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OR7. Health Literacy and the Inpatient Nurse: Defining Core Competencies at an Academic Medical Center

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Background: Limited health literacy is a national health crisis contributing to poor health outcomes including increased hospital readmissions, increased healthcare cost, decreased use of preventive services, and increased morbidity and mortality. Efforts to improve the health literacy of the nation hinge on healthcare provider-level interventions to address social determinants of health. However, these strategies represent an area of care which inpatient providers may not be prepared. Despite cascading poor outcomes associated with limited health literacy, staff nurses at a large urban medical center are not professionally prepared with integral health literacy competencies, skill sets, or screening tools to identify and support their patients. Setting: A large, urban medical center with a 720-bed specialized acute and critical care hospital serving a racially and socioeconomically diverse population. The Nursing Strategic Plan integrates social determinants of health and health literacy goals into the framework of nursing operations in efforts to demonstrate commitment to health equity initiatives.

Purpose: To evaluate staff nurse competencies in the care of inpatients with low health literacy and complete compulsory groundwork for future health literacy programming at the medical center.

Objectives: (1) Evaluate staff nurse knowledge, attitudes, and skills pertaining to health literacy; (2) test-run the Brief Health Literacy Screen tool on inpatient acute care units; (3) quantify rates of limited health literacy among adult inpatients; (4) design patient education care algorithms and staff training in health literacy; and (5) disseminate findings to the Health Equity Council.

Methods: Pilot goals were developed by a steering group of key stakeholders. Staff nurses in acute care units were surveyed to assess baseline knowledge, attitudes, and skills of health literacy concepts. The Brief Health Literacy Screen was introduced to staff nurses as an option to objectively identify individuals with limited health literacy. A 4-week pilot of the tool was completed. Rates of health literacy level were tallied and analyzed. Statistical analysis of survey responses and pilot results was shared with the Health Equity Council at the medical center.

Results: Despite demonstrating proficiency in health literacy concepts, staff nurses lack clinical skills and resources to effectively identify patients with low health literacy and address this patient’s unique clinical needs. Staff nurses are ambivalent about their role as patient education providers. The Brief Health Literacy Screen was introduced to staff nurses as an option to objectively identify individuals with limited health literacy. A 4-week pilot of the tool was completed. Rates of health literacy level were tallied and analyzed. Statistical analysis of survey responses and pilot results was shared with the Health Equity Council at the medical center.

Conclusions: The medical center has the opportunity to adopt routine health literacy screening for all adult inpatients and professionally prepare staff nurse with clinical skills essential to the care of the patient with limited health literacy via comprehensive health literacy programming.

Practice Improvement

P015. Implementing Telemedicine Practices for Mechanical Circulatory Support Patients During COVID-19 Global Pandemic

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Objective: To provide safe, comprehensive, medical care to home-bound MCS patients during the COVID-19 global pandemic.

Background: The first case of COVID-19 was diagnosed in New Jersey on March 2, 2020. Eight days later the first death from the virus occurred. With cases rapidly increasing, the statewide stay at home order came shortly after on March 21, 2020, closing down all non-essential businesses and non-urgent travel. Hospitals became COVID only and the majority of non-emergent medical cases were discharged home. MCS patients, who were used to being seen in clinic on a monthly basis, were suddenly required to adapt to a new care model. The team of MCS coordinators collaborated and were able to provide continuous, safe, medical care remotely to this complex population by utilizing telemedicine and home diagnostic services; a novel change in practice.

Methods: • Initiation of telemedicine platform for routine "visits"
  • Referral of all patients to mobile lab services for blood work and/or administration of home INR monitoring equipment
  • Utilization of mobile radiology for remote x-rays, CT scans, and ultrasounds
  • Patients given Doppler and blood pressure cuff with instructions for home use

Results: The team completed a total of 81 telemedicine visits in 4 months, averaging 20 visits/month. There was 100% compliance with visits. Providers worked around the patients' schedules, completing visits outside of regular business hours. Our average monthly visits prior to COVID were around 30 visits/month, with 25% no show/cancellation rate. The MCS team was able to increase our compliance with weekly lab reporting from April (60%) to July (93%). Patients stated that they like the option of telemedicine and are more comfortable in their home setting during visits. The coordinators also like the ability to see patients in their home environment and the ability to observe return demonstration of dressing change at follow up intervals via video conferencing.

Conclusion: Telemedicine and home monitoring have come a long way in the past few months, and can most definitely be used effectively in the MCS population. We observed an increase in adherence with treatment and an overall satisfaction in care received when patients were able to take an active role in their care, in their home, and at their preferred time of day. This study supports a change in practice to incorporate telemedicine into the routine care of the MCS population. We hope this will continue to increase patient satisfaction and decrease time patients spend in the hospital, which will increase quality of life.

Practice Improvement

P016. Evaluating the Efficacy of Focused Nurse Practitioner Visits on Heart Failure Outcomes Among Patients Enrolled in the Program for All-Inclusive Care of the Elderly (PACE): A Quality Improvement Project

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Background: Symptom management in heart failure (HF) is the cornerstone to improve outcomes in this complex population. Rehospitalization rates due to HF sequelae are high and symptom management remains an ongoing issue. Focused Nurse Practitioner (NP) visits with evidence-based patient education will enhance engagement and self-care management of HF. Ultimately, this will improve HF outcomes for participants in the PACE program.

Purpose: The purpose of this quality improvement project was to evaluate the efficacy of focused NP visits on improving HF related outcomes among participants of the PACE program in western Florida.

Methods: The project was based on the Information, Motivation, Behavioral skills theoretical model with patient engagement as the key mediator to achieve improved HF self-management. The NP saw each participant twice. The first visit established baseline data through questionnaires. The second visit was to discuss the evidence-based HF patient education booklet created by this author and complete the post-intervention questionnaires. Table 1 describes the outcome measures and instruments used. The outcomes evaluated included HF knowledge, quality of life, HF self-care and symptom burden, demographic data, medical history, and clinical variables. The questionnaires used included the Kansas City Cardiomyopathy Questionnaire (KCCQ), the Atlanta HF Knowledge Test (AHFKT), the Self-Care of HF Index questionnaire (SCHFI), the Symptom Status Questionnaire - Heart Failure (SSQ-HF).

Results: The results for the AHFKT were statistically significant (p = .037) indicating the evidence-based education provided was effective. The self-efficacy and knowledge portion of the KCCQ was statistically significant (p = .047) indicating the education and focused NP visits increased participant knowledge and ability to effectively manage their HF. The result of the AHFKT surmises the evidence-based education provided was effective, which is supported by the results from the KCCQ on knowledge and self-efficacy. In evaluation of the symptom severity questions, it was determined that participants were more self-aware of their HF symptoms after the HF education, thus providing responses to the KCCQ that showed an inverse relationship.

Conclusion: The clinical implications for this practice change indicates the evidence-based education booklet is an effective tool in the management of HF when combined with focused NP visits. The NP visits showed improved outcomes and would be beneficial to HF patients ongoing. In terms of sustainability, the evidence-based education booklet has been adopted for all HF patients.