CE 2.5 contact hours

A Transitional Care Model

Using Faith Community Nurses

By Deborah Ziebarth and Katora P. Campbell

ABSTRACT: *The Medicare mandatory readmission reduction program has hospitals scrambling to reduce 30-day readmissions.* A Faith Community Nurse *(FCN)* Transitional Care Model *was developed from systematic literature review of predictive factors of readmission and pre- and postdischarge interventions that decrease readmission. The model presents specific FCN care that occurs pre- and posthospital discharge to support the patient in transitioning from one level of care to another, move toward wholistic health, and avoid unnecessary readmission.*

KEY WORDS: *case management, discharge planning, faith community nursing, hospital reimbursement, readmission reduction, transitional care*

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Hospitals have been scrambling in recent years to reduce readmission rates. With passage of the Affordable Care Act in 2010, Medicare was required to set up a readmission reduction program to lower readmission rates after hospital discharge. Payment penalties began in October 2012 for hospitals subject to the Inpatient Prospective Payment System (IPPS). Hospitals lost up to 1% of *every* Medicare payment if the hospital had an excessive 30-day readmission for only three specific diagnoses—acute myocardial infarction, congestive heart failure, and pneumonia. The penalty increased to up to 2% for 2013 readmissions and 3% for 2014 readmissions. In 2015 exacerbation of chronic obstructive pulmonary disease (COPD) and total hip and knee arthroplasty were added as additional diagnoses to measure hospital performance. In 2017, coronary artery bypass surgery will be added (Centers for Medicare & Medicaid Services, 2015). *Modern Healthcare* reports that only 799 of more than 3,400 IPPS hospitals performed well enough in 2015 to avoid penalties in 2016 (Rice, 2015).

People who are readmitted to the hospital tend, among other things, to be older and have multiple chronic illnesses. Policy researchers assert that the relatively high readmission rates for patients with chronic illness may be due to various factors, such as: (1) an inadequate relay of information by hospital discharge planners to patients, caregivers, and postacute care providers; (2) poor patient compliance with care instructions; (3) inadequate follow-up care from postacute and long-term care providers; (4) variation in hospital bed supply; (5) insufficient reliance on family caregivers; (6) the deterioration of a patient's clinical condition; and (7) medical errors (Stone & Hoffman, 2010).

Faith Community Nurses (FCNs) can impact factors that contribute to hospital readmission. The goal of this article is to revisit predictive factors for hospital readmission and pre- and postdischarge interventions that aid in decreasing hospital readmissions, and describe an evidence-based *Faith Community Nurse Transitional Care Model*.

READMISSION, PRE-, & POSTDISCHARGE FACTORS

A recent systematic literature review (Ziebarth, 2015) delineated predictive factors of hospital readmission and pre- and postdischarge interventions that reduce hospital readmission. The complete reference list from the review (Ziebarth, 2015) can be found online as supplemental digital content (SDC) at http://links.lww.com/NCF-JCN/A48.

Predictive factors of hospital readmission found by Ziebarth (2015) included: Medicare and Medicaid payer status; elderly persons with complex medical, social, and financial needs; absence of a formal or informal caregiver; markers of frailty; living alone; disability; poor overall health condition; poor health literacy; self-rated walking limitation; psychosis; depression and/or other serious mental illness; recent loss of ability for self-feeding; underweight; pressure sores; and/or subjective reported health outcomes. Specific physical conditions that were predictive hospital readmission factors included multichronic diseases, congestive heart failure, vascular surgery, cardiac stent placement, COPD, pneumonia, diabetes or glycemic complication, stroke, major hip or knee surgery, major bowel surgery, and gastrointestinal issues in terms of functional status. These predictive factors give direction in identifying patients most at risk for hospital readmission and offering them additional services.

Interventions performed prior to discharge that decrease readmission (Ziebarth, 2015) were identified as early discharge planning, case management, education, certain tools, and collaboration. Studies suggest strong care-transitions leadership is important to decreasing readmissions (i.e., Fabbre, Buffington, Altfeld, Shier, & Golden, 2011; Watkins, Hall, & Kring, 2012). A patient booklet educational tool has been used to encourage self-management and contains personalized care records, medications list, appointments, emergency plan, contact information, 30- and 60-day plans, and illness-specific information. A checkoff list tool was used by hospital staff prior to discharge to ensure readiness for discharge (Halasyamani et al., 2006). Other tools mentioned were electronic in nature to promote cross-site communication (Holland, Harris, Leibson, Pankratz, & Krichbaum, 2006). Collaborative hospital–clinic partnerships were encouraged, along with information sharing through electronic medical records access between the attending physician and hospital staff (Coleman, 2010; Hernandez et al., 2010; Osei-Anto, 2010).

Interventions performed after discharge that decreased readmissions were identified in the systematic review (Ziebarth, 2015) as follow-up, clinic visits, telehealth, and transitional care programs provided by community-based nurses. Follow-up calls were made to patients by hospital staff anywhere from 1 to 7 days after discharge and described as answering medication questions, general information, and follow-up with physician information. The post hospital, follow-up clinic visit presented a critical opportunity to address the conditions that precipitated the hospitalization and to prepare the patient and family caregiver for self-care activities. Telehealth technology allowed for remote monitoring of patients who required higher levels of care (Bowles et al., 2011; Looman et al., 2013). Naylor, Aiken, Kurtzman, Olds, & Hirschman (2011) found that medication reconciliation and support services for patient self-management were key components of nearly all nurse-led transitional care models. Nurses in

the community coached patients through transition. Coaching patients and their caregivers during care transitions ensured that discharge education was revisited and needs were met, which reduced the rates of subsequent hospital readmissions.

FAITH COMMUNITY NURSING

Faith community nursing is a recognized and reliable resource of primary healthcare and wholistic health-related services. FCNs are registered nurses with additional training to provide wholistic healthcare (American Nurses Association [ANA] & Health Ministries Association [HMA], 2012; Ziebarth, 2014a). Historically, wholistic health is conceptualized in the modern FCN movement, as "a whole or completely integrated approach to health and healthcare that integrates the physical and spiritual aspects of the whole person" (ANA & HMA, p. 7), noting *wholistic* is the preferred spelling when referring to care provided by FCNs. In this discussion, wholistic healthcare is defined as the:

> *Human experience of optimal harmony, balance and function of the interconnected and interdependent unity of the spiritual, physical, mental, and social dimensions. The quality of wholistic health is influenced by human development at a given age and an individual's genetic endowments, which operate in and through one's environments, experiences, and relationships. (Ziebarth, in press, p. 30)*

Wholistic healthcare providers recognize the importance of a relationship to God or a higher power (ANA & HMA, 2012; Ziebarth, in press).

In a literature review of 124 articles, Ziebarth (2014a) found that FCNs commonly use 16 nursing interventions, five of which are unique to FCN practice (Table 1). In summary, the FCN practices with the goal of wholistic health functioning. Interventions occur over time when clients seek or are targeted for wholistic healthcare (Ziebarth, 2014a). The delineation of what are uniquely FCN interventions is important because The Joint Commission (2010) states that patients have specific characteristics and nonclinical needs that can affect the way they view, receive, and participate in healthcare. In addition, supporting patients' spiritual needs helps them cope with their illness.

In a recent evolutionary conceptual analysis, the practice of faith community nursing is described as:

> *A method of healthcare delivery that is centered in a relationship between the nurse and client (person, family, group, or community). The relationship occurs in an iterative motion over time when the client seeks or is targeted for wholistic healthcare with the goal of optimal wholistic health functioning. Faith integrating is a continuously occurring attribute. Health promoting, disease managing, coordinating, empowering, and accessing healthcare are other essential attributes. All essential attributes occur with intentionality in a faith community, home, health institution, and other community settings with fluidity as part of a community, national, or global health initiative. (Ziebarth, 2014a, p. 1829)*

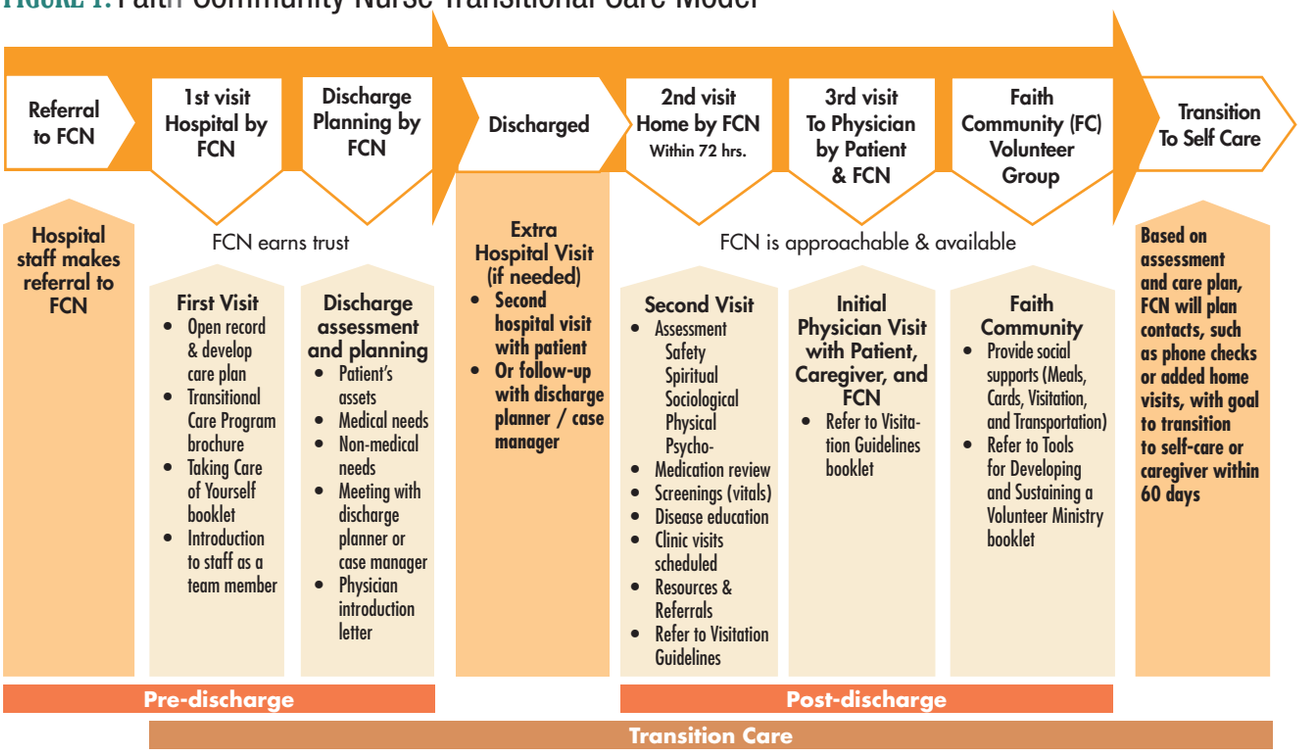
Collaborative hospital-faith community partnerships address wholistic healthcare, improve discharge experience...and reduce rehospitalization.

TABLE 1: Commonly Used and Unique Faith Community Nursing Interventions*

Interventions FCNs Commonly *Use*	Interventions *Unique* to FCN Practice
Routinely perform intentional spiritual care, spiritual leadership/practices, and integrate health and faith	Spiritual care, spiritual leadership/practices, and the integration of health and faith
Practice with, and in, the faith community, home, health institution, or other community setting with fluidity and consistency	
Are multidisciplinary and interdisciplinary team members, advocating and providing resources on many different levels	Are multidisciplinary and interdisciplinary in resourcing and referring
Coordinate, implement, and sustain ongoing care activities	Coordinate, implement, and sustain ongoing activities
Routinely utilize and apply results from surveys	Utilize and apply results from surveys
Are familiar with, and able to implement, community and public health nursing concepts and practices	
Are familiar with motivational and empowering techniques to encourage lifestyle change	
Routinely train and utilize volunteers	Train and utilize volunteers from the faith community
Practice with the knowledge and skills as a generalist (assessment, prevention, disease processes, procedures, treatments, and end-of-life issues)	
Are accessible (long-term), approachable, professional, good communicators, and culturally sensitive	
Understand the concept of wholistic health functioning	

*Derived from a systematic literature review of 124 articles (Ziebarth, 2014a).

FIGURE 1: Faith Community Nurse Transitional Care Model



The FCN is part of the healthcare team and does not duplicate, but rather compliments, services provided by other team members. Just as more than one healthcare team member provides services in the hospital, the FCN is part of the interdisciplinary healthcare team in the community. The FCN has the flexibility to visit the patient as needed to optimize wholistic health functioning. The FCN engages the healthcare team, based on assessed needs. Based on the assessment, the FCN may refer the client to the physician for a clinic appointment, medication change, support services, or whatever is needed. The FCN may request home health nursing services if the patient meets the criteria for referral. In addition, the FCN has the flexibility to access the faith community volunteers/services to support the patient's needs.

FCN TRANSITIONAL CARE MODEL

Hospitals are using FCNs in transitional care programs with the goal of decreasing readmission rates. Collaborative hospital-faith community partnerships address wholistic healthcare (Ziebarth, in press) and may improve the patient's discharge experience, ensure postdischarge support, and reduce rehospitalization of patients (Hennessey, Suter, & Harrison, 2010; Marek, Adams, Stetzer, Popejoy, & Rantz, 2010; Ziebarth, 2015; Ziebarth & Campbell, 2015). The FCN effectively assists at-risk older persons to obtain needed healthcare and prevent crisis care or hospital readmissions. FCNs help older adults link to community long-term support services, such as chore service and Meals-on-Wheels, and to access information resources such as free prescription medications for low-income individuals. Of great significance, the FCN provides emotional and spiritual support for anxious and isolated elders (i.e., King & Pappas-Rogich, 2011).

Based on literature (Ziebarth, 2015), a theoretical model for FCN transitional care was developed. *Faith community nurse transitional care* is defined as care provided by an FCN and a faith community to support the patient's experience of transition from one level of care to another. The FCN Transitional Care Program goals are to: (1) Endorse whole-health by using FCNs and faith communities to provide transitional care; (2) Enhance patient discharge experience from hospital to home; (3) Engage patients in their care, thereby increasing self-efficacy and positive health outcomes; (4) Eliminate unnecessary hospital admissions; and (5) Encourage collaboration and shared visioning between healthcare institutions and faith communities (Ziebarth & Campbell, 2015).

The *Faith Community Nurse Transitional Care Model* is found in Figure 1 and is discussed below. The activities are presented in a linear fashion that moves from a predischarge phase to a postdischarge phase. Certain essential nursing interventions are achieved during each phase. Concepts for phase goals, such as trust and being approachable and accessible, were borrowed from the *Conceptual Theory of Faith Community Nursing* (Ziebarth, 2014a). The model was developed with the paid FCN position in mind; however, the unpaid FCN volunteer role may also benefit from the model. The resources discussed in the model and how to obtain these tools are found in Table 1.

Referral. Referral to the FCN to initiate care is made when the case manager or nurse determines that the patient is a candidate and meets

the criteria for transitional care. The criteria are determined by the hospital, faith community, and FCN. For example, if the FCN is practicing in a particular faith community, the criteria may be that the patient attends the faith community or lives near it. Or, the FCN may be hired directly by the hospital. In that instance, the referral may come when the patient has increased risk for readmission, based on diagnosis, surgical procedure, or functional status.

Predischarge. In the predischarge phase, the first FCN visit is made with the patient. The goal in this phase is for the FCN to earn the trust of the patient, caregiver, and hospital staff. This is done by introduction, information sharing, and plan development. The FCN delineates a patient's assets and strengths, along with medical and nonmedical needs. The *Transitional Care Program* brochure is used by the FCN to introduce the patient and his or her caregivers to the program and the role of the FCN and Transitional Care Ministry Group. A booklet entitled, *Taking Care of Myself: A Guide for When I Leave the Hospital* (Ziebarth, 2014b) is used to promote self-care and collect important information for patient and caregiver. The booklet, when completed by the patient and FCN, includes medications, primary care provider (PCP) visits, contact information, emergency plan, and patients' goals. Discharge assessment and care planning occur, which may include a meeting with the discharge planner. An introduction letter and brochure are sent/given to the PCP.

The FCN official documentation record is opened at the first visit. Several documentation tools are available for faith community nursing. The Henry Ford Macomb electronic documentation tool (www.fcndocumentation.com) was developed, using a standardized nursing language, the Nursing Interventions Classification. Another available tool is from the Pittsburgh Mercy Parish Nurse & Health Ministry (www.pmhs.org/parish-nurseprogram/education-and-resources.aspx).

An extra hospital visit with the patient or case manager may occur if: (a) the patient, caregiver, or case manager was not available during the first visit; (b) a visit is requested by the patient, caregiver, or case manager; or (c) the patient has had complications necessitating a longer hospitalization. The goal of this visit is to develop a working relationship with patient, caregiver, and case manager prior to discharge and to educate all regarding the FCN Transitional Care program.

Postdischarge. The goal of this phase is for the FCN to be approachable and available. Soon after discharge (24–72 hours), a second FCN visit is made in the home setting. The visit includes medication review, screenings (vital signs), physical and safety assessments, acute and chronic disease(s) management and education, coordination of physician/clinic visits, and resources and referrals, as needed. Socialization and spiritual components of visits are routine. The FCN shows concern for the wholistic well-being of the patient and encourages frequent communication by leaving her or his contact information with the patient and caregiver(s). Communication with the patient and caregiver(s) is done in a prompt and professional manner.

Arrangements are made with faith community volunteers, according to the patient's and caregiver's needs. The role of the faith community is to provide *community* through the use of volunteers. Volunteers may provide needed social supports, such as encouraging cards, transportation, chore service, or meals. The FCN has access to the booklet *Tools for Developing and Sustaining a Volunteer Ministry* (Table 2).

Only 799 of more than 3,400 IPPS hospitals performed well enough in 2015 to avoid reimbursement penalties in 2016.

The Visitation Guidelines 2014 for Faith Community Nurses for Transitional Care (Table 2) provide assessment guidelines for the first home visit and first PCP visit. The role of the FCN is to avert unnecessary rehospitalization by increasing contact with the PCP, home visits, and to offer nursing interventions, such as disease education, medication reconciliation, and self-care training—all of which are a part of every visit. Based on assessment, the FCN will plan contacts and home visits with the goal to transition the patient to self-care or caregiver within 30 to 60 days.

The third FCN visit is the patient's initial visit with the PCP postdischarge. The FCN attends the first visit with the PCP to: (a) ensure that the visit occurs; (b) introduce self and the FCN role to the PCP; (c) facilitate information exchange between patient, caregiver(s), and healthcare provider; and (d) make sure that the patient and caregiver(s) are fully engaged and

participate in healthcare decisions. The *Visitation Guidelines* provide assessment guidelines for the first PCP visit.

Additional home visits with the patient and caregiver may occur to continue the nursing plan of care, or are based on assessment and patient's need. In addition, telephone check-ins may occur. The FCN may need to provide care coordination and advocate on behalf of the patient to set up services, change medications, access care, and so forth. The duration of transitional services provided by the FCN is determined by patients' needs, diagnoses, and program outcomes, but generally, will not exceed 60 days.

CASE STUDY IN TRANSITIONAL CARE

Mrs. M is an 82-year-old female, living alone in a community-based apartment. She relies on monthly Social Security payments and Medicare. At 162.56 cm (5 ft. 4 in.), she weighs 40.82 kg (90 lb.). She uses a walker for ambulation. Mrs. M is hospitalized for congestive heart failure (CHF) and is a Type II diabetic.

The hospital case manager, Roger, began assessing Mrs. M on admission and planning for care after discharge. The hospital employs community health workers to assist with transitional care; however, Roger believes Mrs. M will need higher-level care provided by a nurse. The hospital has set up partnerships with FCNs in the city. Mrs. M did not give a religious preference on admission, but she lives near a faith community with a paid FCN, who has had transitional care training. Roger makes a referral to the FCN, Sharon.

Sharon visits Mrs. M in the hospital, taking the time to establish relationship and assess and understand Mrs. M's physical, mental, social, and spiritual needs. Mrs. M is lucid and fully aware of her situation. She reports no family in the area. Sharon gives Mrs. M a brochure on the FCN transitional care program, a booklet on how to prepare for discharge, and what to expect from the program when returning home. Sharon learns Mrs. M has a faith background and offers to pray with Mrs. M, who happily consents. Sharon also meets with Roger, the case manager, and mails an introductory letter about the care program to Mrs. M's PCP.

Roger notifies Sharon of Mrs. M's discharge date, and Sharon goes to the hospital the morning of discharge. Roger has made arrangements for a home health aide to assist Mrs. M with activities of daily living three days a week. With Mrs. M's permission, Sharon has set up Monday–Friday meal service from the local Meals-On-Wheels organization. The discharge nurse, Sharon, and Mrs. M go through Mrs. M's medications, home activities, symptoms of CHF, contacts for assistance, and follow-up PCP appointment. Mrs. M is discharged home via a community-based transport service.

The next day, Sharon makes a home visit to Mrs. M and performs another wholistic assessment. Mrs. M shows no signs of recurring CHF and accurately verbalizes CHF symptoms. However, Mrs. M is not able to correctly explain her medications. Sharon uses the teach-back method to review Mrs. M's medications and helps her set up a weekly pill organizer. Sharon asks Mrs. M if she can employ the help of church volunteers to assist with housekeeping and shopping, assuring her the volunteers have nametags, and Mrs. M will know who is coming and when they will arrive. Mrs. M agrees to this support. Mrs. M's PCP provides transportation for office visits, and Sharon arranges with Mrs. M to be at the PCP visit that will occur the following week. Sharon and Mrs. M pray together at the end of the visit. Sharon assesses and prays with Mrs. M by phone every day until the PCP visit.

At the PCP visit, Mrs. M continues to have no signs of CHF, is ambulating well by walker, and says she feels stronger. The PCP, Mrs. M., and Sharon review Mrs. M's medication, and activities; Mrs. M is able to correctly describe her medications. Sharon makes arrangements to call Mrs. M every other day and visit her in two weeks, while the volunteers and home healthcare aides continue their visitation. Mrs. M says she feels much better knowing help is available, and she will have visitors every few days who will assist her, as well as talk and pray with her.

Six weeks after her hospitalization, Mrs. M continues doing well. Sharon dismisses her from the transitional care program but keeps Mrs. M on her list of monthly clients to check in with, and she arranges for church volunteers to help Mrs. M with cleaning and shopping biweekly. Mrs. M hires a personal aide to come in three times weekly for other assistance and knows she can reach out to Sharon and a caring faith community in the future.

TABLE 2: Resources for Implementing the Faith Community Nurse Transitional Care Program*

- *Transitional Care Program Brochure*
- *Taking Care of Myself: A Guide for When I Leave the Hospital Booklet*
- *Introduction Letter*
- *Tools for Developing and Sustaining a Volunteer Ministry*
- *Visitation Guidelines 2014 for Faith Community Nurses for Transitional Care* (available for purchase in print or digital format at http://store.churchhealthcenter.org)
- International Parish Nurse Resource Center Position Paper: Faith Community Nursing and Home Health Nursing
- Transitional Care Training for nurses. Contact FCO@churchhealthcenter.org

*All resources are available from the Church Health Center by contacting Deborah Ziebarth at ziebarthd@churchhealthcenter.org

CONCLUSION

As hospitals increasingly use FCNs for transitional care to reduce patient readmissions, the *Faith Community Nurse Transitional Care Model* offers a professional guidebook for FCNs and hospitals to offer consistent, high-quality care. Involving FCNs and the

faith community ensures the promotion of wholistic health for these special patients.

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