

Transitioning Hospital to Home

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Background and Significance

- While the full impact of the COVID 19 pandemic is still evolving, the physiological, functional, and psychosocial impacts of hospitalization for the coronavirus are thought to be substantial, with economic hardships, family and social support disruptions, anxiety and depression that most often accompany severe acute and chronic comorbidities.
- Transitioning from hospital to home has long been documented as a time of critical importance in achieving improved health status and functioning. However, little is known about the unique needs of the COVID-19 survivors and best practices to help them achieve optimal recovery when transitioning home.
- As a first step in developing targeted interventions, a multi-disciplinary Rapid Needs Assessment¹ (RNA) model was used to identify and analyze comprehensive health needs.
- Major characteristics of the RNA model include beginning with informed hypothetical areas of evaluation and engaging in an iterative process with patient/family evaluation and feedback.
- Interdisciplinary collaboration has grown over the last decade in education, practice, and research. Our interdisciplinary approach to determining the needs of this population demonstrates a team-focused, patient-centered care model.

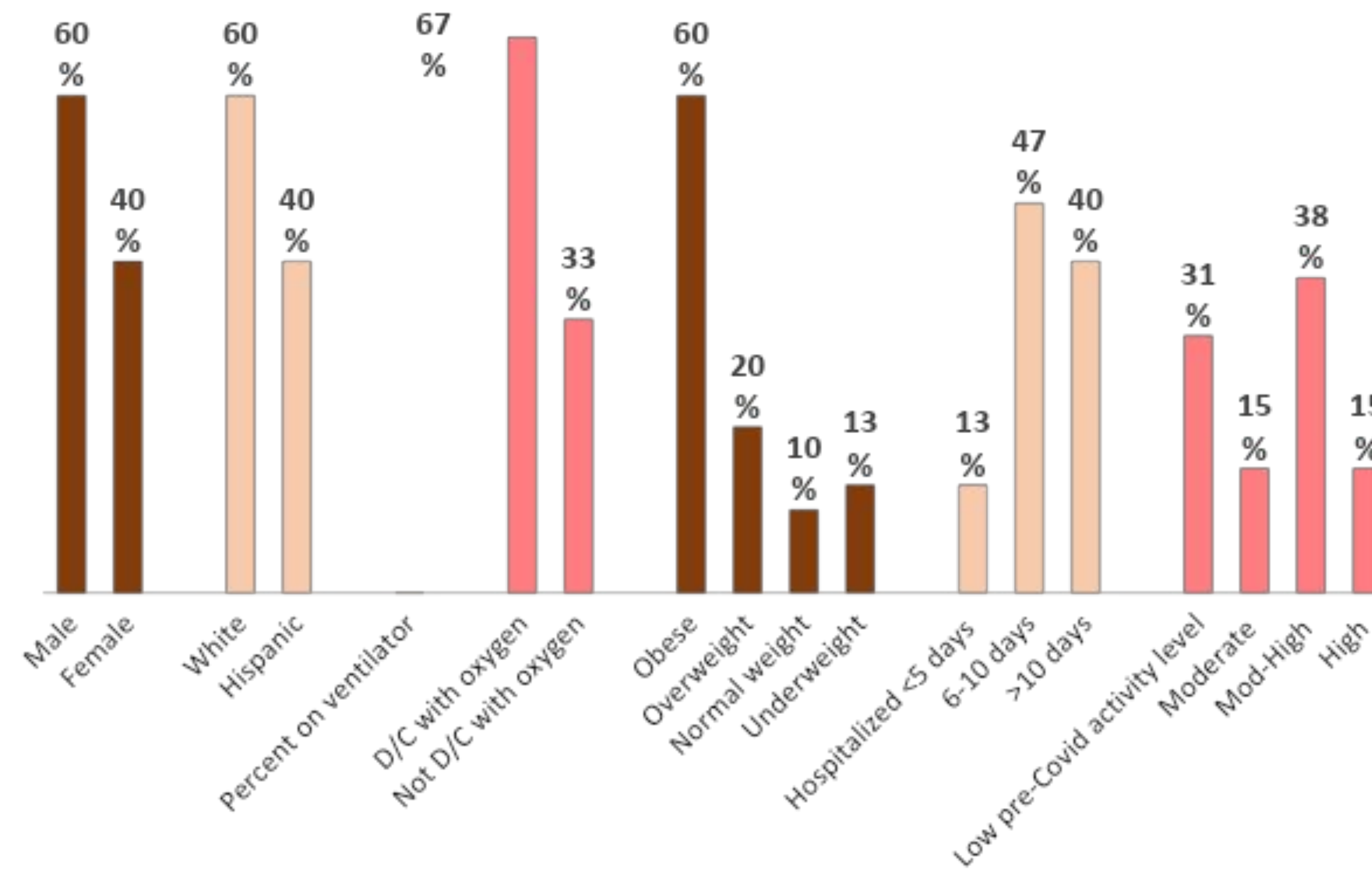
Purpose

- The aim of this project was to pilot test an evidence-based, multi-disciplinary Rapid Needs Assessment¹ (RNA) model to uncover the medical, psychosocial and rehabilitation needs for patients discharged after COVID-19 infection.

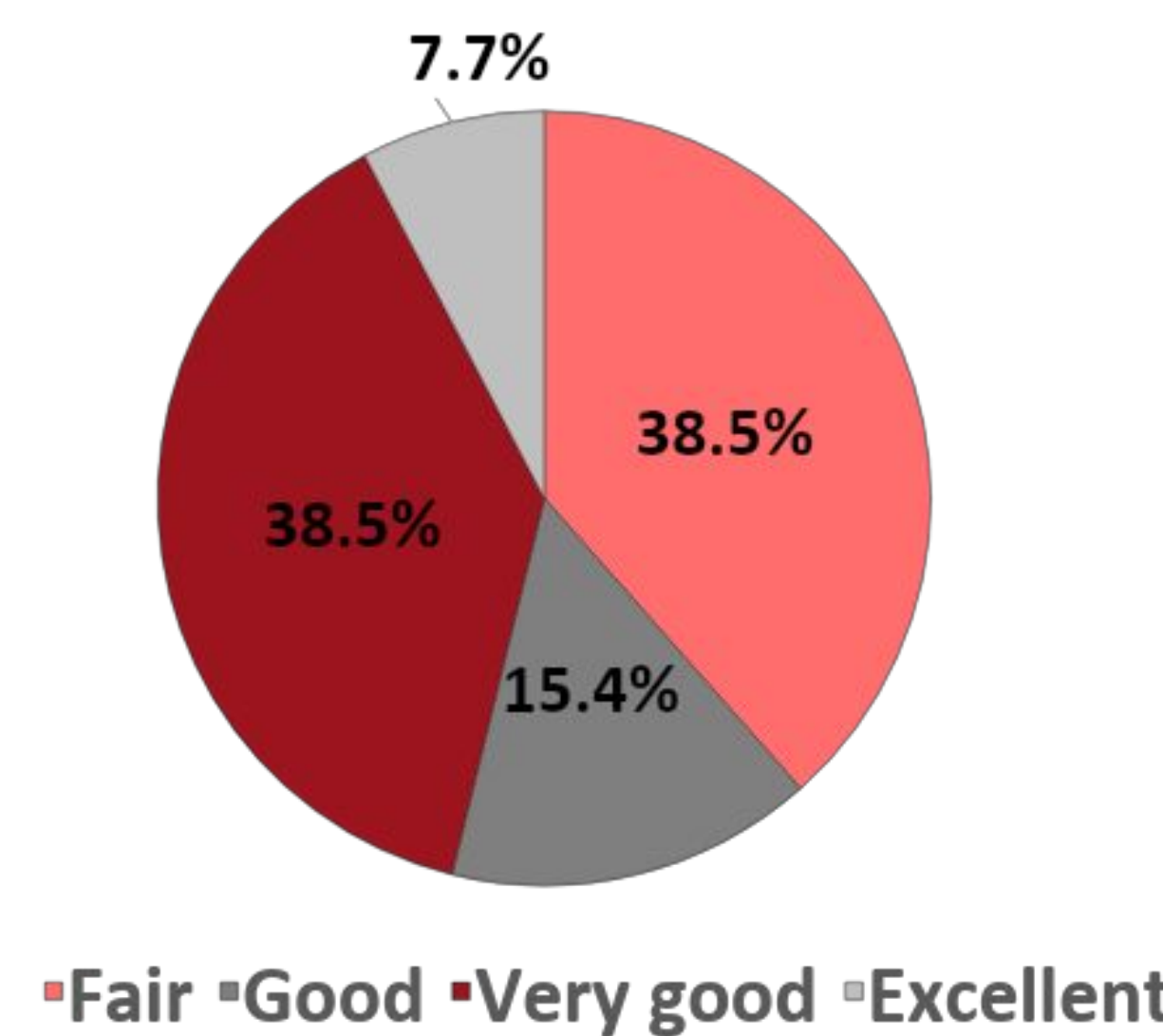
Study Design & Procedures

- Four-week longitudinal, observational study assessing physiological, physical, mental, and emotional function of patients discharging from the hospital after surviving COVID-19.
- Convenience sample of individuals treated at OU Health for COVID-19.
- Participants recruited from OUMI through OU-Nursing Case Management. Obtained informed consent prior to discharge
- Each participant received a COVID-19 assessment kit at discharge including an electronic scale, BP monitor, thermometer, pulse oximeter, EKG monitor, a 10 foot measure, and a GeneActiv Activity Monitor wristband.
- Each individual participated in a video conference or phone call at least weekly from OUHSC/OU faculty and/or students to assess symptoms, vital signs, cognition, gait, emotional status, and self-reported functioning.
- A battery of standardized and routine care assessments, biomedical sensor monitoring and qualitative data was collected and assessed from multiple disciplines at baseline and up to 30 days post discharge.

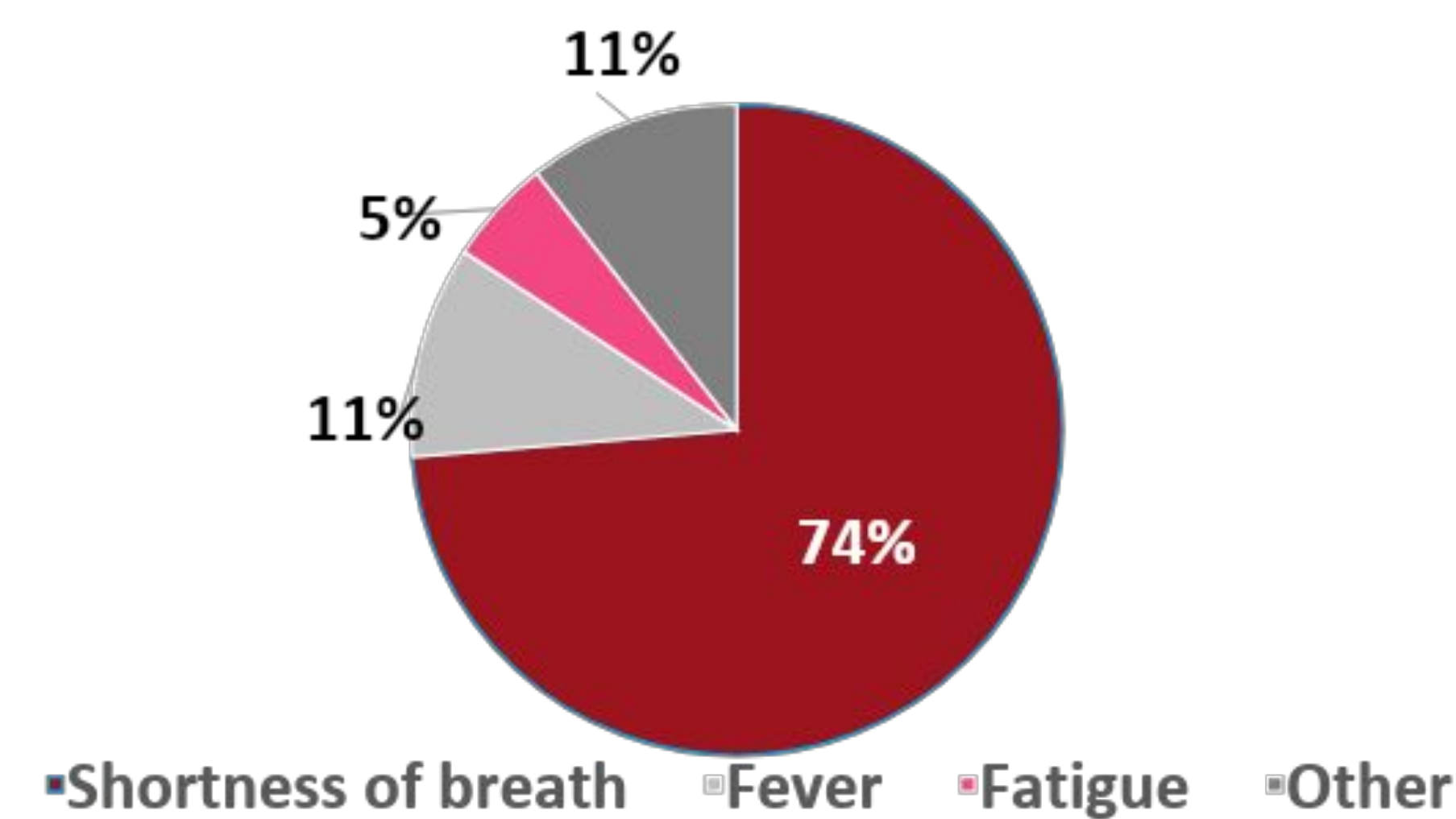
Overview of Participants



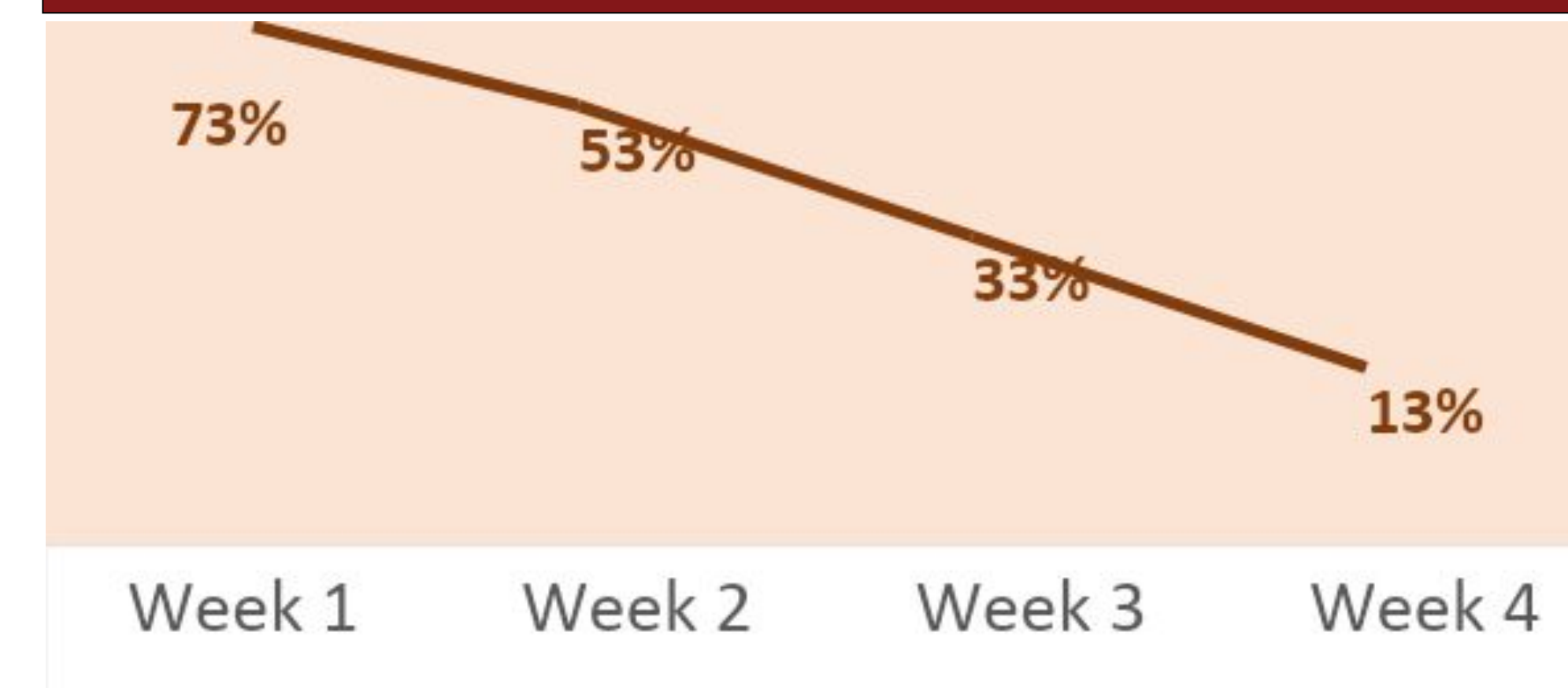
Overall Health Prior to Covid-19



Chief Complaint at Hospital Admission



Percentage of Participants Reporting Fatigue



Montreal Cognitive Assessment

	Week 1	Week 4	Possible
Language	3	3	4
Orientation	6	6	6
Memory	3	4	5
Total	11	13	15

Benefits & Challenges of Multidisciplinary Teams

Competency 3: Communication

- Communication among team members and participants was critical to the success of our project.
- Communication occurred almost daily in the form of emails and weekly through scheduled team meetings using Zoom
- Communication served to notify team members of a potential participant in the hospital, to coordinate timing for delivery of the COVID-19 assessment kits to participant and timing of participant assessments, to sharing findings, professional knowledge and perspectives, and to raise awareness of unforeseen barriers to planned processes.
- Regular communication was also needed to manage the unexpected challenges that arose during recruitment, delivery of study materials, obtaining consent, and sharing of participant impressions related to participant status.

Competency 4: Relationship Building

- Weekly interprofessional team meetings throughout the study.
- Discussions facilitated more comprehensive understanding of various assessment methods, perspectives, and approaches each discipline used to determining participant needs.
- Meetings also encouraged development of professional relationships and a greater appreciation for each team members' unique perspectives and contributions.
- As a result of this interprofessional teamwork experience we anticipate future opportunities for collaboration in research, education, and other initiatives in the clinical setting.

Practice Implications

Post-hospital Individuals need:

- Comprehensive nursing, social work, occupational and physical therapy assessments and interventions in the hospital
- Recommendations for assistive devices at discharge and an extensive home program determined by in-patient professionals for gradual exercise and activity.
- Support for demonstrated cognitive effects that persist over time including deficits in immediate memory and word finding.
- Caregiver education for home discharge programs
- Primary care follow-up appointments
- Multi-disciplinary and comprehensive home health or outpatient assessment (OT, PT, NS, SW)
- Education in energy conservation, activity simplification, progressive exercise, stress relief, and activity.

Acknowledgements

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