Reducing Cardiac Surgery Readmissions

Panel Discussion

Moderator: Melissa Clark, MSN, RN

MSTCVS Cardiac Surgery Data Manager Meeting

Traverse City, MI – July 27th, 2017

Sleeping Bear Dunes National Lakeshore near Traverse City, MI

MSTCVS QC Readmission Reduction Practices

Preoperative

- Identify patients at high risk for readmission using program's historical data or by screening all patients using a readmission prediction tool.
  - Phase of Care Readmission Evaluation Tool – Henry Ford Macomb
  - LACE tool
- Post discharge follow-up appointments scheduled at the same time as OR rather than instructing patient to call for appointment.
- Preoperative education focusing on what to expect during entire episode of care.

In-Hospital Discharge Planning and Care Coordination

- Begin discharge planning and teaching upon admission to the hospital. Determine who the patient's primary caregiver at discharge will be and schedule discharge teaching with the patient and caregiver.
- Daily interdisciplinary rounds that include home care, social work, and case management to determine discharge needs and disposition.
- Review printed discharge instructions (don't forget to assess patient and caregiver reading level) with patient and caregiver daily once discharge date is determined. Printed discharge information is provided in the patient's preferred language and use pictures for patients with low literacy.
- Provide patient with arm band that has phone number(s) (office, MD, midlevel provider) that the patient or caregiver may call when they have questions and that emergency room personnel will call if the patient returns to the ER. The band serves as a reminder for the patient and caregiver to call when necessary and is also an alert for other medical personnel to notify the surgeon if the patient is being seen in the ER or clinic, so he or she may see the patient and determine whether the patient should be readmitted.

Post-Discharge

- Discharge summary is sent to the patient's primary care physician.
- Patients instructed to call any time before going to the Emergency Room.
- Patients are visited by home health nurse within 24 hours.
- Office visit scheduled with NP or PA within 3 days of discharge.
- Use communication template or critical path to communicate expectations to Extended Care Facilities and Home Health Agencies.
- Conduct post discharge follow up phone calls at specific intervals depending on readmission risk. High risk patients should be called within 24 hours of discharge. Follow up phone call is scripted and includes medication reconciliation questions.
- Consider having high risk patients return to the office within 5 to 7 days after discharge. Factors contributing to readmission are rarely sudden and can often be managed in the outpatient setting when discovered early on. Recognition of these factors requires understanding of cardiac surgery.
- EMR alert to notify CT surgeon when patient is admitted to the ER.

Post-Readmission Learning from Defects

- Phase of Care Evaluation of Readmission (POCER)

Predicting Hospital Readmissions

Risk Assessment Tools… Do They Work?

MR#_____
UNIT_____
DOS_____

LACE Index Scoring Tool for Risk Assessment of Hospital Readmission

Step 1. Length of Stay
Length of stay (including day of admission and discharge): _____ days

Length of stay (days)	Score (circle as appropriate)
1	1
2	2
3	3
4-6	4
7-13	5
14 or more	7

L

Step 2. Acuity of Admission
Was the patient admitted to hospital via the emergency department?
If yes, enter "3" in Box A, otherwise enter "0" in Box A

A

Step 3. Comorbidities

Condition (definitions and notes on reverse)	Score (circle as appropriate)
Previous myocardial infarction	+1
Cerebrovascular disease	+1
Peripheral vascular disease	+1
Diabetes without complications	+1
Congestive heart failure	+2
Diabetes with end organ damage	+2
Chronic pulmonary disease	+2
Mild liver or renal disease	+2
Any tumor (including lymphoma or leukemia)	+2
Dementia	+3
Connective tissue disease	+3
AIDS	+4
Moderate or severe liver or renal disease	+4
Metastatic solid tumor	+6
TOTAL	

If the TOTAL score is between 0 and 3 enter the score into Box C. If the score is 4 or higher, enter 5 into Box C

C

Step 4. Emergency department visits
How many times has the patient visited an emergency department in the six months prior to admission (not including the emergency department visit immediately preceding the current admission)? _____
Enter this number or 4 (whichever is smaller) in Box E

E

Add numbers in Box L, Box A, Box C, Box E to generate LACE score and enter into box below.

LACE

LACE Score Risk of Readmission: ≥ 10 High Risk

JAMA Intern Med. 2016;176(4):496-502. doi:10.1001/jamainternmed.2015.8462
Published online March 7, 2016.

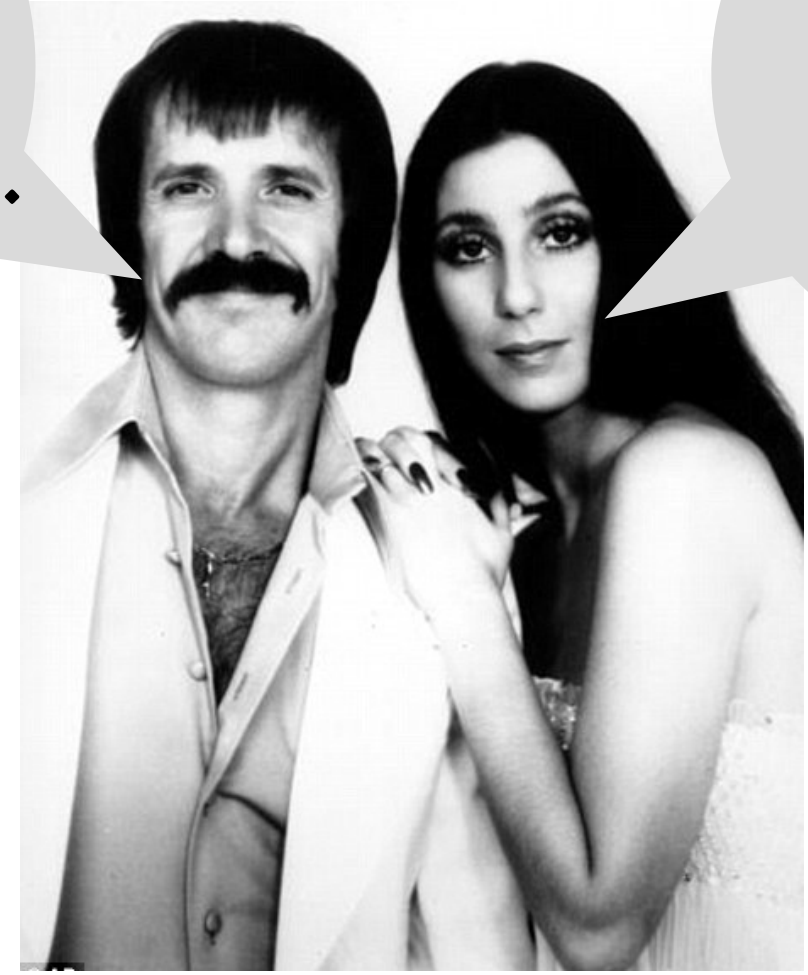
Original Investigation

International Validity of the HOSPITAL Score to Predict 30-Day Potentially Avoidable Hospital Readmissions

Jacques D. Donzé, MD, MSc; Mark V. Williams, MD; Edmondo J. Robinson, MD, MBA, MSHP; Eyal Zimlichman, MD, MSc; Drahomir Aujesky, MD, MSc; Eduard E. Vasilevskis, MD, MPH; Sunil Kripalani, MD, MSc; Joshua P. Metlay, MD, PhD; Tamara Wallington, MD; Grant S. Fletcher, MD, MPH; Andrew D. Auerbach, MD, MPH; Jeffrey L. Schnipper, MD, MPH

- Hemoglobin at Discharge
- Sodium at Discharge
- Discharge from Oncology Service
- Procedure Performed During Hospital Stay
- Elective vs Urgent/Emergent Admission
- Number of Hospital Admissions During Previous Year
- Length of Stay

You've Got Me
and
I've Got You....



Let's Cher
Best Practices
to
Reduce
Readmissions

DECREASING AVOIDABLE READMISSIONS

Donna Banaldi-Swan, RN, BSN
Quality Specialist, Cardiothoracic Surgery
Henry Ford Macomb Hospital

REASONS FOR READMISSION

- 6- Superficial wounds
- 3-recurrent angina/ MI
- 3- PE
- 1-stroke
- 3- GI issues---1-N/V/D(gastroenteritis) - hypotension dehydration, Diverticulitis, Constipation
- 1-Anemia- Hx of ITP
- 1-Renal failure
- 1-pericardial effusion
- 1-stroke
- 1-UTI- urosepsis
- 2- Pleural effusions
- 1-DVT
- 2-pneumonia

MONTHLY MEETINGS TO REVIEW READMISSION

USE ON A NEWLY DEVELOPED PHASE OF CARE EVALUATION FORM

WE LOOKED AT WHAT PHASE OF CARE THE READMISSION WOULD FALL UNDER

Pre-Operative Phase

Management & Optimization of Co-morbidities

- <u>High risk:</u>
- Advanced age (>75)
- Heart failure within 2 weeks
- Low albumin
- Previous myocardial infarction
- Diabetes mellitus
- Deconditioned
- Poor social support system
- Frailty

Post-Operative ICU/SDU Phase

Resolve post-op issues

- Atrial Fibrillation- rate control and anticoagulated
- Heart Failure- appropriate medications: Diuretics, ACE-I, Aldosterone antagonist
- Pleural effusion – was early thoracentesis done
- Gastrointestinal – last bowel movement
- Oxygen saturation – off oxygen for at least 24 hours
- Ambulate to baseline

PHASE OF CARE EVALUATION OF READMISSIONS: (POCER)

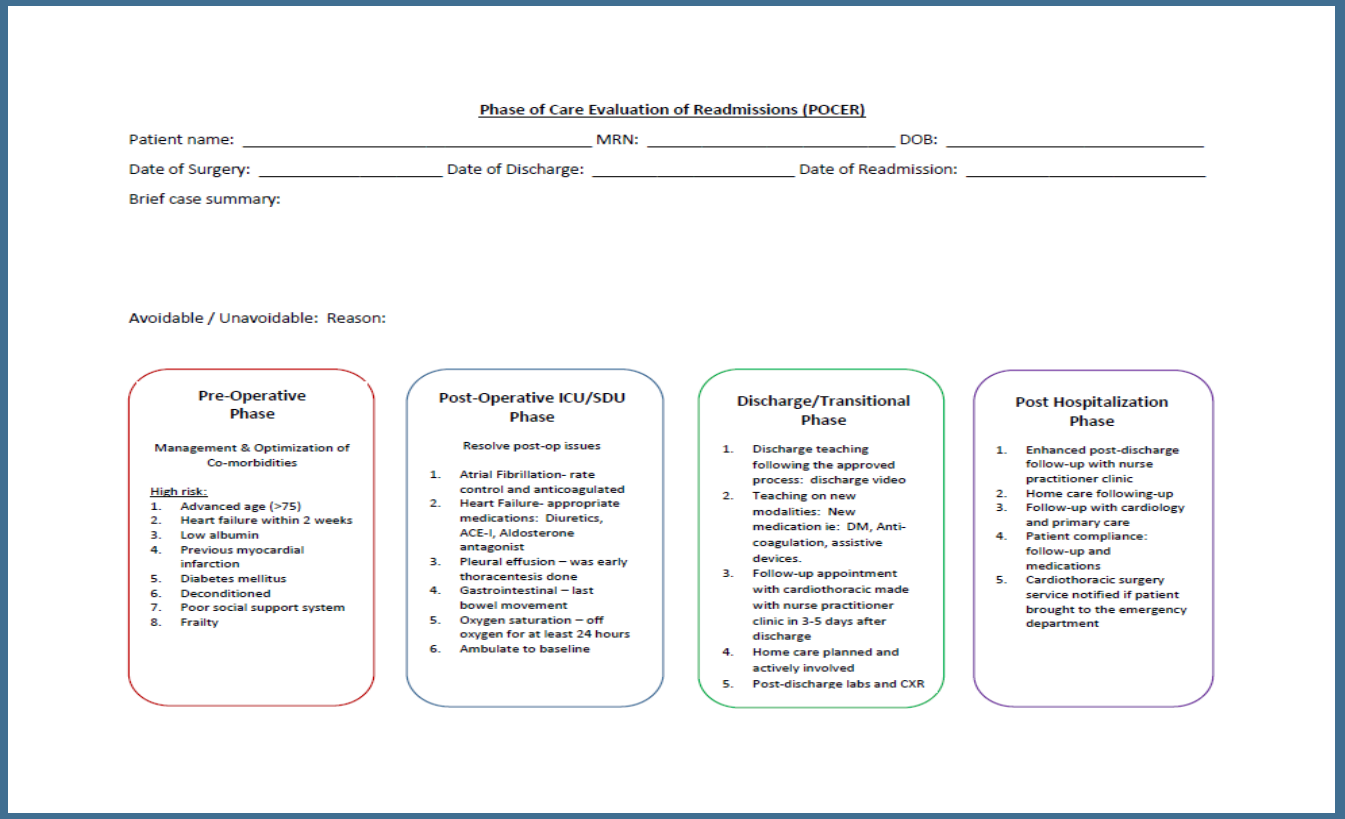
Discharge/Transitional Phase

- Discharge teaching following the approved process: discharge video
- Teaching on new modalities: New medication ie: DM, Anti-coagulation, assistive devices.
- Follow-up appointment with cardiothoracic made with nurse practitioner clinic in 3-5 days after discharge
- Home care planned and actively involved
- Post-discharge labs and CXR

Post Hospitalization Phase

- Enhanced post-discharge follow-up with nurse practitioner clinic
- Home care following-up
- Follow-up with cardiology and primary care
- Patient compliance: follow-up and medications
- Cardiothoracic surgery service notified if patient brought to the emergency department

MONTHLY READMISSION MEETING



Phase of Care Evaluation of Readmissions (POCER)

Patient name: _____ MRN: _____ DOB: _____

Date of Surgery: _____ Date of Discharge: _____ Date of Readmission: _____

Brief case summary:

Avoidable / Unavoidable: Reason:

Pre-Operative Phase

Management & Optimization of Co-morbidities

High risk:

1. Advanced age (>75)
2. Heart failure within 2 weeks
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4. Previous myocardial infarction
5. Diabetes mellitus
6. Deconditioned
7. Poor social support system
8. Frailty

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DESIGNED BY MARGARET GLEMBLOCKI DNP

WHAT DID WE FIND ?

- MANY OF THE READMISSION WERE UN- AVOIDABLE
- MANY OF THE READMISSION FELL INTO THE POST DISCHARGE PHASE:
  - RELOOK AT DISCHARGE PROCESS, EARLY FOLLOW UP, REVISIT EARLY PHONE CALLS
- LOOKING AT THE READMISSION THAT WE COULD AVOID
- SOME OF THE READMISSION FELL INTO PRE-OPERATIVE PHASE : HOME ENVIRONMENT/ CARE GIVER TO PATIENT/ ABILITY OF PATIENTS TO FOLLOW INSTRUCTIONS.

CHANGES THAT WERE MADE IN 2015 AND 2016

- CHANGED STAFFING MODEL TO ADVANCED CARE COVERAGE FOR THE OR ONLY AND ADVANCE CARE PROVIDER COVERING ICU/ STEP DOWN & CONSULTATION COVERAGE. A LOT OF NEW STAFF AND TRAINING.
- GOAL WAS TO HAVE 24/7 COVERAGE BY END OF 2016, NOT ACHIEVED SO GOAL CHANGED TO MIDDLE OF JULY 2017.
- ELIMINATED THE TRANSITIONAL NURSE NAVIGATOR: WHO'S ROLE WAS TO EDUCATE PATIENT AND FAMILIES PRE-AND POST-OP AND BEING A LIASON FOR FAMILY : CHANGED TO THE ROLE OF ADVANCED CARE PROVIDER
- PROCESS IMPROVEMENTS: INITIATE A MULTIDISCIPLINARY ROUNDS
- WORKED ON IMPROVING COMMUNICATION WITH HOME CARE AND PROVIDERS
- ATTEMPTED TO INITIATE MEDSTAR PROGRAM - TO HELP WITH TRANSITION OF CARE
- EARLY FOLLOW UP IN CLINIC SEEN BY ADVANCE CARE PROVIEDERS AT 3-5 DAYS POST DISCHARGE, 2 WEEK FOLLOW UP AND 30 DAY POST DISCHARGE

CHALLENGES WE FACED

- **UNREALISTIC EXPECTATION OF HAVING 24/7 COVERAGE IN LESS THAN 2 YEARS**
  - APPLICANTS FOR POSITION WITH LITTLE OR NO CARDIAC SURGERY EXPERIENCE/ NEW GRADUATES
  - CREDITIALING AND HIRING PROCESS EXTENSIVE(3 to 6 months)
  - CAN ONLY HIRE A FEW AT A TIME – SO TRAINING CAN BE DONE MORE EFFICIENTLY
  - UNREALISTIC TIME FRAME FOR TRAINING
  - HAVING NP STUDENTS – AND TRAINING NEW STAFF WAS CHALLENGING
- **Eliminated Nurse navigator position-**
  - No transition, just more added responsibility for advance care provider to perform.

CHALLENGES:

- **STAFF OUTPATIENT CLINIC**
  - NOT HAVING THE STAFF TO DO THIS
  - WANTING TO START AS SOON AS POSSIBLE – REALITY NOT READY TO START
- **PROCESS IMPORVEMENT : MULTIDISCIPLINARY ROUND**
  - STAFF RESISTANT TO CHANGE
  - POORLY COMMUNICATED CHANGES TO STAFF
  - EXPECTATION NOT CLEARLY DEFINED
- **BEGAN WORKING ON MEDSTAR PROGRAM** – LOST FUNDING FOR PROJECT
- **NO COMMUNICATION BETWEEN HOME CARE AND PROVIDER, UNLESS PROBLEM OCCURED**

RESOLUTIONS

- STAFFING:
  - **NEED MORE TIME TO HIRE ADVANCED CARE PROVIDERS & REHIRE ONES THAT HAVE LEFT THE POSITION.**
  - **NEED APPROPRIATE TIME ALOTTED FOR ORIENTATION, CLEAR EXPECTATION SET**
- FOLLOW UP IN CLINIC
  - THE SURGEON SEES PATIENTS AT 5 TO 10 DAYS POST DISCHARGE OR WHEN PATIENTS HAS AN ISSUE IDENTIFIED BY HOME CARE
  - 30 DAY FOLLOW UP.
  - SURGEON IS CALLING PATIENT 1 DAY AFTER DISCHARGE TO IMPORVE PATIENT SATISFACTION.
- PROCESS IMPROVEMENT:
  - CLEARLY IDENTIFIED TO STAFF
  - ROLES AND EXPECTATION DEFINED
  - IMPROVED COMMUNICATION AND TRAINING TO BE DONE PRIOR TO STARTING
  - BUILDING TRUSTING RELATIONSHIPS BETWEEN STAFF, PROVIDERS AND MID LEVEL PROVIDERS
- COMMUNICATION BETWEEN HOME CARE AND PROVIDER
  - LIASON REPRESENTING HOME CARE ATTEND CTS HUDDLE MEETING EVERY WEDNESDAY
  - CASE MANAGEMENT ALSO INCLUDED IN HUDDLE MEETINGS EVERY WEDNESDAY
  - BOTH CM, HC PARTICIPATE IN THE DAILY MDR TEAM
  - IN-SERVICE HAS BEEN DONE WITH HOME CARE TO REVIEW EXPECTATION OF THE PROVIDER
  - TEMPLATE WAS DEVELOPED FOR HOME CARE TO IMPROVE COMMUNICATION WITH PROVIDER
  - HFHC USES SECURE EMAIL- THROUGH SECURE I-PHONE FOR DAILY PROGRESS REPORTS- VIEWED BY STAFF DAILY
  - WORKING WITH A SECOND PROVIDER OF HOME CARE IN SERVICE WITH REVIEW OF EXPECTATION AND USE OF COMMUNICATION TOOLS VIA SECURE FAX- WHEN WE ARE UNABLE TO USE HFHC.

TEMPLATE OF COMMUNICATED INFORMATION FROM HOME VISIT TO PROVIDER

- Name:
- MRN:
- Subjective:
- VS: BP ____ HR ____ RR ____ Temp ___ Pulse Ox ____
- Weight _____ (+/-)
- PE: General: Overall _____ Pain _____ Activity _____
- Resp: Lungs ____
- CV: Heart ____ Edema ____
- Thoracic incision _____ Sternal incision ____ Radial/leg harvest site ____
- GI: Tolerating diet _____ BM _____
- Endo: Bld Sugars _____
- Medication questions/compliance:
- Next HC visit scheduled:
- HC Plan:
- Needs and follow-up for the CT surgery team:

2017 UPDATES TO CQI

- MANY NEW CHANGES:
  - FOLLOW UP PHONE CALL MADE BY SURGEON 1-2 DAYS POST-DISCHARGE
  - FOLLOW UP IN OFFICE 5-10 DAYS AFTER DISCHARGE & AT 30 DAYS.
  - IMPROVED COMMUNICATION BETWEEN HOME CARE NURSES, SURGEON AND MID-LEVEL PROVIDER, WITH EMAILS WITH PATIENT ASSESSMENT OF NON URGENT MATTERS, OR PHONE CALLS WITH URGENT ISSUES.
  - INSERVICE TO HOME CARE, REVIEW EXPECTATIONS WITH STAFF
  - MULTIDISIPLINARY ROUNDS INVOLVING HOME CARE/ CASE MANAGEMENT DISCUSS PATIENTS NEEDS FOR DISCHARGE
  - INSERVICES OF EXPECTATION OF DISCHARGE TO UNIT NURSES
    - REVIEW DISCHARGE PROCESS
    - POWER POINT TO REVIEW EDUCATIONAL MATERIAL TO BE DISCUSSED WITH PATIENTS ON DISCHARGE
    - DISCHARGE CHECKLIST IS LAMINATED AND PLACE AT EACH NURSES STATION.
    - IMPROVE PATIENT SATIFICATION WITH MORE TIMELY DISCHARGE
  - DISCHARGE PROCESS EVALUATION SURVEY TO ASSESS PATIENTS SATISFACTION AND UNDERSTANDING OF DISCHARGE INSTRUCTIONS
  - EVALUATE ALL READMISSIONS WITH THE USE OF PHASE OF CARE EVALUATION OF READMISSION(POCER FORM)

Call Anytime and Call Often

Sparrow Hospital Readmission Plan

Diane Donovan, RN, BS, CPHQ

July 27, 2017

PATIENT
CAREGIVER
VISION
MISSION
VALUES
PILLARS OF EXCELLENCE
THE SPARROW WAY

How Did We Do It?

- Kendra Wright, NP
- Pre-op Education- Patient's were taught what to expect throughout the whole procedure. Major focus on call the office anytime before going to the hospital
- Wrist Bands- Given as a reminder to call surgery with any questions and to call before going to the ED. Also for ED to identify surgery patient's and call before admitting
- Identify High Risk for Readmission
- Early Follow Up- Phone calls and office visits

Follow-Up Phone Calls

General:

- Any changes in how you have been feeling since you were discharged?
- How is your energy level? Are you up and walking at least 4 times a day?
- How is your pain? Is it controlled? How do you rate on 1-10 scale?
- Have you had any fevers/ chills?

Cardiac:

- Have you felt a racing heart beat or palpitations?
- Have you had chest pain?
- Have you noticed increased swelling in your arms, legs or feet?
- Have you been weighing yourself daily?
- Has your weight increased by 5 or more pounds since discharge?

Respiratory:

- Have you noticed increasing shortness of breath?
- Have you had a new or increasing cough?
- Do you have difficulty breathing when you lay down flat?
- Are you continuing to use your Incentive Spirometry?

GI:

- How is your appetite?
- Are you having any abdominal pain, n
- Are you having regular bowel moments?
- Are you diabetic? If so, have you been monitoring blood sugars? What has been range?

Genitourinary:

- Have you noticed a decrease in or difficulty with urinating?

Neuro:

- Have you fallen since you were discharged?
- Have you had or has anyone told you that you have had periods of confusion?
- Have you noticed any visual changes?
- Have you noticed any weakness in your arms or legs?

Incisions: (Chest and/or Leg)

- Have you noticed any drainage, redness or openings in your incision(s)?
- Have you noticed any “clicking” or “popping” in your chest with movement?
- Have you had any fevers/chills?

PATIENT
CAREGIVER
VISION
MISSION
VALUES
PILLARS OF EXCELLENCE
THE SPARROW WAY

Current Focus-ED

- Working on Hard stop in EPIC. Best Practice Advisor (BPA) would fire before any surgery patient could be admitted
- ED Physician would either need to address that they had called the cardiovascular surgeon or that this is an emergency (cardiac arrest, etc.)
- All emergency cases would be reviewed by surgery and discussed with the ED physician as needed

QUESTIONS?

Reducing 30 Day Readmissions

Jill Teats, RN, Quality Data Manager
Ascension / Crittenton Hospital

Primary Line of Defense…

Education

Pre surgical Education…

- In office and/or in unit with <u>patient and family</u>.
- Pre-surgical video in unit
- Pre-surgical Booklet given in office

Post surgical Education…

- <u>Pain</u>…how to manage pain and when to take pain medication
- Activity expectations
- Medications

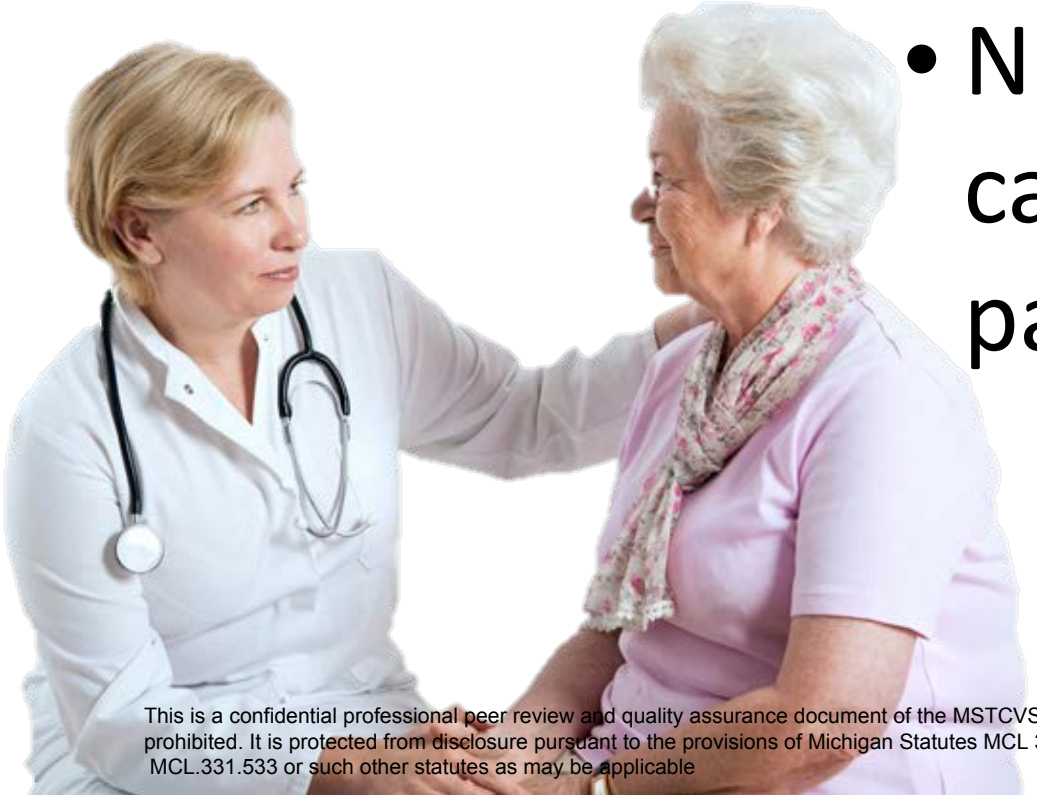
Discharge Education..

- Discharge Video
- <u>Chest Pain</u> …teach difference between angina and surgical pain.
- Can the pain be reproduced with movement?
- Is the pain diffuse or can it be pinpointed?
- Educate them on their pain medication, when and/ how to take their medication.
- Also explain to your patients that if they do go to an E.R. to have the E.R. physician call their cardiothoracic surgeon prior to being readmitted.
- Reinforced by home care RN within 24 hours and in office visit within 5 days

Secondary Line of Defense…

Post-Discharge

- **Seen by Home Health** within 24 hours
- **Seen in office** by NP or PA within 3 days
- **Seen in office** by surgeon at 30 days



- NO follow up phone call unless high risk patient

Third Line of Defense…

Emergency… now what!?

- We educate and encourage the patients to call CTS office prior to going to any ER so they can be seen in office right away
- We met with ER staff last year to discuss notification and communication with CTS prior to readmission
- We implemented a **Readmission Alert** that will pop up on the electronic medical record once a patient enters the ER to alert staff prior to readmission

"Are you under a lot of stress lately, or have you always had six separate heartbeats?"

Keys to Success…

- Education pre-surgery and throughout their stay.
- We are a single unit Admission – Discharge hospital with primary nurse assignments allowing for only a handful of caretakers involved in the patient's care and education. This makes their experience very personal and could contribute to decreased stress and anxiety allowing them the comfort to ask questions and comprehend the information being given to them.
- Home care team and ER team involvement.
- 3 day post-discharge in office visit.

McLaren
FLINT

Readmission Reduction Strategies

2016 Isolated CAB

Megan Yusko, RN-BSN & Data Manager

Contact Info - Megan.Yusko@mclaren.org (810) 342-2139

2016
DATA & STRATEGIES

Quarterly Data

2016 GOAL: Reduce 30 Day Readmission Rate in Isolated CABG patients

ROOT CAUSES:

- Our efforts for reduction will be focused on:
  - Clear instructions upon discharge
  - After discharge provide follow up care/contact with patients to answer questions
  - Education of Home Care & SNF staff

ACTION PLAN:

Monthly Meetings – Cardiac Surgery Cabinet

March 2016 – Implemented Call Back post discharge. Physician Assistant and Clinic Coordinator call at 72 hours, 1 week and 30 days

March 2016 – Updated surgeon protocols for homecare

August 2016 – ED Utilization review nurse will notify ED physician if patients are being readmitted within 30 days

October 2016 – Education breakfast for homecare and SNF. Physicians and NP's spoke to expectations of post operative recovery

November 2016 – Began trial of post op visits in surgeon office at 7-10 days post op

ADDITIONAL INTERVENTIONS

Post Discharge - Follow Up Care

- "Call Back" Logs – *Excel Spreadsheet & Form*
  - tracks F/U phone calls at 3 days, 7 days, & 30 days

Surgery Date	Patient Name	Visit ID	Surgeon	Phone Number	D/C Date	D/C Location	3 Days Due On	1 WEEK Due On	30 DAYS Due On	PATIENT READMIT Where? Why? Dates?	Action Taken
1/1/17	DOE, JOHN	xxxxxxxxx	DOCTOR	xxx-xxx-xxxx	1/7/17	Home w/HC	1/10/17	1/14/17	2/6/17	ER visit 1/12 UTI, no admission	spoke to pt on 1/13
							1/3/00	1/7/00	1/30/00		
							1/3/00	1/7/00	1/30/00		

F/U DONE- Spoke to pt/family/etc.
F/U NOT DONE- no answer

Questions for Patients

- 30 Day MD appointment confirmed?
- Have all Rx filled? Any medication questions?
- Using IS/C&DB?
- Ambulating well?
- Bowel/Bladder concerns?
- Pain controlled?
- Signs of infection at the incision(s)?
- Fever?
- Cough?
- SOB?
- Leg Swelling?
- Daily Weight Gain >1-2lbs?

❖ *Be sure they have the phone numbers for their PCP, Cardiac Surgeon & Cardiologist from their D/C paperwork on their refrigerator for easy access.*

- Cardiac Surgery Clinic Visits – *within 7-10 days s/p discharge*
  - F/U Appointments scheduled by NP's BEFORE patients leave the hospital at discharge

McLaren Flint
Cardiac Surgery
Post-Op Assessment

Patient Name: _____ DOB: _____ Phone: _____ Encounter: _____
Surgeon: _____ Date of Surgery: _____ Procedure: _____
Date of Discharge: _____ Discharge Disposition: _____
Follow up Diagnostics to be completed by (Date): _____

Callback 1- 72 Hours post discharge: ____/____/____

Follow Up: ☐ None _____
Signature:_____ **Date/Time:**_____

Callback 2- 1 week post discharge: ____/____/____

Follow Up: ☐ None _____
Signature:_____ **Date/Time:**_____

Callback 3- 30 days post discharge: ____/____/____

Follow Up: ☐ None _____
Signature:_____ **Date/Time:**_____

Any visits to an ER or admission to a hospital within 30 days post discharge: ☐ No ☐ Yes, Date: _____
Location of admission: _____ Reason for admission: _____
Procedures performed on readmission: _____
Status 30 days post discharge (REQUIRED): ☐ **Alive** ☐ **Deceased** ☐ **Lost to follow Up**

Filed by: _____ Date: _____ Time: _____

Cardiac Surgery Callback Form
17346 Rev. 04/2017
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680

PT.
MR.#P.
DR.

ADDITIONAL INTERVENTIONS

ID's Surgeon, Hospital & Emergency Hotline #

Discharge Bracelets

- All patients get a bracelet at discharge with phone number of heart surgeon
- Surgeon to be called with any issues
- ER in serviced to utilize the bracelet phone number if patient comes back in through ER
- Prompt surgeon notification if patient comes into hospital ED
- Ordered online from "Amazing Wristbands"
  - *Cost $400 for 200 bands*

Readmission Subcommittee – meets monthly, reviews LOS & readmit data