



Transitional Care Position Statement

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

1. How is transitional care provided by faith community nurses similar and different from other nurses?
2. What is transitional care?
3. What interventions (Classes of NIC) are done most often by faith community nurses while providing transitional care?
4. What is a good Transitional Care Model for FCNs?

How is transitional care provided by faith community nurses similar and different from other nurses?

When compared to what is considered to be successful transitional care nursing interventions, FCNs provided the same interventions and also provided emotional and spiritual support. This is important because supporting a patient's spiritual needs may help them to cope better with illnesses, changes, and losses in life.

What is transitional care?

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).

In a systematic review of literature (N= 62), factors that increase hospital readmissions were identified along with successful transitional care interventions; both prior and post hospital discharge (Ziebarth, 2015).

1. Factors that increase hospital readmissions: elderly with complex medical, social and financial needs, markers of frailty such as immobility, living alone, poor health literacy, multi-chronic diseases, serious mental illness, stroke, and major surgery.
2. Successful transitional care interventions prior to hospital discharge:
 - o Early discharge planning
 - o Case management
 - o Patient education
 - o Understandable tools
 - o Collaboration with clinic (cross-site communication)
3. Successful transitional care interventions post hospital discharge:
 - o Early and frequent primary care visits
 - o Telehealth
 - o Contact with trained nurses providing time-sensitive interventions: (a) Comprehensive medication reconciliation; (b) Case management; (c) Education revisited; (d) Advocacy- needs are met; (e) Coaching patients and their caregivers regarding self-care; and (f) Assessment and screenings (vitals).

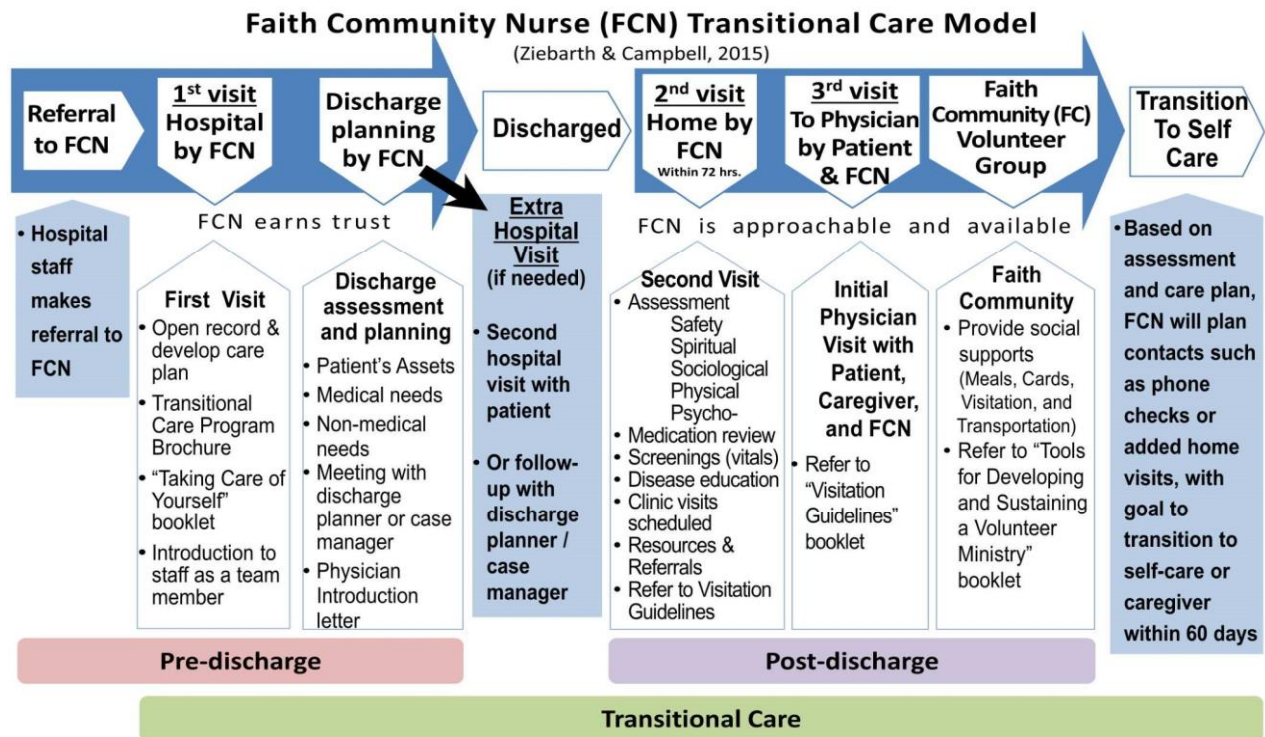
What interventions are done most often by faith community nurses while providing transitional care?

In two recent studies exploring transitional care (from hospital to home) as provided by FCN, four years of documentation was analyzed using the Nursing Intervention Classifications (NIC). The Classes of NIC most frequently documented 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 NIC Classes containing the most frequently reported interventions were Coping Assistance, Communication Enhancement, and Patient Education. These three Classes contain interventions such as Active

Listening, Hope Instillation, Bibliotherapy, Emotional Support, Spiritual Support, Decision-Making Support, Presence, Relocation Stress Reduction, Health Education, Anticipatory Guidance, Teaching: Disease Process, Teaching: Prescribed Diet, Teaching: Prescribed Medication, Teaching: Procedure/Treatment, Anxiety Reduction, Simple Relaxation Therapy, Communication Enhancement, Grief Work Facilitation.

What is a good Transitional Care Model for FCNs?



Pre-discharge.

Earn trust of patient, caregiver, and staff.

1. The FCN introduces self to patient, caregiver and staff.
2. Use the Taking Care of Yourself Booklet to promote self-care and collect important information for patient and caregiver.
3. The documentation record is opened.
4. Discharge assessment and planning occurs, which includes a meeting with the discharge planner and care-giver.
5. An introduction letter is sent/given to the primary care physician.

Post-discharge.

FCN is approachable and available.

1. Visitation Guidelines provide assessment guidelines for the first home visit and first primary care physician (PCP) visit.
2. The role of the FCN is to avert unnecessary re-hospitalization by having "frequent" contact with the patient and care-giver.
3. Based on acuity, the patient may require frequent contact with the PCP.
4. Every home visit, the FCN should do a wholistic assessment (physical - disease specific, spiritual, and psychosocial).
5. Every visit do these 3 interventions: 1. disease education, 2. medication reconciliation, and 3. self-care training. Use demonstration and be sensitive to literacy issues and disabilities.
6. Volunteer Program Development: For Faith Communities provide the role of the faith community in providing community through the use of volunteers. Volunteers may provide needed social supports such as encouraging cards, transportation, or meals.
7. Based on your nursing assessment, FCN will plan phone and home visits with a goal to transition to self-care or caregiver within 60 days.

Transitional Care Resources

- Taking Care of Yourself Booklet: A guide when I leave the hospital (*free)
<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-Communities/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

References

- American Nurses Association and Health Ministries Association. (2017). *Faith community nursing: Scope and standards of practice* (3rd ed.). Silver Spring, MD: Nursesbooks.org.
- Naylor, M. D., Aiken, L. H., Kurtzman, E. T., Olds, D. M., & Hirschman, K. B. (2011). The importance of transitional care in achieving health reform. *Health affairs*, 30(4), 746-754.
- Ziebarth, D., & Campbell, K. P. (2016). A transitional care model using faith community nurses. *Journal of Christian Nursing*, 33(2), 112-118.
- Ziebarth, D. J. (2015). Factors that lead to hospital readmissions and interventions that reduce them: Moving toward a faith community nursing intervention. *International Journal of Faith Community Nursing*, 1(1), 1.
- Ziebarth, D. (2016). *Transitional care interventions as implemented by faith community nurses* (Doctoral dissertation, The University of Wisconsin-Milwaukee).

Written by

Deborah Ziebarth, and edited by Katora Campbell, Sharon Hinton, Susan Jacob, Georgia Oliver, and Lisa Zerull for the Westberg Institute, 2018.

Citation

Westberg Institute (2018) Transitional Care. Retrieved from <https://www.westberginstitute.org>