinical Pharmacist
- J. Kimmons, Dietary Mgr.
- J. Anderson, OP, ADE
- Dr. R. Bount
- Dr. K. Jamison
- Dr. K. Winkelmeyer
- M. Smith, MSN, Director
- K. Leuckel, Education
- L. Mefrakis, RN, ICU
- K. Gerling, RN, Ocm Gen Med.

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Our Journey

• BJ C Preventable Harm Initiative
• Adverse Drug Event analysis - Hypoglycemia #1
• Implemented system team (2010)
• Developed hospital Diabetes Action Committee (DAC) January 2011)
• Hypoglycemia Event Analysis Tool (HEAT) (March 2011)
• Causative Factors Identification
• Education ongoing
• Physician Champions added to Diabetes Action Committee (DAC) (May 16, 2012)

Our Journey continues

• Align & improve various order sets
• Align hypoglycemic protocol with order sets
• Letter to providers with prescribing recommendations (June 12)
  ➢ Consider 20% reduction of home basal insulin dose at admission
  ➢ Consider stopping oral agents for most patients at admission
  ➢ Stop sulfonylurea agents in high risk patients (age > 75, CrCl < 30 ml/min, or body weight < 75 kg)
  ➢ Review history of blood glucose levels daily and adjust basal, and especially bedtime dosing, as needed.
Our Journey continues

- Small Test of Change – RN using Diabetic Review Report (2S & Gen Med) (June 12)
- Small Test of Change – POC BG + Mealtime Insulin + Meal Within 10 Minutes (June - July 12)
- Lean event – Value Stream Map “Late Tray Process” (July 12)
- Small Test of Change – Printing Diabetic Review Report for diabetic patients on 2 units (July - Aug 12)

Improvements Started

Ordering Meal Trays

If you are ordering a meal tray it needs to be entered into Horizon/Clinicals before the following times. Otherwise the tray will be considered late and will not be delivered at the normal meal time.

- For Breakfast 0630
- For Lunch 1100
- For Dinner 1600

**You must send a "Late Tray" notification in addition to the diet order, if diet order is entered into Horizon/Clinicals after cutoff time shown above.

The earliest you can expect to receive a late tray for each meal is listed below:

- For Breakfast 0815
- For Lunch 1245
- For Dinner 1800

**Please call 3401 if you plan to send someone down to pick up the tray.

Communication to nursing unit regarding meal timing expectations (nothing in place currently)
Improvements Started

Nutrition and Food Service
Helpful Information

Our goal is to provide excellent food service at Boone Hospital. In order to place your menu order by phone please call, 3401 before the specified times:

Breakfast: 6:30 AM
Lunch: 11:00 AM
Dinner: 4:00 PM

If you have questions about your diet I'll be happy to answer them. If you wish to speak with the dietitian, your nurse or I will contact her.

Diet Technician

Will be left in the patient room when diet tech rounds

What Did We Test?

For your diabetic patients – Please utilize the Diabetic Review Report Historical Data
Access through the “Reviews” tab at the top of HC.

To be used:
• at the beginning of your shift
• following any POC testing or administration of glycemic control agents
• at the end of your shift
• as a point of discussion in your bedside shift report
What Did We Test?

Twice daily report for all diabetic patients, prints at 0630 & 1830 with snapshot of previous 24 hours diabetic review.

What Did We Test?

Objective: Know when to give mealtime insulin.

3 things should occur within 10 minutes

1. Point of care glucose test
2. Rapid acting insulin - NovoLog (insulin aspart) administered
3. Patient begins meal

Help prevent hypoglycemic events. Keep our patients safe.
What Have We Learned So Far?

- Neither the ICU or General Medicine nurses found the Diabetic Review Report in a print format added value.
- The Outcomes Coordinators that round with physicians on General Medicine find the Diabetic Review Report very helpful.
- Novolog (Insulin Aspart) MAR scheduled times are not aligned with meal tray delivery creating conflict between night and day shift.
- Workload of POC BG needs to change from the way we have always done it.

What Were Our Barriers?

- Technology – inability to print color graphics
- Novolog (Insulin Aspart) MAR scheduled times are not aligned with meal tray delivery creating conflict between night and day shift.
- Workload of POC BG needs to change from the way we have always done it.
How Did Do We Overcome These Barriers?

- Patient Care Steering to approve change to Novolog (Insulin Aspart) timing and realization that timing of POC BG must change
- Education of approximately 500 nurses regarding the above
- Continue to find need for more just-in-time coaching
- Ongoing revisions to improve order sets for patients that are NPO or on TPN
- Dietary awareness of patients with POC BG

What Can We Teach From Our Journey?

- The truth can be found at gemba
- Better, not perfect.
- Our staff are juggling many priorities.
- How can we truly have multi-disciplinary teamwork?
Feel Free to Contact Us:

Cheryl Eady, MSN, RN, NE-BC, CPHQ
Director of Patient Safety, Clinical Quality & Infection Prevention
Boone Hospital Center
1600 E. Broadway
Columbia, MO

System Focus on ADE/Errors

Renee Trewyn, PharmD, BCPS
Director of Pharmacy,
Citizens Memorial Healthcare
Bolivar, MO
About Citizens Memorial Healthcare

- Hospital – 76 bed acute inpatient (med surg, OB, ICU, ER) Ambulatory Surgical Center, Geriatrics/Psych Unit, Swing Bed, Cancer Center, outpatient clinics
- LTC – 6 facilities in 5 counties
- Physician Clinics – 26 clinics in 8 counties
- Home Care Services - 7 counties
- Active physicians on staff - 90

One EMR/CPOE used across the continuum of care

What are we doing to reduce ADE/ errors at CMH?

- On-line “event” reporting includes medication errors, ADE
  - Routes to each manager affected
  - Discussed at monthly medication management meeting

- Smart Pump installation
  - Edits to drug library managed through event reports
What are we doing to reduce ADE/ errors at CMH?

- Pyxis update with enhanced reporting
  - Changing more units to “profiled” mode
  - “cubies”
  - Anesthesia: Automatic Dispensing Cabinet to each OR and procedure room
- Expanding role for pharmacy
  - ED decentralized pharmacist
    - Assist with med reconciliation; patient education
    - Proactive review of medication orders
    - Enhance use of order sets/protocols
  - Goal: decentralize pharmacist to med surg, add additional staff for geriatric/psych

What Have We Learned So Far?

- Quality Reporting Module (QRM) allows data to be compiled and analyzed quickly (vs. sorting paper reports)
  - real time reporting (minutes vs. months)
- Monthly medication management meeting
  - fruitful discussions between parties (nursing/IS/pharmacy) and QUICK fixes
- QRM is seen by employees as communication tool vs. punitive report.
- Easier to have the position approved than to find right candidate
What Were Our Barriers?

- Corporate Approval
  - Budget
  - Time

How Did We Overcome These Barriers?

- Automatic Dispensing Cabinet upgrade and Smart Pump
  - Approval
    - IS strategic planning with input from Pharm, RN
    - Data from literature to support the need
    - Grant writing
    - Physician champion
  - Implementation
    - Well defined time lines with project managers
    - Strong interdisciplinary team
How Did We Overcome These Barriers?

• Justifying additional pharmacist position
  ➢ Literature search to determine return on investment (ROI)
  ➢ Enlist Chief Compliance Officer (CCO) as “corporate champion”
  ➢ CCO presented justification to Budget Committee and CEO

• Filling the position
  ➢ Local effort x 60 days not fruitful
  ➢ Professional recruiters presented several good candidates; interviewing now

• Additional training for existing staff

What Can We Teach From Our Journey?

• Find return on investment – most convincing argument for approval of projects

• Automate event reporting
  ➢ emphasize the non-punitive
  ➢ expand to include med events, pt events, non pt and adverse drug reaction
  ➢ Discuss summary reports of events and adverse drug reactions in routine multidisciplinary meetings
Feel Free to Contact Us:

Renee.trewyn@citizensmemorial.com

Readmission Race

There are six steps in running the race:

**Lap 1**  Develop AIM statement, choose outcome and process measures, submit baseline data.

**Lap 2**  Start testing change ideas on a small and frequent scale so that you can learn from these tests of change.

**Lap 3**  Submit data on a monthly basis

**Lap 4**  Participate in the Race Checkpoint calls and webinars to learn from SME and other hospitals.

**Lap 5**  Participate in the Readmissions LISTSERV® as an ongoing opportunity to exchange ideas and share learning.

**Lap 6**  Submit your hospital’s Readmission Progress Report to the Listserv or MHA
Readmission Data Submission

- 92% baseline data
- 79% outcome data
- 51% process data
- 46% outcome and process data
- Only required to submit data on one process and one monitoring measure
- Contact Clay Gemmill if you want to remove additional process measures

Submit Data

- Baseline: Calendar Year 2011 and/or January - June 2012
- Monitoring: July to December 2012 (monthly)
- Alternative - Only submit number of readmissions (all cause, all diagnosis, same hospital) within 15 days or 30 days of discharge per month beginning with July 2012
- Alternative - MHA submit all cause, all diagnosis, same hospital readmission rate (readmissions/discharges/month)
All Cause, All Conditions, Same Hospital Readmission Rate

<table>
<thead>
<tr>
<th>Definition</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult inpatients who were readmitted to same hospital within 30 days for any reason (All Cause, all diagnosis, 18 and older, all payer)</td>
<td>Inpatients returning as an acute care inpatient to the same facility within 30 days of date of discharge</td>
<td>Total adult inpatient acute discharges</td>
<td>OB patients, deaths, transfers to another acute care facility, admissions to psych, rehab or SNF units, observation only patients.</td>
</tr>
</tbody>
</table>

Readmission Race Checkpoint Calls and Webinars

- **Root Cause Analysis**

- **Hospital Sharing & Coaching**
  September 14, 12 – 1 p.m. [https://event.on24.com/eventRegistration/EventLobbyServlet?target=registration.jsp&eventid=504169&sessionid=1&key=363ED385C1AB389B24979925AE004F89&sourcepage=register](https://event.on24.com/eventRegistration/EventLobbyServlet?target=registration.jsp&eventid=504169&sessionid=1&key=363ED385C1AB389B24979925AE004F89&sourcepage=register)

- **Conducting Risk Assessment During the Patient Stay**
  September 24, 12 – 12:45 p.m. [https://event.on24.com/eventRegistration/EventLobbyServlet?target=registration.jsp&eventid=504184&sessionid=1&key=810C936FEEA9C40CDE57A9D842A5F6&sourcepage=register](https://event.on24.com/eventRegistration/EventLobbyServlet?target=registration.jsp&eventid=504184&sessionid=1&key=810C936FEEA9C40CDE57A9D842A5F6&sourcepage=register)

- **Hospital Sharing & Coaching**
  October 10, 12 to 1:30 p.m.
Aim Statement

Reduce preventable inpatient readmissions for patients discharged from 5.2 (pilot unit) within 30 days of discharge by 20% from the baseline hospital rate ** (preventability not determined) of 10.3% * (a reduction to 8.2%) by December 31, 2013.

Why is this project important?: Our hospital has opportunity to reduce our readmission rate, improve patient discharge experience, decrease costly readmissions and improve the quality of life for our patients.

Changes being Tested, Implemented or Spread

Case Manager will identify high risk patients by using a formal readmission risk assessment tool, LACE Tool. (I)

Discharge Checklist will be utilized for all 5.2 patients discharged from that unit. (I)

(For each listed change, indicate whether it is being tested (T), Implemented (I) or Spread (S))

Team Members

• Administrative Champion: Sherry Stromme, Chief Quality & Patient Safety Officer
• Leader: Wanda Carlson, Director Case Management
• Physician Champion: Dr. Ken Donovan - Hospitalist
• Cathy Grant, RN-Nurse Manager 5.2
• Verna Curry, 5.2 Case Manager
• Melinda Roberto, Jill Czernicki, 5.2 Clinical Coordinators
• Jean Van Arnam, QRM Data Analytics Coordinator

** Denominator excludes patients who expired or were transferred to another acute care facility.

Lessons Learned

• Prior to discharge, assess all patients to determine if they can afford their medications.

Recommendations and Next Steps

Start Collecting the measures. Measures agreed upon:

1) Identify high risk patients by using a formal readmission risk assessment tool
Numerator: number of patients assessed for risk of readmission using the tool; Denominator: all eligible patients (Case Management, initially using the LACE tool)

2) Evaluate readmitted patients
Numerator: number of readmitted patients assessed for reasons for readmission; Denominator: all eligible patients (Case Management)

3) Discharge Checklist
Numerator: number of patients with all of the following completed:
• OT/PT consult within 2 days
• O2 walk with titration within 2 days
• Follow-up appointment made and listed on W-10
• PCP identified on the W-10
• Patient asked if they can afford their medications

Denominator: all eligible patients (Nursing, Case Management, Social Work, MD)

Adverse Drug Events Data Submission

• 58% baseline data
• 50% outcome data
• 58% process data
• 56% outcome and process data
• Required to submit data on one process and one outcome measure
• Baseline data from 2011
Aim: Lower the risk of bleeding in patients that are receiving warfarin anticoagulant therapy.

Why is this project important?: Within the four hospitals that make up the system, there are approximately 10 to 20 cases where patients receive a warfarin dose and experience an elevated INR while being hospitalized. The primary drivers for this situation have not been determined. An elevated INR can lead to patient bleeding.

Changes being Tested, Implemented or Spread:

(1) Review of individual patient charts for each case identified (T)
(2) Determine the adoption rate for the current standards associated with the use of warfarin (T)

Run Charts:

Since tracking this data in 2006, the incidence of these cases has dropped about 20%. Initial findings show elevated INRs in patients receiving warfarin therapy in the hospital may be related to concomitant drug therapy and caregiver communication.

Recommendations and Next Steps:

• Identify an executive sponsor for this project
• Consent check with Medication Safety team regarding the warfarin protocol
• Conduct a chart review to identify primary and secondary drivers

Team Members:

Owner: Dan Degnan
Executive Sponsor: None
Members: Nurses, physicians and pharmacists on the medication safety committee

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Venous Thromboembolism Data Submission

- 63% baseline data
- 88% outcome data
- 100% process data
- 77% outcome and process data
- Required to submit data on one process and one outcome measure
- Baseline data from 2011
Increase utilization of appropriate VTE prophylaxis in at risk patients to 100% by 2013 and sustain that rate.

In spite of formal guidelines, pulmonary venous thromboembolism (VTE) and Deep Vein Thrombosis (DVT) is a very significant cause of preventable death and disability in hospitalized patients.

Aim Statement

Changes being Tested, Implemented or Spread

Physician order set in EMR. Risk assessment based on ACCP risk stratification guidelines.

Education of RNs and providers of VTE risk categories and prevention.

Recommendations and Next Steps

- Increase use of VTE order sets (Med/Surg-ICU) to 100%.
- Improve timeliness of prophylaxis order.
- Continuing education through the team members in the field.

Lessons Learned

- Tracking compliance with order sets.
- Non use of order set not an indicator that VTE prophylaxis has not been addressed.

Team Members

Karen Gessner, Quality RN, Oliver Herfort MD physician Champion.
Hospitalist DR R Veerareddy. Mike Saracino pharmacist. Jan Goedwaagen ICU RN. Deb Tribou RN nurse manager. Amy Zullo RN. Sue Thompson RN ICU

Organizational Assessment Tool (OATs)

- Activity - self assess your hospital’s current processes and opportunities for improvement aimed at reducing readmissions
- Discussion — how can we support each other in the planning of immediate next steps and tests of change