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the patient. As the patient recovers their involvement significantly increases, and family involvement is reinforcement for the patient. Education and plans upon discharge seem to be more successful when support systems are involved. Post discharge follow-up with a nurse, hopefully through a home visit, helps to ensure that the patient is doing well and the support following discharge is adequate. Ms. Christian collaborated with Ellen J. O’Conner, MS, RN, CS, a community health nurse in rural North Dakota and northwestern Minnesota for many years, in conducting a pilot Hospital-to-Home program at Altru Hospital during the summer of 2000. Most of the patients involved had multiple diagnoses such as COPD and a variety of cardiovascular problems, or had had a cardiac procedure such as CABG. The students functioned in leadership and primary care roles while their patient was hospitalized. They were able to observe what the patient and family were going through during and after a short but intense hospital stay. Patients loved the support and wanted it to continue. Thus, these rural nurses describe some ways to smooth the transition from hospital to home for rural residents.

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