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# Factors That Lead To Hospital Readmissions and Interventions that Reduce Them: Moving Toward a Faith Community Nursing Intervention

## **Cover Page Footnote**

I would like to acknowledge, God, my family, Church Heath Center, specifically Katora Campbell, and the University of Wisconsin

## **Factors That Lead To Hospital Readmissions and Interventions that Reduce Them: Moving Toward a Faith Community Nursing Intervention**

### **Introduction**

With the implementation of the Patient Protection and Affordable Care Act (PPACA), (Cauchi, 2012), there have been many changes affecting the beneficiaries in the Medicare program. On top of standard monthly premiums, "...Medicare enrollees pay a \$1,132 deductible for each hospital stay" (p. 15) and they pay hundreds more when the enrollee has longer hospital stays or are readmitted (Estes, Chapman, Dodd, Hollister & Harrington, 2013). Hospital readmissions affect over 80 percent of all Medicare enrollees (Stone & Hoffman, 2010). Nearly one-fifth of fee-for-service Medicare beneficiaries discharged from the hospital are readmitted within 30 days (Burton, 2012). Furthermore, three-quarters of these readmissions, costing an estimated \$12 billion a year, are considered potentially preventable, especially with improved care transitions (Burton, 2012). Hospitals have a responsibility to their Medicare patients to keep them well and safe after discharge in their community and outpatient environments (Berry et al., 2011; Pham, Grossman, Cohen & Bodenheimer, 2008).

In addition to the PPACA impact on Medicare beneficiaries, Medicare trustees are requiring hospitals to pay more with decreasing payment reimbursements. The Continuity Assessment Record and Evaluation Medicare Tool measures the health and functional status of Medicare beneficiaries at acute discharge and assist in determining payment reimbursement for hospital readmissions of less than 30 or 60 days (Smith et al., 2012). With changes in the Medicare reimbursement model, hospitals are examining efficient methods of decreasing avoidable re-admissions. The aim of this integrative review is to examine key findings of literature related to: what predictors lead to readmissions and what interventions decrease them.

People who are readmitted to the hospital tend, among other things, to be older and have multiple chronic illnesses (Condelius, Edberg, Jakobsson & Hallberg, 2008). Policy researchers assert that the relatively high readmission rates for patients with chronic illness may be due to various factors, such as: (a) an inadequate relay of information by hospital discharge planners to patients, caregivers, and post-acute care providers; (b) poor patient compliance with care instructions; (c) inadequate follow-up care from post-acute and long-term care providers; (4) variation in hospital bed supply; (d) insufficient reliance on family caregivers; (6) the deterioration of a patient's clinical condition; and (e) medical errors (Stone & Hoffman, 2010). A study of Medicare fee-for-service beneficiary claims data from 2003 to 2004 shows readmission rates that ranged broadly by condition and procedure, with some of these conditions and procedures representing the majority of all hospital readmissions in that 12-month period (Jencks, Williams, & Coleman, 2009). Specifically, 30-day readmission rates for heart failure (26.9%), pneumonia (20.1%), chronic obstructive pulmonary disease (22.6%), psychoses (24.6%), and gastrointestinal conditions (19.2%) were higher than the 30-day readmission rates for cardiac stent placement (14.5%) and major hip or knee surgery (9.9%). Clinical conditions and procedures can predict readmission risks when the deterioration in health status occurs (Jencks et al., 2009).

Currently some of the activities used to decrease readmissions are mentioned in a systematic review from four case study hospitals with lower than average readmission rates. Silow-Carroll, Edwards, and Lashbrook (2011) suggested solutions include the use of health information technology to integrate care across settings, begin care management and discharge planning early prior to discharge, educate patients and their families in managing conditions, communicate with the high risk patients through telephone calls, and align hospitals efforts with those of community providers to provide a continuum of care post discharge.

In a recent study, eleven hospitals participated in Project BOOST (Better Outcomes for Older Adults through Safe Transitions) and saw a 2% absolute drop in readmissions rates after one year compared with pre-implementation rates (Beresford, 2013). BOOST screenings identify risk factors early on admission, which are followed by risk specific interventions. Risk factors include poor health literacy, more than five medications and problem medications, lack of patient support, a prior hospitalizations in the last six months, principle diagnosis, psychological, and palliative care. The effectiveness of Project BOOST varied greatly among participating sites with the project's utility in question (Beresford, 2013). To date there are no specific transitional program mandated by policymakers to decrease readmissions, instead hospitals are looking at many options to decrease avoidable re-admissions.

Services provided by faith community nurses may be a potential solution to address unnecessary readmissions. In preparations for testing a Faith Community Nurse Transitional Care Program, a systematic integrative review was needed. A systematic integrative review will provide the underpinnings for a Faith Community Nurse Transitional Care Model.

## **Method**

Using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) model (Liberati et al., 2009), a search was done, inclusion criteria identified, and articles retrieved. The University of Wisconsin, Milwaukee (UWM) provides access to literature through a search of academic publishers, research institutes, and organizations. Using the term "transitional care", 35,432 titles were identified in the initial search. Using limitations such as publication date (after 1999), language (English), and methods or interventions, the search yielded 32 articles. Another search was conducted using the key phrase "transitional care of adults from hospital to home". After using the same exclusions, there were 1,399 titles. The search was further reduced by using the terms elder, elderly patients, or older adults. Of the 91 articles, 19 were excluded after the abstracts were reviewed. Each of the remaining articles underwent full review, and those not meeting the inclusion criteria were excluded for the following reasons: did not describe an intervention; did not study adults > 65 years of age, or did not describe a transition between hospital and home.

After a thorough examination, key findings of 62 articles were collected, compared, and combined using a descriptive matrix template (Marsh, 1990). The tool is a spatial representation of compacted data, which creates an audit trail to view the data findings. Key findings were divided into three distinct groupings. The first group was factors that increased hospital readmissions. Second group was interventions that decreased readmissions prior to discharge.

The third group was interventions that decreased readmissions post discharge or after hospitalization.

## Findings

### Factors That Increase Hospital Readmission

A study of 1,378 patients from nine Veteran Administration Medical Centers examined clinical and patient-centered factors predicting hospital readmission (Smith et al., 2012). The study population included patients discharged from the medical service with a diagnosis of diabetes mellitus, congestive heart failure, and/or chronic obstructive pulmonary disease (COPD). A readmission rate of 23.3% occurred. The two patient-centered factors significantly and independently associated with readmission were lower mental health status and higher satisfaction with access to emergency care. Of the disease variables, COPD increased the most risk for readmission (Smith et al., 2012).

Studies describe predictive factors of hospitals readmissions such as Medicare and Medicaid payer status, elderly with complex medical, social and financial needs, absence of a formal or informal care giver, markers of frailty, living alone, disability, poor overall health condition, poor health literacy, multi-chronic diseases, heart failure, vascular surgery, cardiac stent placement, COPD, pneumonia, diabetes or glycemic complication, stroke, major hip or knee surgery, self-rated walking limitation, psychosis, depression and/or other serious mental illness, major bowel surgery, gastrointestinal in terms of functional status, recent loss of ability for self-feeding, underweight, pressure sores, and/or subjective reported health outcome (Baker, et al., 2002; Billings, Dixon, Mijanovich, & Wennberg, 2006; Boulton, et al., 1993; Carryer, Budge, Hansen, & Gibbs, 2010; Cawood, Elia, & Stratton, 2012; Coleman, Austin, Brach, & Wagner, 2009; Gariballa, Forster, Walters & Powers, 2006; Gazmararian et al., 1999; Gazmararian, Williams, Peel, & Baker, 2003; Holland, Harris, Leibson, Pankratz, & Krichbaum, 2006; Kurek, 2011; LaMantia, et al., 2010; Mistry, Rosansky, McGuire, McDermott & Jarvik, 2001; Mudge, et al., 2010; Norman, et al., 2008; O'Reilly, 2011; Parker, Baker, Williams, & Nurss, 1995; Riegel, et al., 2009; Rodríguez-Artalejo, et al., 2006; Silow-Carroll et al., 2011; Strunin, Stone, & Jack, 2007; Wagner, et al., 2001; Wong, et al., 2010).

In addition, some medications increase the likelihood of adverse events after discharge. These medications are warfarin, insulin, digoxin, and aspirin when used in combination with clopidogrel. Patients on five or more medications (scheduled, not as needed) are at increased risk of adverse event after discharge. With an increasing number of medications, adherence also decreases (Budnitz et al., 2006; Budnitz, Shehab, Kegler & Richards, 2007; Coleman, Smith, Raha, & Min, 2005; Forster et al., 2004; Forster et al., 2005; Forster, Murff, Peterson, Gandhi, & Bates, 2005; Oake, Fergusson, Forster, & van Walraven, 2007).

Allaudeen, Vidyarthi, Maselli, and Auerbach, (2011) identified readmission risk factors for general medicine patients. The 30 day readmission rate was 17.0% (Allaudeen et al., 2010). In multivariate analysis, factors associated with readmission included black race (odds ratio [OR], 1.43; 95% confidence interval [CI], 1.24–1.65), inpatient use of narcotics (1.33; 1.16–1.53) and corticosteroids (1.24; 1.09–1.42), and the disease states of cancer (with metastasis

1.61; 1.33–1.95; without metastasis 1.95; 1.54–2.47), renal failure (1.19; 1.05–1.36), congestive heart failure (1.30; 1.09–1.56), and weight loss (1.26; 1.09–1.47) (Allaudeen et al, 2010).

Research by Joynt, Oray, and Jha (2011), examined hospital characteristics associated with readmissions. Several factors were noted to be associated with increased readmission rates for patients with CHF. These included being discharged from a publically owned hospital in a county with low median income, a hospital lacking cardiac services, small hospitals and units with lower nursing staffing (Joynt, et al, 2011).

### **Interventions performed prior to discharge that decreased readmissions**

**Early discharge planning.** Studies referred to preparing the patient for discharge early in the hospitalization (Cohen, McGregor, Ivanova, & Kinkaid, 2012; Desai & Konstam, 2012; Holland et al., 2006; McCorkle, et al., 2011; Silow-Carroll et al., 2011). Most agreed, the earlier discharge planning is addressed the better the transitional outcomes. Discharge planning can start as early as 24 hours after admission (Cohen et al., 2006; McCorkle et al., 2011). Writing the anticipated discharge date in the hospital room early offers more opportunities for the patient and family to be involved in discharge planning (McCorkle et al., 2011). Outcomes are better when patients are encouraged to take a more active role in discharge planning and are encouraged to assert their preferences (O'Reilly, 2011).

**Case management.** Studies suggested case management is important in decreasing readmissions (Fabbre, Buffington, Altfeld, Shier, & Golden, 2011; Naylor, et al., 2012; Watkins, Hall, & Kring, 2012). A case manager is often a nurse that provides transitional care incorporating standardize procedures. Social workers were also mentioned (Fabbre et al., 2011; Naylor et al., 2012; O'Reilly, 2011; Watkins et al., 2012). Readmissions decrease when case managers begin the discharge process early and give more opportunities for patient and family to be involved. Case managers counsel patients and explain each piece of paper given to them and write the discharge plan down for them so they can understand it (Naylor et al., 2012; Watkins et al., 2012). A role of the case manager is to perform patient level medication reconciliation prior to discharge (Fabbre et al., 2011; Naylor & McCauley, 1999; Naylor et al., 2012). A home health nurse can act as a case manager (Foust, Vuckovic & Henriquez, 2012). A pharmacist review of the medication lists by a case manager may help identify omitted or indicated medications prior to discharge (LaMantia, et al., 2010).

**Education.** Education is another key intervention for reducing unnecessary readmissions (Baker et al., 2002; Gazmararian et al., 1999; Gazmararian et al., 2003; Williams, et al., 1995). It is recommended to use the teach-back method to ensure patients understand discharge plans (Baker et al., 2002; Cloonan, Wood, & Riley, 2013; Gazmararian et al., 2003; Mayeaux et al., 1996). Patient education should be enforced daily and per Medicare mandate, discharge plans of patients over 65 are in writing (Cloonan et al., 2013; Naylor & McCauley, 1999; Piraino, Heckman, Glenny & Stolee, 2012).

**Tools.** A patient booklet is used to by faith based nurses to encourage self-management and collect personalized care records, medication lists, appointments, emergency plan, contact information, 30 and 60 day plans, and illness specific information (Ziebarth, 2014b). A check off

list is used by hospitalist 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 et al., 2006).

**Collaboration.** Collaborative hospital-clinic partnerships are encouraged. Information sharing through electronic medical records access is important between attending physician and hospital staff (Coleman, 2010; Hernandez, et al., 2010; Osei-Anto, 2010). Clinics block out appointments so patients can see a doctor in a timely manner (Coleman, 2010; Hernandez et al., 2010; Naylor, Aiken, Kurtzman, Olds, Hirschman, 2011). A follow up appointment is made and written in the patient's booklet prior to discharge (Osei-Anto, 2010; Ziebarth, 2014b).

**Diverse community.** Studies looked at interventions such as transitional management programs that started in the hospital and follow patients into the home with calls and/or visits from nurses (Ahmad, Metlay, Barg, Henderson, & Werner, 2013; Fabbre et al., 2010; Foust et al., 2012; Naylor & McCauley, 1999; Naylor et al., 2012). Jack et al., (2009) addressed the particular needs of diverse communities in an inner-city safety-net hospital. The intervention was a "Discharge Advocate," who assisted with patient discharge preparation, medication reconciliation, national guideline adherence, and obtaining aftercare appointments. A low literacy pictorial patient care plan was used with a follow-up phone call from a clinical pharmacist approximately 3-4 days after discharge is routine. This intervention resulted in a 30% decrease in the combined endpoint of readmission and emergency department visits (Jack et al., 2009).

### **Interventions After Discharge That Aided In Decreasing Hospital Readmissions**

**Follow-up.** Follow-up calls are made to patients by hospital staff anywhere from 1-7 days after discharge (Dudas, Bookwalter, Kerr, & Pantilat, 2001; Jha, Orav & Epstein, 2009; Naylor et al., 1999). A follow-up phone call is described as medication questions, general info, and follow-up with physician information (Dudas et al., 2001).

**Clinic visit.** A chronic care clinic has an active role in transitional care post discharge in one study. Care consisted of standardized assessments; visits with the primary care physician, nurse, and clinical pharmacist; and a group education/peer support meeting (Wagner et al., 2001). The post hospital follow-up clinic visit presented a critical opportunity to address the conditions that precipitated the hospitalization and prepared the patient and family caregiver for self-care activities (Wagner et al., 2001; Coleman, 2010). Patient skill-building and ongoing monitoring by the health care team of diagnostic tests and services as well as treatment paths helped to promote confidence and enhance safety of chronic patient management at home (Hernandez et al., 2010).

**Telehealth.** Telehealth technology allowed for remote monitoring of patients that require higher levels of care (Bowles et al., 2011; Looman et al., 2013; Rich et al., 1995). More complex types of home telehealth devices have video capabilities that allow for visual contact with the patient and/or remote biometric measurements, such as weight, blood pressure, pulse, temperature, pulse oximetry, electrocardiogram and blood glucose. Other devices can also include medication reminders and motion and position detectors (Looman et al., 2013).

## **Transitional Care Programs Provide Hospital and Follow-Up Home Visits.**

**Community-based nurses.** Naylor et al. (2011) found that comprehensive medication reconciliation and management, along with support services for patient self-management, are key components of nearly all nurse-led transitional care models. Nurses in the community coach patients through transition. Coaching patients and their caregivers during care transitions ensures that discharge education is revisited, and needs are met, which reduces the rates of subsequent hospital readmissions (Conley, et al., 2011; Hennessey, Suter, & Harrison, 2010; Jha et al., 2009; Marek, Adams, Stetzer, Popejoy, & Rantz, 2010; Naylor et al., 1999; Piraino et al., 2012). Chronically ill patients that were coached had more primary care visits, but significantly fewer specialty and emergency room visits (Morales-Asencio, et al., 2010).

Collaborative hospital-community partnerships address whole health care and may improve the patient's discharge experience, ensure post-discharge support and reduce re-hospitalization of patients (Carson, 2002; Hennessey et al., 2010; Marek et al., 2010; Nelson, 2000; Rydholm, 1997; Rydholm & Thornquist, 2005; Rydholm et al., 2008; Schumacher, Jones, & Meleis, 1999; Ziebarth & Campbell 2014). Faith community nurses effectively assist older persons to obtain needed health care often preventing crisis care or readmissions. They also help older persons link to community long-term care services such as chore service and meals-on-wheels, and to access information resources such as free prescription medications for low-income individuals. Faith community nurses provide emotional and spiritual support for anxious and isolated elders (Rydholm et al., 2008).

### **Next Steps: Testing a Faith Community Nurse Transitional Care Model for Readmission Reduction**

The Church Health Center provides hospitals a solution that involves partnering with faith community nurses and faith communities. Church Health Center (CHC) is a non-for profit organization that cares for the needs of the most fragile in Memphis. They do this through various programming such as medical and dental clinics and wellness activities. In addition, they house the International Parish Nurse Resource Center (IPNRC). The IPNRC seeks to provide critical support and resources to Faith Community Nurses.

It is estimated, that 15,000 faith community nurses serve in a variety of faith settings including synagogues, temples and mosques around the United States and in 23 countries (IPNRC, 2010). In 1998, the American Nurses Association recognized Parish Nursing as a specialty and partnered to publish the first Scope and Standards of Parish Nursing Practice (American Nurses Association & Health Ministry Association, 1998). In 2005, the title changed from Parish Nursing to Faith Community Nursing and the Faith Community Nursing Scope and Standards of Practice was published; followed by a 2<sup>nd</sup> editions in 2010 (ANA & HMA, 2005, 2010). The American Credentialing Center of Nursing recognized Faith Community Nursing as a specialty in 2014 by offering a Faith Community Nurse Board Certificate through portfolio validation.

The Faith Community Nurse Transitional Care Program was created through an effort between the CHC and IPNRC. The program seeks to enhance the patient's experience of

transition from one level of care to another by encouraging collaboration between the hospital and faith community. The program goals are to (a) endorse whole health by using faith community nurses and faith communities to provide transitional care, (b) enhance patient discharge experience from hospital to home, (c) engage patients in their care (by increasing self-efficacy and positive health outcomes, and eliminating unnecessary hospital admissions), and (d) encourage collaboration and shared visioning between health care institutions and faith communities (Ziebarth & Campbell, 2014).

It is a well-known fact that nurses have been used successfully to provide community-based transitional support for patients (Naylor et al, 2004; Naylor, 2011). The use of a faith community nurse to provide transitional support does two things; first, it provides a whole health approach to care and second, adds the additional support of a “faith community support team”. Faith community nurses in a transitional care program are trained experienced registered nurses with additional education to do care-coordination and to incorporate spiritual related interventions. Patients that are cared for by nurses without this specialty training may experience a restrictive range of assessment and interventions that prohibit a person with the adaptive process of attaining or maintaining whole health care (Cavan Frisch, 2001).

**Program details.** In this program, the hospital either hires a full-time faith community nurse or partners with a faith community that has a faith community nurse. The nurse attends the Faith Community Nursing Foundation’s Course (IPNRC, 2009) and goes through a specialized training program. The goal of this training is to “...provide practical education and resources that will equip faith community nurses for transitional care practice” (Ziebarth & Campbell, 2014, p.2). The training contains a review of assessment skills, disease management, and documentation. In addition, four Faith Community Nursing Standards are explored: Leadership Standard#12, Communication Standard#11, Collaboration Standard #13, and Coordination of Care # 5A (Ziebarth & Campbell, 2014a). The nurse is also given training to facilitate development of a volunteer program in a faith community to extend their transitional support of the patient. Volunteers help patients in their home through ministerial support such as meals, transportation, cards, and visitation.

The hospital determines the criteria of how patients are chosen to be seen. When the faith community nurse receives the referral, the nurse makes an initial hospital visit prior to discharge with the patient, discharge planner, and family/caregiver. A patient discharge booklet: “Taking Care of Myself” (Ziebarth, 2014b) is completed with vital information that contains medications, doctor’s visits, contact information, emergency plan, and 30 and 60 day goals. The first home visit by the faith community nurse usually occurs within 48 hours of discharge. Visits include medication review, screenings (vitals), 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. Arrangement of the “faith community support team” is according to patient and caregiver’s needs. Length of transitional services provided by the Faith Community Nurse is pre-determined by diagnoses and program outcomes, but generally, will not exceed 60 days. There is no cost to patients receiving the service.

## **Faith Community Nurse Transitional Care Program Research Study**

The CHC has received IRB approval to examine data collected from hospitals. A quasi-experiment may identify how effective the faith community nurse transitional program is in decreasing hospital readmission and emergency room visits among patients. A control group will be patients who have similar disease profiles and hospitalization experiences (preexisting data) but do not participate in the program. Another research study proposed is a qualitative secondary data analysis of faith community nursing documentation to describe transitional care interventions.

### **Discussion**

Through a systematic integrative review, 62 articles were collected, compared, and combined using a descriptive matrix to develop a conclusion about the information. Factors that lead to readmissions are similar in relation to disease and patient variables but vary non-clinically. In examining disease variables, certain conditions such as physical and/or psychological illnesses increased risks for readmissions. Chronic diseases such as heart failure, COPD, diabetes mellitus, cancer, stroke and/or psychosis, depression, and lower mental health status had the highest risks. Readmission risks increased if the patient had more than five medications. In addition, some medications increased the likelihood of adverse events. Patient variables leading to increased readmissions included Medicare and Medicaid payer status, markers of frailty and elderly with complex medical, social and financial needs. A lack of social support, poor health literacy, and inability to navigate the health care system were non-clinical needs leading to readmissions. Hospitals that are resource poor financial or clinical and public owned have higher readmission rates. Higher satisfaction with access to emergency care also indicated higher risk.

Methods or interventions leading to decreased readmissions were divided into “before” and “after” discharge. Before discharge, early discharge planning, case management, self-management, medication education, and standardized tools were interventions to deter readmissions. Early discharge planning provided more opportunities for patient and family to be involved. Case managers performed key leadership roles to initiate specialized transitional care. When educating patients with poor literacy, a teach-back method was preferred. Collaboration with clinics and physician offices meant obtaining aftercare appointments and sharing records.

Transitional management programs started in the hospital and followed patients into the home with calls and/or visits. Interventions included follow-up calls, clinic visits, telehealth, and nurse-led transitional care programs. Clinic visits provided access to the physician, staff, standardized assessments, and treatment paths, while telehealth devices allowed for remote monitoring of a patient. Advanced practice nurses, faith community nurses, and other non-nurses were used successfully to coach patients after discharge. Comprehensive medication reconciliation and management, along with education for patient self-management, were key components of nearly all nurse-led transitional care model; so to with the new Faith Community Nurse Transitional Care Program. This model has the potential to serve as an innovative approach to readmission reduction through collaborations with faith community nurses and faith communities.

Based on this systematic integrative review and matrix analysis, the Faith Community Nurse Transitional Care Program was described and met many of the criteria for decreasing readmission identified in the literature. The program may provide a needed service to decrease readmissions. As a recognized interdisciplinary team member, the faith community nurse case-manages patients before, during and after discharge providing structured visits, education, medication reconciliation, and decision-making support. In addition, a faith community nurse provides interventions that integrate the adaptive process of attaining or maintaining whole health care. Volunteers from a faith community can provide social supports for the patient and caregiver. The faith community may also share in the cost and management of a faith community nurse.

Implications of this systematic integrative review are that hospitals are encouraged to explore efficient methods of decreasing avoidable re-admissions. Hospitals are aware of predictor variables for readmission and need to initiate appropriate evidence-based interventions. Hospitals should consider interventions that integrate the adaptive process of attaining or maintaining whole health care.

Further research is recommended in the area of community-based nursing interventions that impact readmissions rates; particularly in diverse communities. A secondary data analysis may provide a description of faith community nursing interventions that decrease readmissions. In addition, investigating how interventions affect health outcomes, including hospital readmission and emergency room visits among those discharged patients, may be helpful. Transitional care research is lacking in the area of how spirituality or whole health care impacts transitions from hospital to home. Limitations of the systematic reviews included the lack of true meta-analyses, which is quantitative in nature to test the pooled data for statistical significance. Rather, this systematic integrative review focused on collecting, comparing, and combining similar concepts using a descriptive matrix.

## **Conclusion**

A systematic integrative review process identified factors that increased and reduced hospital readmissions. The key findings revealed that certain diseases, patients, and non-clinical variables can predict risks for readmission. Interventions done before discharge and after discharge can impact hospital to home transitions and readmissions. A new Faith Community Nurse Transition Care Program was described that included interventions that were found to decrease readmission as identified in the literature. The purpose of the program is to provide whole health care transitional support to improve the discharge experience, ensure post-discharge support and reduce re-hospitalization of patients.

The systematic integrative review was done to provide the underpinnings for the Faith Community Nurse Transition Care Program. In addition, the review was done in preparation for a research study that aims to describe faith community nurse transitional care and interventions used. After faith community transition care is defined, a study to test the intervention and the impact of health outcomes among discharged patients from the hospital is planned.

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