

# Closing the Gap after Discharge from Rehab: An APRN-Led Transitional Care Clinic

Corrine Gogert, MSN, MBA, APRN, AGACNP, ACCNS-AG, CCRN  
Dr. Beth Quatrara, DNP, APRN, CMSRN, ACNS-BC



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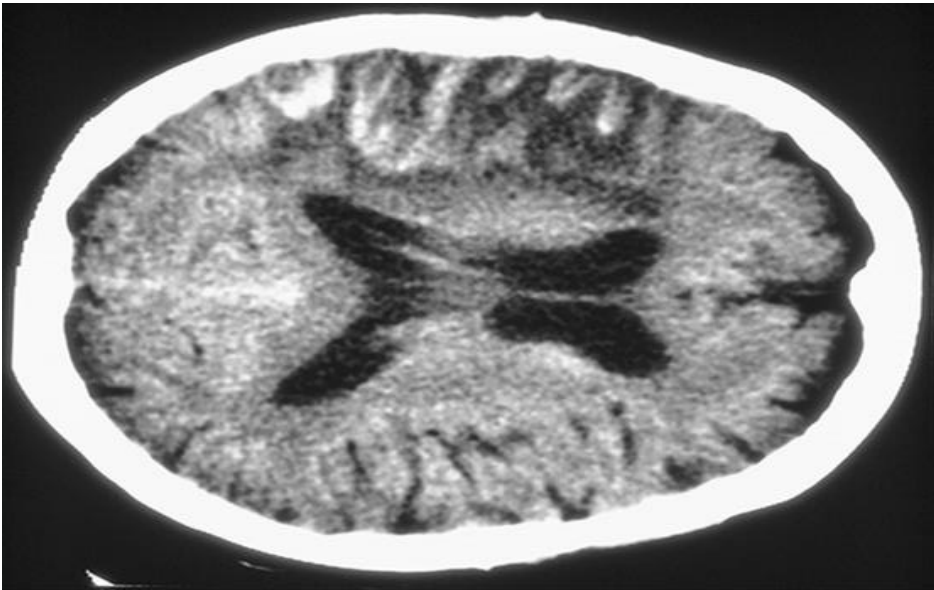
## Purpose

Enhance transition of patients discharged from neurocritical care as they move from rehabilitation to home with the goal of bridging care caps and decreasing readmission rates



## Background

- Patients discharged to rehab facilities face more difficult transitions, longer lengths of stay and higher readmission rates
- APRN-led clinic pilot noted a gap in practice with patients discharged to rehab experiencing a 30-day readmission rate of 35%

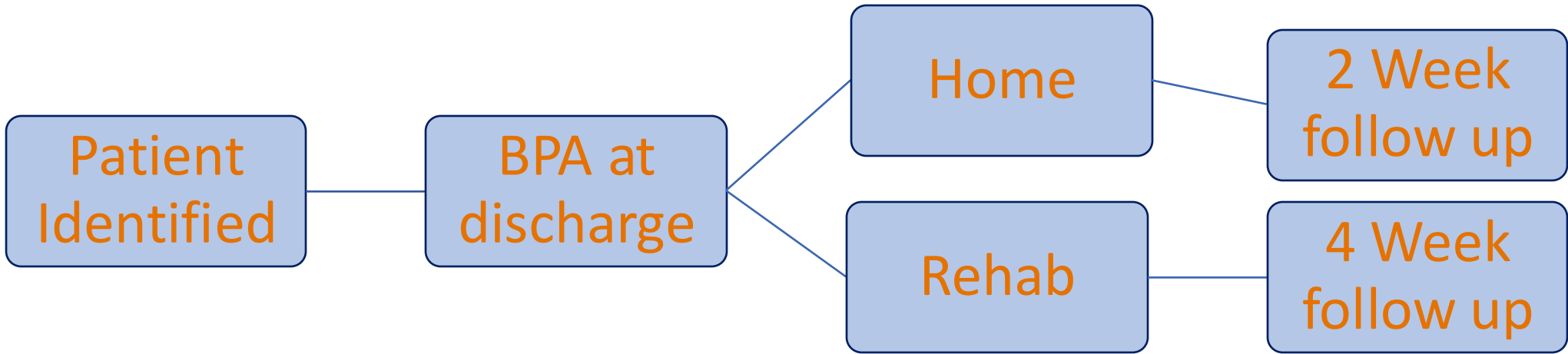


## Evidence

- Transitional care appointments decrease healthcare costs, reduce readmissions and improve patient's ADL abilities (Bindman & Cox, 2018; Cumal, et al., 2022; Sezgin, et al., 2020; Stark, et al., 2018; Chakravarthy, et al., 2018)
- Making transitional care appointments before or at discharge improve likelihood of attendance (Ader, 2023)
- Rehabilitation is associated with increased difficulty with transition to home/community (Zimmerman, et al., 2021)
- Patients discharged to rehab (versus home) had difficulty with medication adherence, regular exercise and toxic habit cessation (Dong, et al., 2023)

## Methods / Results

- **Plan:** Implement an APRN-led clinic for patients discharged from neuro ICU to rehab before home.
- **Do:** Network with inpatient and Rehab teams and establish scheduling plan to address gap in EHR systems. Identify patients via admission ICD-10 code, decision point at discharge for 2-week vs 4-week follow up appointment
- **Study:** Utilizing simulated EHR test environment, perform simulated patient scenarios, review messaging and communication
- **Act:** Systems built with successful testing. Inpatient and rehab team networking established. Ready for full implementation



## Discussion

- The process is streamlined with communication across two distinct institutions.
- A Best Practice Advisory (BPA) automatically identifies qualifying patients in EHR
- One point person provides continuity for the transition to rehab and home

## References

