

The faith community nurse (FCN) provides transitional care (ANA & HMA, 2017). This position statement aims to answer:

1. What is transitional care?
2. How do transitional care interventions FCNs provide compare to established successful transitional care interventions?
3. What is a good Transitional Care Model for FCNs?

## What Is Transitional Care?

Transitional care encompasses 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 are 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).

## How do transitional care interventions FCNs provide compare to established successful transitional care interventions?

When compared to what are considered to be successful transitional care nursing interventions, FCNs provide not only the same interventions but also additional transitional care interventions, including emotional and spiritual support (see Table 1). This is important because supporting patients' spiritual needs may help them to cope better with illnesses, changes, and losses. Transitional care experts point to the need for a broader focus in transitional care that addresses aspects beyond physical health needs (Coleman, 2003).

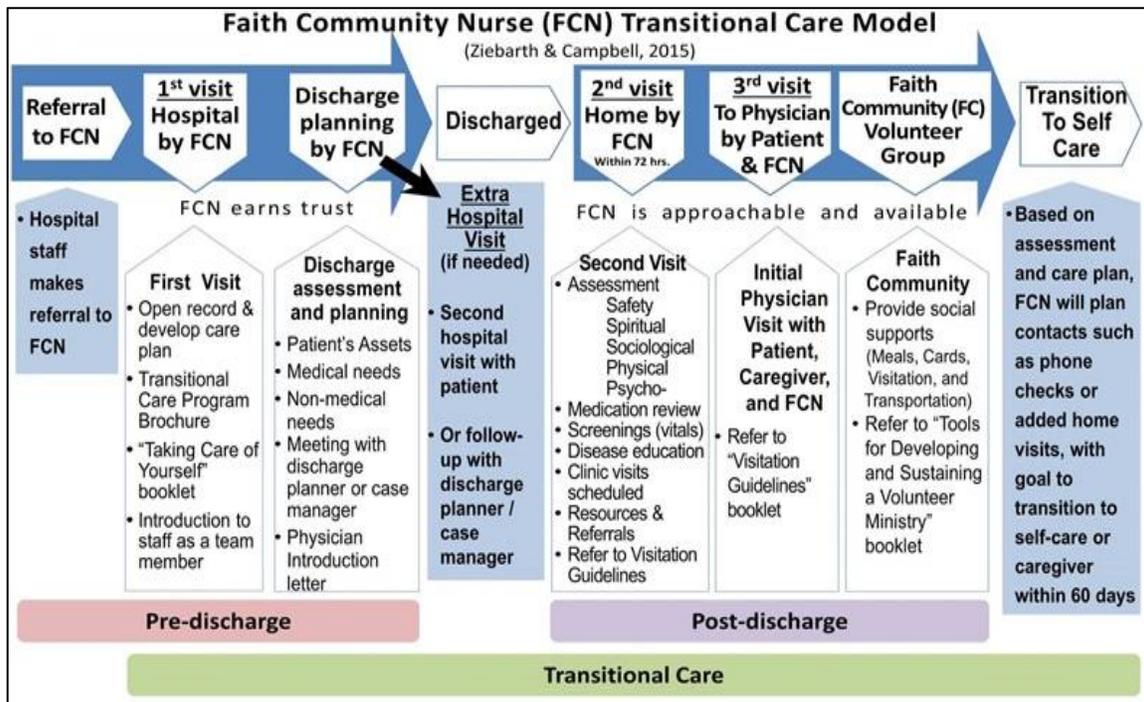
**Table 1. Comparison of FCN Transitional Care and Other Successful Care Interventions**

<b>Established Successful Transitional Care Interventions*</b>	<b>FCN Transitional Care Interventions**</b>	<b>Additional FCN Transitional Care Interventions**</b>
<ul style="list-style-type: none"> <li>• Early discharge planning</li> <li>• Case management</li> <li>• Patient education</li> <li>• Understandable tools</li> <li>• Collaboration with clinic</li> <li>• Early and frequent primary care visits</li> <li>• Telehealth</li> <li>• Medication reconciliation</li> <li>• Education revisited</li> <li>• Advocacy needs are met</li> <li>• Coaching on self-care</li> <li>• Assessment and screenings (vitals)</li> </ul>	<ul style="list-style-type: none"> <li>• Anticipatory guidance</li> <li>• Health system mediation</li> <li>• Patient education</li> <li>• Health education</li> <li>• Communication enhancement</li> <li>• Decision-making support</li> <li>• Drug management</li> <li>• Teaching: prescribed medication</li> <li>• Teaching: disease process</li> <li>• Teaching: prescribed diet</li> <li>• Teaching: procedure/treatment</li> <li>• Information management</li> <li>• Communication enhancement</li> <li>• Self-care facilitation</li> <li>• Tissue perfusion management</li> <li>• Nutrition support</li> <li>• Physical comfort promotion</li> </ul>	<ul style="list-style-type: none"> <li>• Lifespan care</li> <li>• Activity and exercise management</li> <li>• Relocation stress reduction</li> <li>• Active listening</li> <li>• Hope instillation</li> <li>• Anxiety reduction</li> <li>• Simple relaxation therapy</li> <li>• Grief work facilitation</li> <li>• Emotional support</li> <li>• Spiritual support</li> <li>• Community health promotion</li> </ul>

\* Systematic review of 62 research articles, Ziebarth, 2015

\*\* Ziebarth, 2016

## What Is a Good Transitional Care Model for FCNs?



The above diagram presents a transitional care model based on a full-time, paid FCN who works for a health care system. The diagram also provides the key visits and interventions of the FCN during the pre- and post-discharge phases. However, FCNs desiring to engage in this model should review the detailed description of the model's components described in the article, "A Transitional Care Model Using Faith Community Nurses" listed in reference section below.

The resources identified in the model, *Taking Care of Yourself Booklet*, *Visitation Guidelines*, and *Tools for Developing & Sustaining Volunteer Ministry* are included in the resource section below.

FCNs who are in an unpaid or part-time position not in a hospital should consider ways of adapting components of the model into their practice. For example, the FCN should proactively seek to develop relationships with primary care health care professionals as well as office staff about their role as an FCN. These relationships are critical to have in place if care coordination needs arise after a parishioner is discharged. A way to reduce communication barriers with health care professionals such as discharge planners or case managers is to have the parishioner add the FCN to the *Authorization for Release of Information* form.

### Resources

*Taking Care of Yourself Booklet: A guide for when I leave the hospital.* Free booklet at <https://www.ahrq.gov/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome/index.html>

*Faith Community Nurse Visitation Guidelines.* <https://www.amazon.com/Visitation-Guidelines-Faith-Community-Nurses/dp/1546311459>

*Volunteer Program Development: For faith communities:* <https://www.amazon.com/Volunteer-Program-Development->

Faith%20Communities/dp/1973994925/ref=sr\_1\_fkmr1\_1?s=books&ie=UTF8&qid=1510854806&sr=1-1-fkmr1&keywords=Developing+a+Volunteer+program+for+a+faith+community  
*Transitional Care Training Guide for Faith Community Nurses.*  
<https://store.churchhealth.org/collections/for-faith-community-nurses/products/transitional-care>

## References

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