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## Orofino hospital to track patients after they leave

*Follow-up health care is important in preventing readmissions as pressure is brought to keep costs down*

OROFINO - Kelly McGrath, chief medical officer for Clearwater Valley Hospital, was surprised recently when his 92-year-old father was moved from an acute care hospital to a nursing home.

Even though the elder McGrath was in a top-flight hospital in Denver, with experienced doctors, "yet when he was discharged it was clear to me that the physician that picked up his care knew very few details about what occurred during his acute care hospitalization," McGrath said. "And it's just astounding to me, even as a physician, to go and speak to his doctors and talk about a critical, life-threatening (condition) that my father had and just mention it and the doctor gave me a blank stare. They had no awareness of it."

*Clearwater Valley Hospital Grants Director Pam McBride (left), Chief of Staff Dr. Kelly McGrath and Director of Nursing Sharon Moriarty check out a new Workstation on Wheels at the Orofino hospital, plus a wireless scanner for patients' digital wristbands.*

McGrath said his father's experience is a good example of why health care professionals have to change the way they're managing transitional care.



It's a nationwide concern and one that will be coming more into focus in the coming year when health care reforms cut back Medicare and Medicaid reimbursements to hospitals when patients who have been discharged are readmitted within a short span of time.

Clearwater Valley Hospital recently received a federal Flex grant from the Idaho Department of Health and Welfare to initiate a pilot program aimed at filling the gaps between a patient's discharge from the hospital to home or wherever the patient ends up. The \$25,000 grant will be used to support the Visiting Nurse Services program to reduce readmission rates.

The 2-year-old nursing program, similar to home health, provides follow-up care and services for patients recently discharged from hospitals. In this case, the nurses will help patients coordinate their medications, follow discharge instructions and help them schedule follow-up visits with their doctors within a week of discharge.

That's important, said Sharon Moriarty, director of nursing services at the hospital, because it's a risky time shortly after patients have left the hospital.

"Oftentimes it's people who don't have a good, clear understanding of what their physician plan is," Moriarty said. "We just want to make sure they're very clear about what they should be taking. That way patients are on the correct medications and not overmedicated, nor undermedicated."

The hospital uses a team approach for patients' care utilizing the new electronic medical records system to coordinate treatment from various caregivers.

Kristy Fresh, director of physician services at the hospital, said all insurance carriers in the past several years have been looking at ways to get patients out of the hospital sooner. Where in the past a patient stayed close to a week after a procedure, now he might be out in a day or two.

"And we, as a health care team, need to find a way to help make sure nothing falls through the cracks and nobody's dropped just because they don't meet the criteria to stay in the facility," Fresh said.

Pam McBride, the chief grants officer for the hospital, said if the visiting nurse program proves successful in reducing readmissions, it will be launched at St. Mary's Hospital in Cottonwood and perhaps serve as a model for other critical care hospitals in the country.

"It's no surprise to anyone - not just here, but nationally - health care costs keep rising," McBride said. "Something's going to have to be done to cut those health care costs. This is a program that can provide less expensive care for patients but still high-quality care to keep them out of the hospital. Right now it is a financial disincentive - if we don't have people in the hospital we don't get paid for that. The grant helps cover some of that, but we're just trying to work smart ahead of the curve."

McGrath said the risks involved in transition from hospital to home are high and medical professionals have not managed that risk well in the past.

"Statistics for readmissions are really concerning," McGrath said. "I feel I'm probably more aware of the danger that all of us have accepted throughout our entire careers because I'm more aware of the failures.

"Acute care hospitals are going to be held accountable for their readmissions statistics and appropriately so. ... The right reason to look at it is because it's a patient safety issue. And that's really the reason that, hopefully, most hospitals are looking at it. Because there are financial implications, everyone's feet are being held to the fire.

"But because we're smaller and have a close community we're better positioned to be able to try to make some of these things work out and do some of these things through these research grants to see if we can come up with a better system that will work. From a fiscal standpoint it's the right thing to do. But just from a moral, ethical and patient safety standpoint it's the right thing to do, as well."