NATIONAL RURAL HEALTH RESOURCE CENTER

CRITICAL ACCESS HOSPITAL RECOGNITION: FY2019 INNOVATIVE APPROACH TO POST-ACUTE CARE

HARRISON COUNTY COMMUNITY HOSPITAL

Bethany, Missouri

Harrison County Community Hospital (HCCH), located in Bethany, Missouri, is one of three critical access hospitals (CAHs) that received national recognition for demonstrating an innovative approach to post-acute care that supports a patient's continued recovery from illness, or management of a chronic illness or disability.

From left to right: Amy Pickren, Director of Inpatient Services and Quality Management; Elisa Welp, Care Coordinator; Tina Gillespie, CEO.

Positive Outcomes

- Forty percent of all patients discharged to home received a complimentary nurse home visit, and the care coordination nurse attempted 100% of follow-up phone calls.
- The readmission rate (11%) remained below the national average for 2019. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Care Transition scores averaged 3.5 out of 4, communication about medication scores averaged 3.6 out of 4, and overall patient satisfaction averaged 9.1 out of 10.
- Prior to the initiative, 40% of patients discharged to home reported that they had questions or concerns with discharge home medication lists upon their next doctor visit. As of Quarter 1 of 2020, that number was reduced by more than half. Eighty-eight percent of patients surveyed stated they had a good understanding of their discharge.

Top Accomplishments

HCCH established an interdisciplinary Transitions of Care team to improve patient satisfaction HCAHPS scores, lower hospital 30-day readmission rates by enhancing patient education methods, and providing structured, scheduled, timely follow-up calls and/or visits with patients after discharge. The overarching goal of the program is to improve health outcomes for all patient populations that are discharged from the hospital. This is directly linked to the hospital strategy by monitoring HCAHPs scores, sending surveys to swing bed patients upon discharge to monitor for areas of improvement for this particular patient population, and providing care coordination follow-up phone calls to identify and resolve any concerns or educational gaps.

"HCCH has developed an innovative Transitions of Care team to help patients transition to home safely," said CEO Tina Gillespie. "Our goal is to reduce or eliminate the need for rehospitalizations and to keep the patient in their own home for treatment rather than in the hospital setting."

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