Transitions in Care: Piloting a Neuro Advanced Practice Provider Clinic

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Abstract

The transition period from hospital to home is a vulnerable time for rehospitalization and adverse events for patients. Follow-up clinic visits within 7-14 days of discharge is an effective strategy for reducing hospital readmissions. Neurocritical care patients have a unique set of needs to safely transition to home. We evaluated the feasibility of a Neuroscience Advanced Practice Provider (APP) Clinic to meet transitional care gaps in neurocritical care patients and prevent rehospitalization. Clinic procedures and documentation templates were customized for the pilot clinic. Six critical care APPs underwent a brief training course for the ambulatory care setting. Eligible patients were tracked throughout the hospitalization and the APP team made follow-up appointments. The pilot clinic took place from October 2022-January 2023. Nine patients were seen in the clinic approximately eight days after discharge. Clinic attendance rate was 90%. Among the clinic attendees, 66% received referrals to a primary care provider or other services, one third received medication changes or refills and all received patient-specific education. There were no rehospitalizations among the clinic patients. Implementation of this pilot clinic was possible with the current departmental resources. This innovative model of care has the potential to reduce hospital readmissions.

Keywords: transitional care; critical care; neuroscience nursing; patient readmission; nurse practitioner; physician associate.