

Students' Coach to Increase Health Literacy in Hospital to Home Intervention

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PROJECT DESCRIPTION

Sonoma State University Nursing partnered with St. Joseph's Health System Sonoma County to provide a Hospital to Home service utilizing students' nurses as transitions coaches.

The Hospital to Home project is a free program designed to empower clients and their caregivers to better understand management their care after hospitalization.

Based on Coleman's Care Transitions model in which clients are offered a transitions health coach upon hospital their discharge.

APPROACH

Student nurses coach hospitalized patients before and after their discharge.

The student coach develops a relationship through interactions in the hospital before discharge, one home visit and 3 weekly phone calls. Based on Coleman's Care Transitions model to improve client's self care:

- ✓ medication self-management
- ✓ use of a patient centered record
- ✓ primary care/specialty follow- up appointments are kept
- ✓ knowledge of red flags that indicate a worsening condition

EVIDENCED BASED OBJECTIVES

Client's will become more activated in their care by further developing:

- ▶ literacy/understanding of their health information
- ▶ adopt tools to support self-management of health care needs
- ▶ a more active role during transitions in their care
- ▶ lasting self-management skills
- ▶ more confidence in asking questions and navigating their own health care

TARGET POPULATION

This is a free service for any hospitalized (in Santa Rosa Memorial) patient who is at risk for readmission.

Efforts are made to invite higher-risk patients that are:

- ▶ 65 and over
- ▶ with one or more chronic diseases,
- ▶ on 5 or more medications,
- ▶ lives alone

OUTCOMES

- ▶ A pre- and post survey tool of client's abilities named Patient Activation Measurement (PAM) is used
- ▶ An average of 22% increased self care abilities in group of 200 patients
- ▶ Lowered hospital readmissions in hospital population by 8%

IMPLICATIONS

This project has shown that a low cost evidence based model (Coleman's Care Transitions Intervention) can positively impact populations by increasing health literacy and avoid hospital readmission by utilizing student nurses as transition coaches.

Simple but effective tools to increase patient activation and could be considered in several settings.