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Describing Transitional Care Using the Nursing Intervention Classification: Faith Community Nursing

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Faith Community Nursing

Specific nursing interventions provided during the patient's transition from hospital to home, may reduce unnecessary readmissions of Medicare patients (Cubanski & Neuman, 2010; Naylor, Kurtzman, Grabowski, Harrington, McClellan & Reinhard, 2012, Ziebarth, 2015). Faith community nurses (FCN) are providing transitional care for hospitalized patients yet there is limited research in nursing literature. The aim of this study is to describe transitional care as implemented by (FCN).

Hospital readmissions affect over 80 percent of all Medicare enrollees (Stone et al, 2010). Nearly one-fifth of Medicare patients discharged from the hospital are readmitted within 30 days. Furthermore, three-quarters of these readmissions, costing an estimated $12 billion a year, are considered potentially preventable, especially with improved care during transitions from hospital to home (Burton, 2012). Hospitals have a responsibility to their Medicare patients to explore ways to keep them well after discharge in their homes (Page, 2004; Pham, Grossman, Cohen & Bodenheimer, 2008; Berry, Hall, Kuo, Cohen, Agrawal, Feudtner & Neff, 2011). One of the strategies to decrease Medicare spending outlined in the Patient Protection and Affordable Care Act (PPACA) is reductions in hospital readmissions (Cutler, Davis, & Stremikis, 2010; Cauchi, 2012). The Independent Payment Advisory Board (IPAB) created the Continuity Assessment Record and Evaluation Medicare Tool to measure the health and functional status of Medicare patients at acute discharge and determines payment reimbursement for hospital readmissions of less than 60 days (Smith, Deutsch, Hand, Etlinger, Ross, Abbat et al & Gage, 2012). The IPAB is requiring hospitals to pay more while decreasing payment reimbursements (Stone et al, 2010). Payment penalties began in October 2012 for hospitals subject to the Inpatient Prospective Payment System (IPPS). Hospitals lose 3% of every Medicare payment if

the hospital has an excessive three-day readmission for three specific diagnosis: acute myocardium infraction, congestive heart failure, and pneumonia for 2014 readmissions (Centers for Medicare & Medicaid, 2015). In 2015 exacerbation of chronic obstructive pulmonary disease, total hip and knee arthroplasty were added as additional diagnosis to measure hospital performance. In 2017, coronary artery bypass surgery was added (Centers for Medicare & Medicaid, 2015). These changes in the Medicare reimbursement model have precipitated the need for hospitals to seek efficient methods of decreasing avoidable readmissions when patients return to the hospital soon after their previous stay. The rate of avoidable readmission can be reduced by improving transitional care for patients out of the hospital to their homes (Boutwell & Hwu, 2009; Burke, Kripalani, Vasilevskis, & Schnipper, 2013).

Purpose of the Study

This article presents findings of a descriptive analysis conducted on de-identified intervention data prospectively captured from the FCN's documentation of transitional care. The purpose of this analysis was two-fold: 1) to describe transitional care as implemented by FCNs using a standardized nursing language, Nursing Intervention Classification (NIC) and 2) to compare the FCN's transitional care interventions to those considered to be evidenced-based transitional care in published research. This description of transitional care as implemented by FCNs will provide additional insight into what interventions are most implemented during transitional care.

Background

Population Health and Transitional Care Interventions

Rising healthcare costs and the impact of penalties from IPPS have fueled the movement to address readmissions (Care, 2012; Wasfy, et al., 2017; Zuckerman, Sheingold, Orav, Ruhter,

& Epstein, 2016). Two levels of efforts for reducing readmission rates have been the focus among health care systems, population health and targeted interventions (Trinh-Shevrin, Nadkarni, Park, Islam, & Kwon, 2015). The population health level focus on the characteristics of high risk population and changing systems of care through partnerships (Stoto, 2013; Trinh-Shevrin, Nadkarni, Park, Islam, & Kwon, 2015;), policy (Birmingham & Oglesby, 2018), and at the same time, interventions are employed that specifically address needs and contextual factors of specific groups within this population (Boccuti & Casillas, 2015; Trinh-Shevrin, Nadkarni, Park, Islam, & Kwon, 2015). Population health focus considerers "health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig, & Stoddart, 2003, p. 381). Interventions are focused beyond medical care for these populations to allay the impact of contextual factors that may contribute to a re-hospitalization, such as geographic location, social connections, socio-economic levels and patient behaviors (Ahmad, et al. 2013; Hesselink, et al., 2014; Kindig, & Stoddart, 2003; Leppin, et al., 2014). In fact, the success of targeted interventions has led to the availability of payment to practitioners for providing targeted care toward the reducing readmissions among at-risk patient populations (Verhaegh, et al., 2014) Many studies point to the most effective of these targeted interventions address a variety of factors that lead to hospital readmission (Burns, Galbraith, Ross-Degnan, & Balaban, 2014; Hesselink, et al., 2014; Leppin, et al., 2014).

Factors that lead to hospital readmissions and interventions that reduce them was explored through a review of literature (Ziebarth, 2015). This exploration is important because patients that have factors that may predispose them for readmission, targeted interventions can be targeted to reduce readmission. Key findings were divided into three distinct groupings:

- Factors that lead to hospital readmissions,

- Interventions that decreased readmissions prior to hospital discharge, and

- Interventions that decreased readmissions post discharge or after hospitalization.

Factors that lead to hospital readmissions

Predictive factors of hospital readmissions were identified 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. Predictive factors of hospital readmissions give direction in identifying those patients most at-risk so that they may receive additional services in the hospital.

Interventions that decreased readmissions prior to hospital discharge

Interventions that decreased readmissions prior to hospital discharge included: preparing the patient for discharge early in the hospitalization, having hospital employees designated to transitional care, patient education, use of a patient booklet to encourage self-management, and a check-off list used by hospitalist prior to discharge to ensure readiness for discharge. Other tools mentioned were electronic in nature to promote cross-site communication between attending physician and hospital staff.

Interventions that decreased readmissions post discharge or after hospitalization

Interventions that decreased readmissions post discharge or after hospitalization were identified as follow-up phone calls, follow-up clinic visit, and remote monitoring with telehealth technology for patients that require higher levels of care.

Nurses role in transitional care

Naylor and colleagues defined transitional care as "A broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another. The hallmarks of transitional care is the focus on highly vulnerable, chronically ill patients throughout critical transitions in health and health care, the time-limited nature of services, and the emphasis on educating patients and family caregivers to address root causes of poor outcomes and avoid preventable hospitalizations" (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011, p. 747). Comprehensive medication reconciliation and management, along with 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. Being present with patients and their caregivers in the community during care transitions ensured that discharge education was revisited, and needs were met, which reduced the rates of subsequent hospital readmissions (Naylor & McCauley1999; Jha, Oravet et al, 2009; Marek, Adams et al, 2010; Hennessey, Suter et al, 2010; Conley et al, 2011; Piraino, Heckman et al, 2012).

The FCN role in transitional care

Some hospitals use FCN programs with the goal of decreasing readmission rates.

Collaborative hospital-faith community partnerships address whole health care, including spiritual care, and may improve the patient's discharge experience, ensure post-discharge support and reduce re-hospitalization of patients (Rydholm, 1997; Schumacher, Jones et al, 1999; Nelson, 2000; Carson, 2002; Rydholm & Thornquist, 2005; McGinnis & Zoske, 2008; Marek, Adams et al, 2010; Hennessey, Suter et al, 2010). The FCN effectively assist older persons to obtain needed health care often preventing crisis or readmissions. They also help older persons link to community long-term support care services such as chore service and meals-on-wheels, and to access information resources such as free prescription medications for low-income individuals. The FCN provides emotional and spiritual support for anxious and isolated elders (Rydholm, 1997; Carson, 2002; Rydholm & Thornquist, 2005, Smucker & Weinberg, 2009; King & Pappas-Rogich, 2011).

Ziebarth, (2014a) states that the definition and conceptual model of Faith Community Nursing may be beneficial to researchers to study practice effectiveness and to create applications for practice. The conceptual model of Faith Community Nursing helps to define and clarify the practice of the FCN and outcomes. See Figure 1: Conceptual Model: Faith Community Nursing. The practice of Faith Community Nursing is described theoretically as:

> "…a method of healthcare delivery that is centered in a relationship between the nurse and client (client as person, family, group, or community). The relationship occurs in an iterative motion over time when the client seeks or is targeted for wholistic health care with the goal of optimal wholistic health functioning. Faith integrating is a continuous occurring attribute. Health promoting, disease managing, coordinating, empowering, and accessing health care 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, 2014b, p

1829).

Faith integrating, health promoting, disease managing, coordinating, empowering, and

accessing health care are essential attributes that operationalize the concept of Faith Community

Nursing. See Table One: Essential Attributes. Faith Community Nursing Manifested (N=124

pieces of literature).

Since FCNs are recognized as a source of primary health care and have additional

training to provide spirtual care, implementing transitional care interventions may look different.

Patients may experience a range of assessments and interventions that considers wholistic health

needs. The FCN may ask questions like "What sustains you during difficult times?" or "Does

your religious or spiritual beliefs influence the way you look at your disease and the way you

think about your health?" (Ziebarth, 2014b). The FCN may use presence or prayer in providing

transitional care. Transitional care interventions rendered by a FCN may elicit an adaptive

response of attaining or maintaining wholistic health functioning.

Research Questions

The questions are:

1. What nursing interventions are provided by FCN during transitional care?

2. Which nursing interventions are implemented the most frequently by FCN during transitional

   care?

3. How does transitional care interventions compare to evidence-based transitional care

   interventions?

Research Design

A mixed method descriptive design was used to describe transitional care interventions as implemented by FCNs. A qualitative descriptive design is often used as a first step towards improving practice by providing evidence to support the fact that certain variables exist and that they have construct validity (agreement) (Maxwell, 2012). Norma Lang has stated, "If we cannot name it, we cannot control it, practice it, teach it, finance it, or put it into public policy" (Wake, Murphy, Affara, Lang, Clark & Mortensen, 1993, p. 109). A qualitative descriptive method operationalized the concepts regarding transitional care interventions performed by FCNs. A quantitative descriptive design was used to count nominal categories of documented nursing interventions.

Setting and Sample

Data was obtained through a collaboration between a community hospital in Jasper, Indiana and a health center. The health center, has a "business associate" contract with the employing hospital to collect nursing intervention documentation data for research purposes. The Privacy Rule portion of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 defines a "business associate" as a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information (PHI) on behalf of, or provides services to, a covered entity (U.S. Department of Health and Human Services' Office for Civil Rights, 2003). The rule requires that a covered entity obtain satisfactory assurance in writing in the form of a contract from their business associates of their commitment to appropriately safeguard PHI. The documentation collected had no patient identifiers.

The health center organization houses a resource center, which provides curriculum, education, and practice resources for FCNs. The health center host the Westberg Symposium,

which serves as the annual research conference for FCNs. The study participants' employing hospital had a business agreement with the health center. For this study, the hospital shared 24 months of the FCN's anonymized documentation with a PhD prepared nurse employed by the health center.

Protection

Prior to the study being initiated, ethical approval was obtained from the Internal Review Board at the University of Memphis, Tennessee. There was minimal risk to participants who were adults, registered nurses, and practicing FCNs. They attended both training for faith community nursing and transitional care.

Faith Community Nurse Foundation's Course

Each study participant attended the Faith Community Nurse Foundation's Course. The course was designed to introduce and prepare registered nurses for the specialty practice of faith community nursing (IPNRC, 2014: Jacob, 2014). The current version (2014) has 19 module authors and 10 reviewers, all considered experts in the field. Module authors represent the practice in a variety of roles, from educator, coordinator, to faith community practicing. Module authors revised the modules based on assessment results and latest scientific evidence related to their topics. The modules are divided into the units of spirituality, professionalism, wholistic health, and community. The total contact hours is 38 to 40.5. This curriculum is taught across the United States and worldwide. It is estimated that 15,000 nurses have taken the course (IPNRC, 2010).

Faith Community Nurse Transitional Care Education Program

In addition to the Foundation's course, the study participants attended the Faith Community Nurse Transitional Care education program. This occurred prior to the study. The

aim of this program is to provide practical education and resources that will equip FCNs for transitional care practice (Ziebarth & Campbell, 2014). The goals of the program are to a) use FCNs and faith communities together to provide transitional care, b) enhance patient discharge experience from hospital to home, c) engage patients in their care; therefore increasing self-efficacy and positive health outcomes, d) eliminate unnecessary hospital admissions, and e) encourage collaboration and shared visioning between health care institutions and faith communities. In addition, a model of transitional care is shared (Figure 2: Faith Community Nurse Transitional Care Model, Ziebarth & Campbell, 2016).

Resources such as: Faith Community Nurse Visitation Guidelines (Ziebarth, 2017a), Taking Care of Myself (Ziebarth, 2014b), and a program brochure are available to participants to use in their contact with the patient. The booklet, Volunteer Program Development: For Faith Communities (Ziebarth, 2017b), previously titled, Tools for Developing and Sustaining a Faith Community Volunteer Ministry Group, is offered to participants to guide them in their contact with faith communities.

Documentation

Participants used the Henry Ford Macomb's electronic tool (Girard, 2013) to document nursing interventions. It was developed for the faith community nursing practice using the NIC format to describe nursing interventions. The Henry Ford Health System in Michigan, developed a password-protected website documentation system for FCNs (Brown, 2006). It is used by over 500 FCNs in 22 states (Yeaworth & Sailors, 2014). The NIC is embedded to capture nursing interventions. Creators chose the NIC over other standardized languages, because the Henry Ford Health System uses Cerner. Cerner is an information system vendor that uses the taxonomies of NANDA, NIC and NOC for nursing documentation (Frederick & Watters, 2003).

The latest edition of NIC includes 13,000 activities that nurses do on behalf of patients, both independent and collaborative, both direct and indirect care (Bulechek, Butcher, Dochterman et al, 2013). A NIC intervention is aligned to these activities to enhance patient outcomes, based upon clinical judgment and knowledge (Bulechek et al, 2013). The 554 interventions in the NIC (6th ed.) taxonomy are grouped into thirty classes and seven domains (Bulechek et al, 2013). An intent of the NIC structure is to make it easier for a nurse to select an intervention for the situation, and to use a computer to describe the intervention in terms of standardized labels for classes and domains (Bulechek et al, 2013).

Handling of the Documentation

Patient visits were provided by the FCN either in person or by phone. The Henry Forbes McCombs (HFM) program contains a list of individual nursing interventions as defined by the Nursing Intervention Classification (NIC) that are easily accessible for selection in an electronic format. The NIC was chosen as the standardized nursing language to describe transitional care as facilitated by FCNs. It was chosen because there has been previous testing in the area of faith community nursing using the NIC (Weis, Schank, Coenen et al, 2002; Burkhart et al., 2004; Solari-Twadell, 2006; Solari-Twadell et al, 2010, Ziebarth, 2016b).

The FCNs in this study entered nursing interventions into the electronic HFM documentation program by selecting the NICs from a programmed list of options. In addition, some FCNs documented interventions narratively in a nursing note. A total of 986 nurse documentation records were analyzed. The FCNs documented an average of 6.4 interventions for each patient visit. FCNs occasionally visited more than one person at a time (N=43). A total of 1556 nursing interventions were documented.

A PhD-prepared nurse employed by CH collected the FCN documentation from the hospital. This PhD-prepared nurse removed any identifying information from the data before transmitting data to the researcher in two forms: 1) a list of NICs and 2) nursing notes. Both were transmitted in Microsoft Excel® format through an encrypted email system. Data were then downloaded onto a password protected Universal Serial Bus (USB) drive. When not in use, the USB drive was secured in a locked drawer in a locked office.

Analysis of the Data

In a previous study (Ziebarth, 2016b), the Nursing Intervention Classification Analysis Program (NICAP) (Lane, 2015) was used to align thematic themes, which were nursing interventions, into the thirty Classes of NIC. This data management program provides the capacity to collect and organize large numbers of individual nursing interventions into a manageable database for the ease of analysis.

In preparation for NIC collection, analysis, and translation (Ziebarth, 2018), 554 non-duplicated NICs (6th Ed.) (Bulechek et al, 2013) and 91 duplications (n= 645) were manually entered into the NICAP. Duplications occur in NIC when interventions are repeated in more than one Class. Each nursing intervention in NIC entered had its own identifying numerical code (n=645) and definition (n= 554). In addition, the 30 Classes and seven Domains of NIC were entered, along with definitions, and programed to align to nursing interventions. All NICs documented electronically by FCNs were entered into the NICAP.

Nursing interventions were also documented in nursing notes which were analyzed thematically using data reduction, interpretation, and translation. The data were reduced when nursing intervention descriptors were underlined electronically. Interpretation occurred when Microsoft Word® computer generated highlighted colors were used to categorize similar nursing

intervention descriptors. The nursing interventions descriptors were then translated into NICs. Care was taken to make sure duplication of NICs did not occur.

Findings

Out of the 554 possible nursing interventions, 40 were reported to have been used with some frequency. A total of 1556 interventions were documented. Table 2 highlights a list of the 32 NICs that describe the bulk of transitional care interventions provided by FCNs. The numeric codes, to the left of the nursing intervention in Table 2, and the definitions to the right, were provided by the Iowa Intervention Project Research Team (Tripp-Reimer, Woodworth, McCloskey, & Bulechek, 1996). The numeric codes were created in NIC to facilitate use in electronic information systems (Bulechek et al, 2013).

A NIC Class contains a standardized group of intervention representing various nursing activities. A few interventions are located in more than one Class but each has a unique numeric code that represents the primary Class (Bulechek et al, 2013, p 2). Chart 1 contains the 17 Classes out of 30 documented by the FCNs. The most frequent Classes of NIC were Coping Assistance, Communication Enhancement, Patient Education, Information Management, Health System Mediation, Physical Comfort Promotion, Lifespan Care, Behavioral Therapy, Activity and Exercise Management, Cognitive Therapy, Tissue Perfusion Management, Self-Care Facilitation, Drug Management, Nutrition Support, and Community Health Promotion. The three Classes containing the most frequently reported interventions were Coping Assistance, Communication Enhancement, and Patient Education.

The NIC Domains contain the Classes in which nursing interventions are aligned. Chart 2 contains the Domains documented by FCNs. The NICs documented by FCNs were found in all seven Domains, although there was only one intervention documented in the Community Health

Promotion Domain as expected. The majority of interventions used while FCNs provided transitional care belonged to the Behavioral Domain (1376).

The Behavioral Domain defined as "Care that supports psychosocial functioning and facilitates life-style changes" (Bulechek et al, 2013, p.40). The Behavioral Domain includes Classes of interventions such as Coping Assistance, Communication Enhancement and Patient Education. The Class of Communication Enhancement was most often used with Patient Education and Coping Assistance also frequently used. See Table 3: Behavioral Domain with Classes and NICs Documented by FCNs.

The second most prominent Domain represented by FCN's transitional care interventions was that of Health System, which is defined as "Care that supports effective use of the health care delivery system" (Bulechek et al, 2013, p.40). The third domain identified as significant was <u>Safety</u>. The Safety Domain is defined as "Care that supports protection against harm" (Bulechek et al, 2013, p.40). The fourth prominent Domain was <u>Physiological: Basic</u>. Physiological: Basic is defined as care that supports physical functioning" (Bulechek et al, 2013, p.40). It contains the Classes of Physical Comfort Promotion and Nutrition Support.

The Domain of Family was fifth and the Domain of Physiological: Complex was sixth. The Family Domain is defined as "Care that supports the family unit" (Bulechek et al, 2013, p.40). The Physiological: Complex Domain is defined as "Care that supports homeostatic regulation" (Bulechek et al, 2013, p.40).

There was only one interventions selected in the Community Domain. The Community Domain represents those activities that occur in the community such as support group, health screenings, and meetings. Since many of transitional care interventions are done with the patient and caregivers directly and during a specific time period, one would not expect the need for

community on-going activities. Community interventions maybe helpful in keeping patients well in their home and reducing unnecessary hospitalizations.

Relationship of the Study Results to Transitional Care Research

This study's results indicate that FCNs provided similar activities to those found in the literature review that were identified as important for successful transitional care. This comparison is included in Table 4. Additionally, FCNs provided "other" interventions, such as spiritual and emotional support. This finding of "other" nursing interventions is consistent with other faith community nursing research studies that found that FCNs provide emotional and spiritual support for anxious and isolated elders as they prevent crisis care or hospital readmissions (Rydholm, Moone, Thornquist et al., 2008).

In Table 4, Transitional Care NICs Aligned to Previous Transitional Care Research Interventions, column one displays nursing interventions found in research and used in transitional care to reduce hospital readmissions. Column two are NICs documented by the FCNs. Column three displays the NIC definitions, and Column four provides the number of potential activities each NIC represents. It is clear that FCNs provide a variety of evidence based "priority" transitional care nursing interventions as previously recorded by APRNs (Naylor et al 1999; 2004; 2011; 2012). These interventions include medication reconciliation, patient self-management support, caregiver support, care coordination and education interventions. This also aligns with previous studies (Verhaegh, et al, 2014; Leppin, et al, 2014; Hesselink, et al, 2014). In addition, the FCN provides emotional and spiritual support interventions.

The fact that, in addition to evidenced best practice transitional care interventions, FCNs provided emotional and spiritual support interventions is important for several reasons: 1) Patients may seek out healthcare providers that include emotional and spiritual support

interventions. Previous research suggests that clients living with chronic illness desired not only symptom management but also wholistic approaches that addressed coping strategies for emotional and spiritual needs (Dyess, 2010). 2) Supporting the patient's spiritual needs may help them to cope better with their illnesses, changes, and losses in life. The Joint Commission on Accreditation of Healthcare Organizations (2010), states that patients have specific characteristics and nonclinical needs that can affect the way they view, receive, and participate in health care. 3) Providing emotional and spiritual support interventions may reduce readmission. FCNs provided emotional and spiritual support for anxious and isolated elders to reduce hospital readmissions (Rydholm, Moone, Thornquist et al., 2008). 4) Transitional care interventions rendered by a FCN may elicit an adaptive response of attaining or maintaining wholistic health. Wholistic health 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" (Ziebarth, 2016, p 22). In summary, FCNs providing transitional care may help patients who seek wholistic health care approaches. These approaches may help patients cope better with illnesses, reduce readmission, and maintain or improve wholistic health. Further research in this area may have practice implications.

Implications

Implications: Nursing Practice

This study has implications for all of community-based nursing practice, most obviously, faith community nursing. The FCN is in a unique position to provide easily accessible health care services to specific populations because they are community based, working in or with faith communities. The study's results showed that while providing transitional care to discharged patients, FCNs (a) the interventions reflected could be described using the conceptual model of

Faith Community Nursing (Ziebarth, 2014a); (b) the study's participants provided evidenced-based transitional care interventions (Ziebarth, 2015). These interventions included follow-up calls, post clinic visit, and home visits. The transitional care nursing interventions performed with the patient were medication reconciliation, patient self-management support, caregiver support, and education; and (c) in addition to the transitional care interventions, "other" interventions were documented by FCNs. These included Coping Enhancement, Emotional Support, Spiritual Support, Hope Instillation, and Presence. This is consistent with other faith community nursing research and important for quality patient care. The FCN provides emotional and spiritual support for anxious and isolated elders (Rydholm, Moone, Thornquist et al., 2008). Dyess, (2010) found that clients living with chronic illness desired not only symptom management but also wholistic approaches that addressed coping strategies for emotional and spiritual needs. The FCN is recognized as a source of primary health care and has additional training to provide wholistic health care. Transitional care interventions rendered by a FCN may elicit an adaptive response of attaining or maintaining wholistic health. The implementation of transitional care interventions may look different in that in addition to providing evidence-based transitional care interventions, patients may experience a range of interventions addressing emotional and wholistic health needs. Hospitals and other health care organizations should consider the use of FCNs as an efficient and effective method for delivering transitional care. To comply with the Patient Protection and Affordable Care Act to reduce in-hospital readmissions, FCNs can provide the type of comprehensive care that can support improvement in discharge care and reduce the stress on the patient and caregivers during their most vulnerable time after discharge (Leppin, et al, 2014).

Implications: Nursing Education

As a source of transitional care support for hospital discharged patients transitioning from hospital to home and a credentialed specialty by the American Nurse Credentialing Center (Phipps, 2016), formal nursing education should consider inclusions of the FCN role as part of a population-based curriculum. Future nursing students need to have a working knowledge of what the faith community nursing core interventions are regarding transitional care and how they can work collaboratively with FCNs to effectively deliver quality patient care. This new knowledge should be included in faith community nursing education and subsequently effect the provision of quality nursing care to community clients.

Significance

The results of this study adds to the body of knowledge of faith community nursing regarding transitional care. Significant findings include: 1) There was limited knowledge about transitional care as implemented by FCNs. In a literature review of 62 articles describing transitional care, only two mentioned FCNs. 2) FCNs provide interventions recognized as evidence-based transitional care. 3) Results can provide the underpinnings for testing FCN transitional care interventions.

Conclusion

The purpose of this study was to describe transitional care as implemented by FCNs using a standardized nursing language, NIC. The findings suggested that the majority of interventions are in the coping assistance, communication enhancement, and patient education classes of the Behavioral Domain. In addition to evidence-based transitional care interventions, FCNs provided emotional and spiritual interventions. This is important as transitional care interventions rendered by a FCN may elicit an adaptive response of attaining or maintaining

wholistic health.

The findings offer insight regarding interventions performed by FCNs while providing transitional care to Medicare patients. This study was important because there was limited research exploring transitional care as provided by FCNs. Concepts such as faith integrating, disease managing, health promoting, coordinating, empowering, accessing health care (Ziebarth, 2014b) further describe the most frequently performed nursing interventions and that also have a role to play in reducing readmissions.

The findings will be helpful for FCNs, nursing educators, FCN program managers, community benefit program leaders, and health care administrators in understanding the nursing interventions performing transitional care. This study may ultimately provide the underpinnings for further research in the area of transitional care or the redesigning of the study to test with other situations of transitioning patients. It may contribute to the development of new training models, educational objectives and competencies to support successful transitional care from hospital to home. In addition, the NICAP's ability to reduce and manage large NIC datasets may support future nursing research.

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Table 1. Essential Attributes Faith Community Nursing Manifested N=124 (Ziebarth, 2014b).

Essential Attributes	Interventions from nurse to patient (Patient as person, family, group or community)
Faith Integrating	Intentional spiritual care and religious interventions: Presence, touch, spiritual and emotional support, prayer and meditation, spiritual growth facilitation, hope and forgiveness instillation, humor, faith related resources and referrals, showing compassion Integration of faith traditions: Aligned religious readings, scriptures, songs, music, etc. Cultural spiritual and religious activities: Communion, healing service, litany reading, etc. Spiritual health assessment
Disease Managing and Health Promoting	Management or surveillance Disease focused programming Disease counseling Disease resources Disease support services: Meals, transportation, calls, visits, cards, etc. Advocacy Primary, secondary and/or tertiary prevention activities Referrals (multidisciplinary and interdisciplinary) Symptom management Care planning Visits: Home, faith community, hospital, etc. End of life planning Assessment: Individual, family, faith community, community, etc. Care giver support
Coordinating	Recurring meetings: Health committee, social/community/global concerns, etc. Identification of barriers and strategies Ongoing activities: Volunteer training, support groups, CPR, community health events, screenings, education, articles, etc. Survey development and results utilization Referrals: Multidisciplinary and interdisciplinary, Health focused programming Documentation: Coordinating the health record, data collection, reports, etc. Care planning

Empowering	Capacity building Supporting Encouraging Self-efficacy activities Health Counseling Symptom management Health promoting education Health resourcing
Accessing Health Care	Health Referrals: Multidisciplinary and interdisciplinary Practicing within a health care team Providing health resources Education and assistance: How, when, where, and why to use the health care system Health support services: Meals, transportation, calls, visits, cards, babysitting, etc Assistance: Filling out forms, finding appropriate medical home,

Faith community nurses perform transitional care

Figure 1: Conceptual Model: Faith Community Nursing.

A Method of Wholistic Health Care Delivery (Ziebarth, 2014b).

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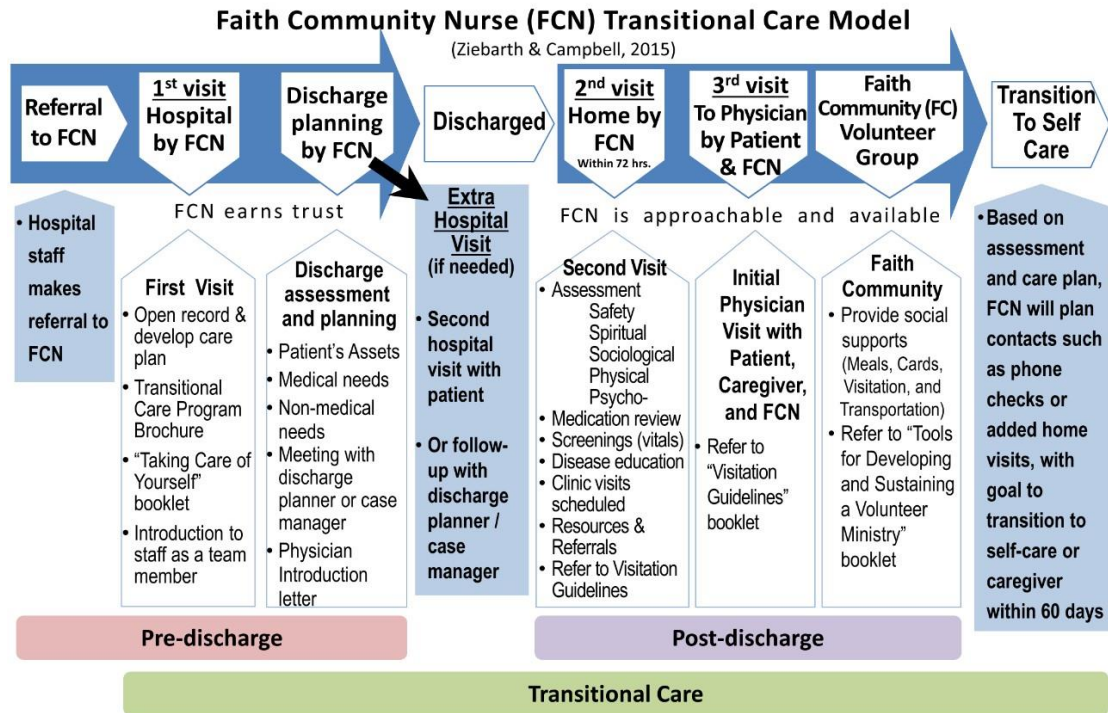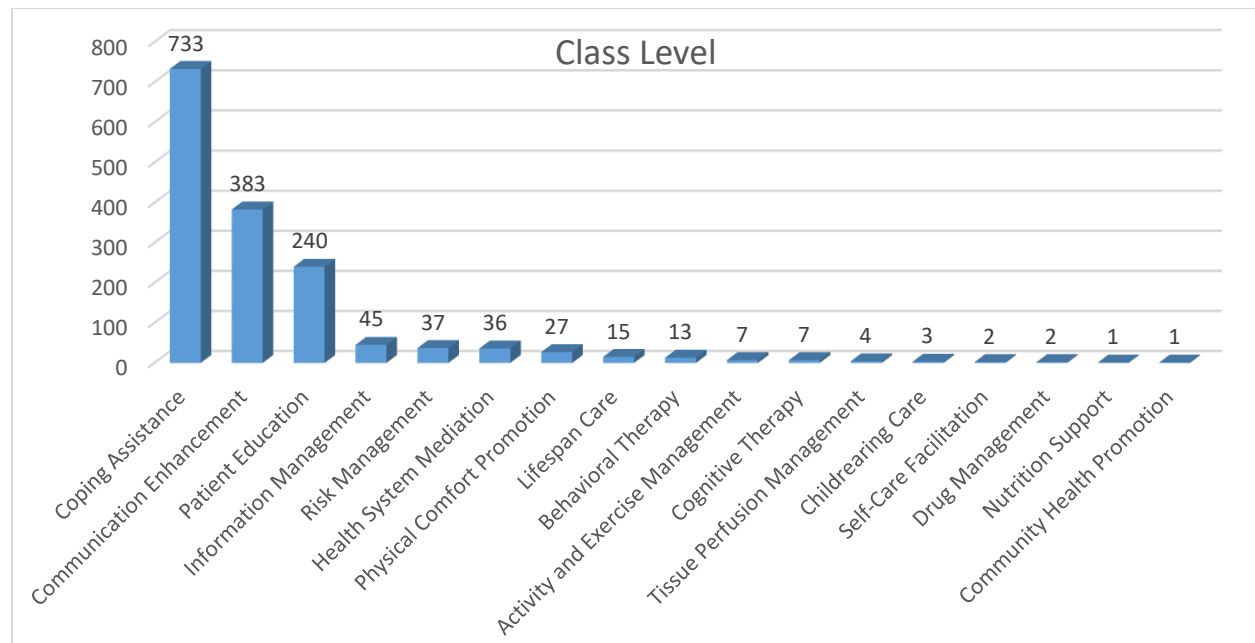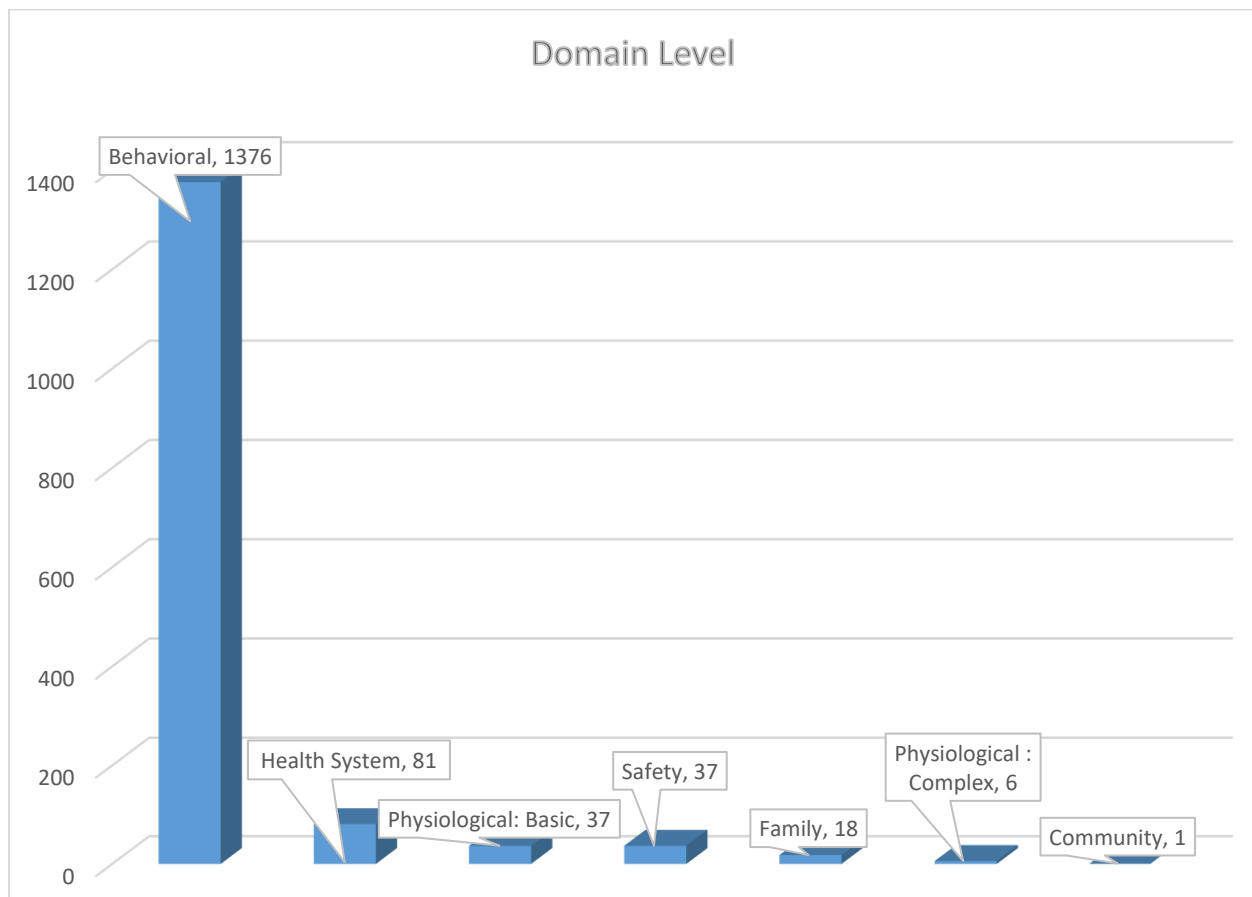Figure 2: Faith Community Nurse Transitional Care Model (Ziebarth & Campbell, 2015; 2016).

Chart 1: Classes Containing NIC Documented by FCNs

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Chart 2: Domains Containing Classes and NICs Documented by FCNs

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Table 2: Results - Frequently Selected Nursing Intervention Classification

Order of	Code	Standardized Nursing Intervention	Standardized Nursing Intervention	Frequency
1	3Q-4920	Active Listening	Attending closely to and attaching significance to a patient's verbal and nonverbal messages	351
2	3S-5510	Health Education	Developing and providing instruction and learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities	239
3	3R-5240	Counseling	Use of an interactive helping process focusing on the needs, problems, or feelings of the patient and significant others to enhance or support coping, problem solving, and interpersonal relationships	195
4	3R-5340	Presence	Being with another, both physically and psychologically, during times of need	187
5	3R-5420	Spiritual Support	Assisting the patient to feel balance and connection with a greater power	164
6	3R-5460	Touch	Providing comfort and communication through tactile	63
7	3R-5230	Coping Enhancement	Facilitation of cognitive and behavioral efforts to manage perceived stressors, change, or threats that interfere with meeting life demands and roles	39
8	6b-8100	Referral	Arrangement for services by other care providers or agencies	33
9	3R-5480	Values Clarification	Assisting another to clarify her or his own values in order to effectively facilitate decision making.	28
10	3Q-5020	Conflict Mediation	Facilitation of constructive dialogue between opposing parties with a goal of resolving disputes in an acceptable manner	25
11	1E-1400	Pain management	Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient	21

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12	6Y-7370	Discharge Planning	Preparation for moving a patient from one level of care to another within or outside the current healthcare agency	21
13	3R-5250	Decision-Making Support	Providing information and support for a patient who is making a decision regarding health care	19
14	4V-6650	Surveillance	Purposeful and ongoing acquisition interpretation and synthesis of patient's data for clinical decision-making	18
15	3R-5390	Self-Awareness Enhancement	Assisting a patient to explore his or her thoughts, feeling, motivations and behaviors	17
16	6Y-7400	Health System Guidance	Facilitating a patient's location and use of appropriate health services	14
17	4V-6490	Fall Prevention	Instituting special precautions with patient at risk for injury from falling	12
18	3O-4480	Self-Responsibility Facilitation	Encouraging a patient to assume more responsibility for own behavior	9
19	1A-0180	Energy Management	Regulating energy use to treat or prevent fatigue and optimize function	7
20	3Q-5328	Listening Visits	Empathic listening to genuinely understanding an individual's situation and work collaboratively over a number of home visits to identify and generate solutions to reduce depressive symptoms	7
21	6b-7910	Consultation	Using expert knowledge to work with those who seek help and problem solving to enable individuals, families, groups, or agencies to achieve identified goals	7
22	3R-5424	Religious Ritual Enhancement	Facilitating participation in religious practice	6
23	3R-5440	Support System Enhancement	Facilitation of support to patient by family, friends, and community	6
24	3P-4820	Reality Orientation	Promotion of patient's awareness of personal identity, time, environment	5

Faith community nurses perform transitional care

25	5X-7040	Caregiver Support	Provision of the necessary information, advocacy, and support to facilitate primary patient care by someone other than a health care professional	5
26	5X-7110	Family Involvement Promotion	Facilitating participation of family members in the emotional and physical care of the patient	5
27	6b-8180	Telephone Consultation	Eliciting patient's concerns, listening, and providing support, information, or teaching in response to patient's stated concerns, over the telephone	5
28	1E-6482	Environmental Management: Comfort	Manipulation of the patient's surroundings for promotion of optimal comfort	5
29	2N-4050	Cardiac Risk Management	Prevention of an acute episode of impaired cardiac functions by minimalizing contributing event and risks behaviors	4
30	3R-5210	Anticipatory Guidance	Preparation of patient for an anticipated developmental and/or situational crisis	4
31	3R-5260	Dying Care	Promotion of physical comfort and psychological peace in the final phase of life	3
32	5X-7140	Family Support	Promotion of family values, interests, and goals	3

Faith community nurses perform transitional care

Table 3: Behavioral Domain with Classes and NICs Documented by FCNs

495	Behavioral Domain	Class	NIC Label			
	9	Behavioral Therapy				
		9	3O-4480	Self-Responsibility Facilitation		
	7	Cognitive Therapy				
		5	3P-4820	Reality Orientation		
		2	3P 5520	Learning facilitation		
	383	Communication Enhancement				
		351	3Q-4920	Active Listening		
		25	3Q-5020	Conflict Meditation		
		7	3Q-5328	Listening Visits		
	733	Coping Assistance				
		3	3R-5210	Anticipatory Guidance		
		39	3R-5230	Coping Enhancement		
		195	3R- 5240	Counseling		
		19	3R-5250	Decision-Making Support		
		3	3R-5260	Dying Care		
		2	3R-5270	Emotional Support		
		7	3R-5328	Listening Visits		
		187	3R-5340	Presence		
		17	3R-5390	Self-awareness Enhancement		
		164	3R-5420	Spiritual Support		
		6	3R-5424	Religious Ritual Enhancement		
		6	3R-5440	Support System Enhancement		
		63	3R-5460	Touch		
		28	3R-5480	Values Clarification		
	240	Patient Education				
		239	3S-5510	Health Education		
		1	3S-5602	Teaching: Disease Process		
	27	Psychological Comfort Promotion				
		21	1E-1400	Pain Management		
		2	1E-1390	Healing Touch		
		4	1E-6482	Environmental Comfort		

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Table 4: Transitional Care NICs Aligned to Previous Transitional Care Research Interventions.

Transitional care research	Top ranked NICs (26) performed by study participants (FCNs) while	Aligned NIC Definitions (Bulechek, Butcher, Dochterman, & Wagner,	Possible number of activities
Follow-up calls and home visits	1. Telephone Consultation 2. Telephone Follow-up 3. Active Listening	1. Eliciting patient's concerns, listening, and providing support, information, or teaching in response to patient's stated concerns, over the telephone (p 388). 2. Evaluating patient's response and determining potential for problems as a result of previous treatment, examination, or testing, over the	1. 35 (p 388) 2. 15 (p 389) 3. 17
Medication Reconciliation	Medication Management	1. Facilitation of safe and effective use of prescription and	1. 36 (p 264)
Case management	1. Pain Management	1. Alleviation of pain or a reduction in pain to a	1. 43 (p 285)