WVUMedicine

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Background:

The WVU Division of Hospital Medicine has teamed up with Encompass Rehab Hospital of Morgantown (Encompass) to provide highquality patient care after discharge from Ruby Memorial Hospital (RMH).

Transitions of care offer great opportunity to improve patient outcomes through continuity of care and communication.

When possible, patients should be rehabilitated and discharged home instead of being readmitted to the hospital or sent to stay at a skilled nursing facility.

Objective

Our goal is improve the percentage of patients from Encompass Rehab Hospital of Morgantown who are discharged home vs sent to Ruby Memorial Hospital or sent to skilled nursing facilities when compared to national average data for Encompass IPR patients

Improvement in Patient Discharge Disposition through Collaboration between WVU Division of Hospital Medicine and Encompass Rehab Hospital of Morgantown

WVU Medicine, Division of Hospital Medicine; Encompass Rehab Hospital of Morgantown

IMPROVEMENT ACTION PLAN WITH ACTIONS TAKEN

- From 1/2022 to 7/2024, the WVU Division of Hospital Medicine has been medical consultations to patients at Encompass.

- During this time, these patients were under the care of WVU PM&R physicians

- In 8/2024, we "flipped" this model by changing the roles of Hospitalists to the primary physicians with PM&R physicians as consultants.

- Now, we provide continuous Internal Medicine care for these patients, while PM&R physicians consult regarding the rehabilitation aspect of patient care.

- We routinely communicate directly with the discharging physicians (as they are often from our own division or are physicians we work with frequently at RMH) regarding post-discharge plan of care

- We are able to easily communicate with specialists who took care of the patient at RMH (fore example: Infectious Disease, Orthopedic Surgery, Cardiology, Nephrology) to ensure appropriate care and follow up

Driver Diagram for Improvement in Patient Discharge Disposition

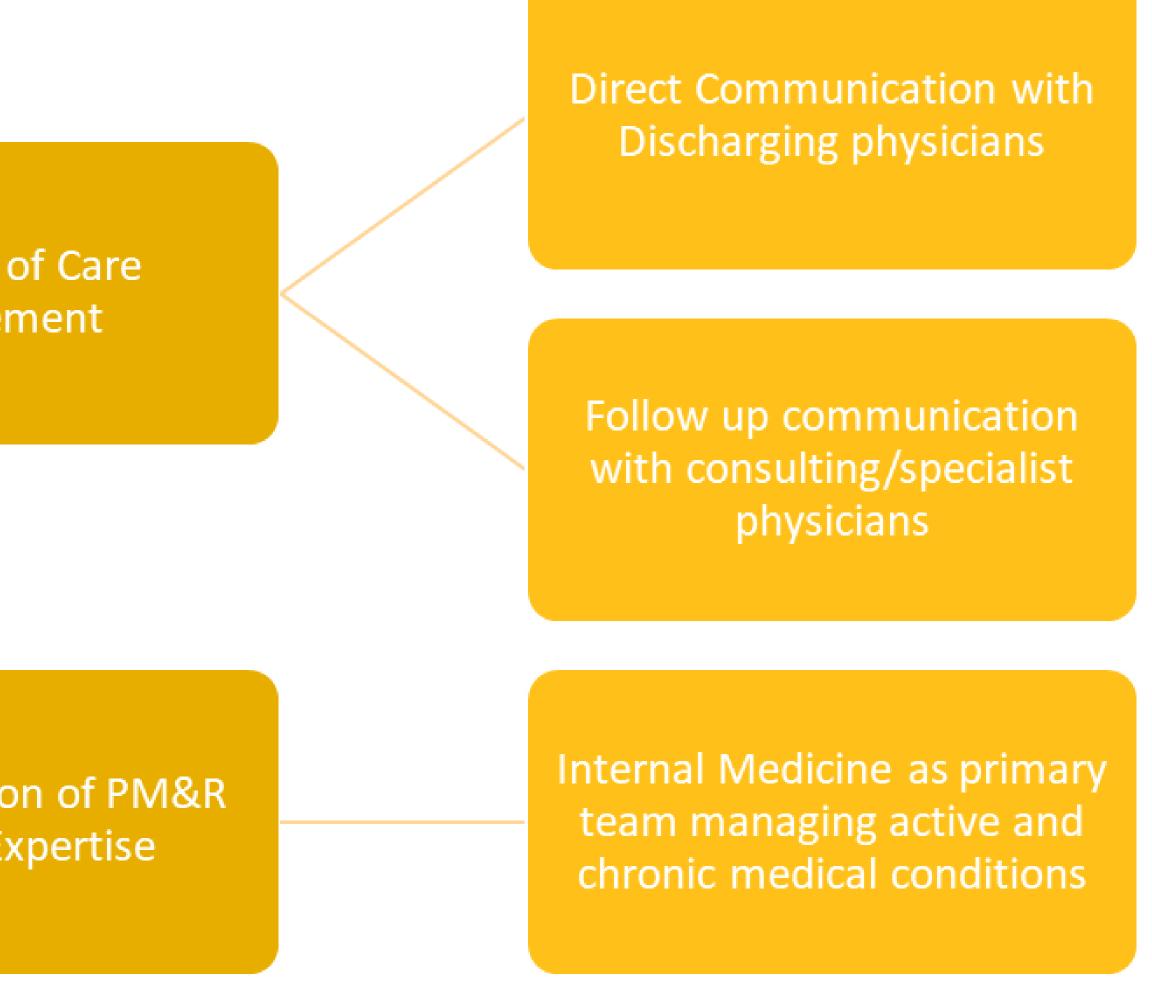
Transition of Care Improvement

Objective: Improve Percentage of patients discharged to home vs Readmitted to Hospital or Sent to Skilled Nursing Facilities

> Better Utilization of PM&R Physician Expertise

DECINTC

<u>RESULTS:</u>	
 Data has been gathered from the first 5 months of this project which shows: 	Conti
 Improvement in percentages of patients discharged to home vs to Skilled Nursing Facility or Readmitted to Ruby Memorial Hospital From 0.52% below the national average for patients at Encompass Hospitals nationwide to 1.05% above the national average for patients at Encompass Hospitals Nationwide Improvement despite an increase in average CMI over that time period From average of 1.494 before intervention to 1.545 	We at dispo • Im an co dis dis dis dis dis dis dis dis dis dis



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SUSTAINAILITY PLAN:

inue to provide care to patients and gather data.

LESSONS LEARNED/CONCLUSIONS:

attribute this improvement in discharge osition to several factors:

nproved communication between discharging nd accepting physicians. We routinely ommunicate with discharging physicians to iscuss the complexities of each patient's ischarge plan.

y allowing PM&R physicians to focus on the ehabilitation portion of patient care, we are tilizing their expertise more efficiently.

dditionally, by seeing patients more often, we re able to better manage acute and chronic edical conditions. We hope to continue to ee improved patient outcomes through our oordination with Encompass