NATIONAL RURAL HEALTH RESOURCE CENTER

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

PINCKNEYVILLE COMMUNITY HOSPITAL

Pinckneyville, Illinois

Pinckneyville Community Hospital, located in Pinckneyville, Illinois, is one of just three critical access hospitals 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: Eva Hopp, Chief Nurse Executive; Deb Hale, Care Coordinator; Barb Brand, Transitional Care Coordinator; Sherrie Morse, Case Management Manager; Michelle Headley, Social Services Coordinator

Positive Outcomes

- Readmissions rates for Pinckneyville have been reduced from 12.6% to 3.1% by using a dedicated Transitional Care Management (TCM) Nurse and improved communication between all the team members.
- Pinckneyville Community Hospital is part of an accountable care organization (ACO) and is therefore cognizant of the need to control its skilled nursing facility (SNF) per member per month (PMPM) costs. Between Quarter 2 2019 and Quarter 1 2020, they have reduced their SNF PMPM spending from $97 to $90.

Top Accomplishments

The focus on TCM has clearly been an innovative approach for post-acute care. In addition to decreasing readmission rates and SNF PMPM costs, Pinckeyville's initiatives have benefited their patient's post-acute experiences in numerous ways. To decrease confusion over discharge medications, Pinckneyville Community Hospital created discharge medication instruction sheets. Also, all follow up appointments for patients are scheduled prior to discharge. If the patient is discharged after hours, the clinic Care Coordinator calls and schedules an appointment time with the patient.

"With the addition of Barb Brand, RN, Transitional Care Coordinator, we have been able to reduce our readmission rate from 12.6 to 3.1. Barb assists with patients who are high risk for readmission to ensure they understand their hospital discharge instructions, obtain their medications, keep their scheduled doctor's appointments, and help coordinate any additional services they may need," said Randall Dauby, CEO of Pinckneyville Community Hospital. "Barb works closely with Deb Hale, RN, Chronic Care Manager at Family Medical Center, to transition these patients to their primary care physician for further monitoring of their medical condition and implementing preventative care measures to keep the patient in their home setting."

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, $1,009,120 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.