ABSTRACT:
Transition of Care Models can reduce the 30-day hospital readmission rate up to 67% by offering coordination and continuity of care. The purpose of this project was to evaluate a Congregation Transition of Care (CTOC) program in faith-based communities with the use of a faith community nurse and volunteer faith-based registered nurses. Descriptive statistics were used to describe findings, revealing a CTOC program can be effective in reducing 30-day readmissions in the faith community.

KEY WORDS: *30-day readmission rate, faith community nursing, hospital discharge, nursing, transitional care, transition of care models*

Hospital readmissions within 30 days after discharge have drawn national attention, accounting for more than $17 billion in avoidable expenditures (Zuckerman, Sheingold, Orav, Ruhter, & Epstein, 2016). Patients over age 65 who are diagnosed with debilitating diseases, such as heart and renal failure or pulmonary disease, and who are discharged from healthcare centers, experience 19% readmission rates within 30 days (Naylor et al., 2017). Of high-risk patients 65 years and older, 34% were readmitted to the hospital from home within 30 days (Fisher, Graham, Krishnan, & Ottenbacher, 2016). Patients with comorbidities are more likely to experience a hospital readmission (Basu, Avila, & Ricciardi, 2016).

Great benefit is seen in using transition of care models (TOC-M) to reduce hospital readmission. Using a TOC-M process, there is a 67% reduction in the 30-day readmission rates of patients over age 65 years (Lovelace et al., 2016). Such models are designed to reduce health complications and rehospitalizations by providing patients with comprehensive discharge planning and home care follow-up (Naylor et al., 2004). TOC-Ms have shown to be successful in disease-focused, at-risk populations, such as those with heart failure (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011; Voss et al., 2011) and in cancer diagnoses (Hughes, Hodgson, Muller, Robinson, & McCorkle, 2000).

CE 1.5 contact hours

A Congregation Transition of Care Program

Lee Ann Strait, Elizabeth Fitzgerald, Joyce Zurmehly, and Janine Overcash

Using Faith Community Nurses and Volunteer Faith-Based Nurses

The focus of TOC-M is to reduce adverse clinical events by ensuring coordination and continuity of care as patients transfer between levels of care (Naylor et al., 2011).

The purpose of this evidence-based practice project was to evaluate a Congregation Transition of Care (CTOC) program intended to decrease 30-day readmission rates in faith-based communities with the use of a faith community nurse (FCN) and volunteer faith-based registered nurses (VFB-RNs). Project objectives were to:

1. Describe the effectiveness of the role of the VFB-RN in a CTOC program by evaluating the number of participants receiving a phone call within 72 hours post discharge, the number of participants receiving a phone call 30 days post discharge, and the number of program participants who returned for an appointment with their primary care provider (PCP) within 30 days post discharge.
2. To decrease 30-day readmission rates for participants in the CTOC program by comparing the CTOC program readmission rates to actual 30-day readmission rates reported by the target hospital for 2016.
3. To evaluate the implementation of the CTOC program by identifying participants who completed the 30-day program.

FCNs are licensed registered nurses, who have completed a *Foundations in Faith Community Nursing* training course (Westberg Institute for Faith Community Nursing [Westberg Institute], 2014), and specialize in the practice of caring for the spirit, promoting holistic health, and facilitating the prevention of illness within the context of a faith community (American Nurses Association [ANA] & Health Ministry Association [HMA], 2017). FCNs have expertise in reducing the risk of readmission by enhancing communication with the PCP, providing self-care education, and supporting the patient and family (Campbell, 2017). They are in a unique position to form and maintain trusted relationships with community members throughout the transition from inpatient to home and enhance the connection with the PCP (Campbell).

TRANSITIONAL CARE

Transition of care (TOC) is traditionally defined as a set of actions designed to ensure the coordination and continuity of care through discharge from an inpatient healthcare setting to home (Coleman & Berenson, 2004). The National Cancer Institute (NCI) defines transition of care as the support provided to patients and families as they move from one phase of healthcare to another (NCI, 2018). Transition of care is further defined as a broad range of time-limited services designed to ensure healthcare continuity and avoid preventable poor outcomes among at-risk populations (Naylor et al., 2011). Critical components in the transition of care include: 1) a focus on logistical arrangements, such as transportation and follow-up with the PCP; 2) the health-related education of the patient and family; and 3) care coordination among healthcare professionals (Coleman, 2003). Addressing these components leads to reducing the risk of preventable hospital readmissions (Naylor et al., 2011).

TOC-Ms provide a blueprint for evidence-based interventions, focusing on preventing errors at hospital discharge (Hansen, Young, Hinami,

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Leung, & Williams, 2011) and provide the essential referrals, discharge directions, filling prescriptions, and other necessities that help patients situate care in their homes. Often, TOC-Ms are designed to decrease six identified overlapping categories of problems that are associated with negative outcomes upon discharge (Hirschman, Shaid, McCauley, Pauly, & Naylor, 2015). These six areas include the lack of patient engagement, inadequate communication, lack of collaboration among the healthcare team, limited follow-up and monitoring, and poor continuity of care (Hirschman et al.). TOC-M interventions tend to be most effective when delivered in a bundle and include patient education, focused on awareness of adverse signs and symptoms, post discharge PCP follow-up occurs within 30 days, and follow-up phone calls from hospital staff (Coleman et al., 2013; Hansen et al.; Hughes et al., 2000; Naylor et al., 2017; Soong et al., 2014; Voss et al., 2011; Ziebarth & Campbell, 2016).

In 2010, the Affordable Care Act required Medicare to set up a readmission reduction program to lower readmission rates after hospital discharge. Payment penalties were implemented in October 2012, and hospitals could lose up to 1% of every Medicare payment if excessive 30-day readmission were identified for specific diagnoses, including acute myocardial infarction, congestive heart failure, and pneumonia (Centers for Medicare & Medicaid Services, 2015). The financial status of the healthcare delivery system benefits from paying fewer payment penalties. Therefore, TOC-Ms were implemented to reduce some readmissions that can enhance costs for healthcare facilities.

Additionally, the Institute of Medicine (IOM) articulated the need for healthcare organizations and nursing schools to develop community-based partnerships to better address community health issues, particularly in the underserved populations (IOM, 2011). The American Organization of Nurse Executives (AONE) and the American Academy of Ambulatory Care Nursing (AAACN) issued a joint statement entitled, *The Role of the Nurse Leaders in Care Coordination and Transition Management across the Health Care Continuum* (AONE & AAACN, 2015). The statement identified that care coordination and transition management roles are needed to improve quality of care to individuals, improve the health of communities, while reducing healthcare costs. The CTOC program relies on the success of the TOC-Ms, which inspired implementation in a faith-based community utilizing FCNs. Implementation of the CTOC program answered the unified call from federal agencies such as IOM, AAACN, and AONE, while benefiting individual healthcare systems and the patients they serve.

Hospital readmissions within 30 days after discharge…account for more than $17 billion in avoidable expenditures.

BENEFITS OF TRANSITIONAL CARE BY FCNS

Faith community nursing is a recognized specialty in nursing practice, that combines professional nursing and health ministry, with an emphasis on health and healing within a faith community (Westberg Institute, 2014). In 2017, the ANA and HMA published an update to its scope and standards, stating that FCNs are *integrating the body, mind and spirit to create wholeness, health, and a sense of well-being* (ANA & HMA, 2017). FCNs interact with their congregation by providing emotional and spiritual support, advocacy, health education and promotion, as well as referrals for needed services (Westberg Institute). The goals of the FCN are the "protection, promotion, and optimization of health and abilities; the prevention of illness and injury; and the alleviation of suffering in the context of values, beliefs, and practices of faith community, such as a church, congregation, parish, synagogue, temple, mosque or faith-based community agency" (ANA & HMA, p. 2). Many benefits of faith-based health programs stem from their presence and credibility with individuals and surrounding neighborhoods (Balint & George, 2015; Pappas-Rogich & King, 2014). Faith community nursing is a well-received healthcare option that blends physical, social, emotional, and spiritual care into one caregiving experience (Westberg Institute). This approach provides the client with an increase in continuity of care during a time of transition after an inpatient hospitalization (Pappas-Rogich & King).

FCNs are in an ideal position to provide advantages to patients during the transition from an inpatient hospitalization to home. FCNs have obtained expertise in delivering necessary care strategies to reduce risk for readmission, such as extensive knowledge of community and faith-based resources (Campbell, 2017). Further, the FCN is a trusted member of the faith community and can leverage relationships to encourage the patient and caregiver to engage in self-care behaviors and face health challenges (Coleman, 2003; Marcum & Hardy, 2015; Mock, 2017). The increasing need for services described in TOC-Ms has created opportunities for the FCNs to impact the health of faith-based communities by utilizing specific nursing knowledge and relationships with those they serve (Campbell; Ziebarth & Campbell, 2016). Utilizing FCNs to support TOC-Ms provides a holistic health approach to caring, which can help achieve both community-based partnerships and strategic goals (Ziebarth,

2014). Again, the purpose of this project was to evaluate a CTOC program to decrease 30-day readmission rates in faith-based communities with the use of an FCN and VFB-RNs.

PROGRAM PREPARATION

In March 2017, an all-FCN leadership team was established to plan program implementation and evaluation. The CTOC-M leadership team completed a retrospective review of aggregate data to identify congregations for inclusion in the program. Inclusion criteria required 20 or more congregation members discharged from the hospital during the 2016 calendar year. Once identified, members of the leadership team met with the congregational spiritual leaders (pastor, priest, or rabbi) to discuss the CTOC-M program, obtain support, and assist in communicating the program to their congregations. This proved to be a favorable recruitment strategy to increase interest.

By May 2017, the team met with stakeholders, including hospital admitting, finance, quality, legal, and population health to gain their support of the CTOC program. The identification of the leadership team early in the planning process was instrumental to the success. This team focused on ensuring that only evidence-based best practice (EBP) supported components of TOC-M were incorporated into the CTOC program. Such focus included assuring that the patient understood the CTOC program, received two follow-up phone calls at 72 hours and 30 days post discharge, and return for a follow-up visit with his/her PCP within 30 days of discharge (Coleman et al., 2013; Hansen et al., 2011; Hughes et al., 2000; Naylor et al., 2017; Voss et al., 2011; Ziebarth & Campbell, 2016).

The project sample included congregational denominations (church, synagogue, or parish) that had 20 or more congregation members discharged from the hospital between December 1, 2015, and December 14, 2016. Congregational selection criteria included proximity and utilization of healthcare facilities, and interest and support of the program. Members of the sample congregations were identified upon admission to a large Midwestern tertiary hospital system during the registration process (see Supplemental Digital Content 1, Figure 1, http://links.lww.com/NCF-JCN/A64). Initially, upon admission, religious and congregational affiliation was voluntarily identified.

The focus of TOC-M is to reduce adverse clinical events by ensuring coordination and continuity of care as patients transfer between levels of care.

Members were excluded from the project if they were receiving or scheduled to receive homecare or discharged to a location other than home. This project was approved by the Institutional Review Board (IRB) of Mount Carmel University.

The CTOC program is fully financially supported by the large Midwestern tertiary hospital system's Foundation and the Department of Church Partnerships. At a yearly anticipated cost of $65,220, the budget includes salary and benefits for the hospital-employed transition of care RN (TOC-RN), who is also an FCN, laptop computer, office expenses, including program informational pamphlets for patients, mobile computer access, and travel mileage reimbursement. The program began in a hospital affiliated with the three-hospital system. Following a comprehensive program review, the organization plans to replicate the program in other acute care hospitals in the system.

METHODS

This program used two types of registered nurses—a TOC-RN and the VFB-RN. The FCN, who had completed specialized faith community nursing training, assumed the TOC-RN role for the project. The TOC-RN was responsible for identifying potential participants and discussing the program, while patients were still in the hospital system. The TOC-RN was employed by the hospital through the department of church partnerships and approached by the organizers to work with the CTOC program. The VFB-RNs were not formally trained as FCNs; however, they were oriented to the role and responsibilities under the direction of the FCN.

VFB-RNs received a mandatory 2-hour orientation from the TOC-RN. Topics included discussion of the CTOC program, including evidence of best practice, the role of the TOC-RN inside the hospital setting, roles and responsibilities of the VFB-RN, benefits of becoming a VFB-RN, and laws protecting volunteers in the United States. The roles and responsibilities of the VFB-RN were identified in current literature (Campbell, 2017; Naylor et al., 2011; Rutherford, Nielsen, Taylor, Bradke, & Coleman, 2013). These included calling patients at 72 hours and 30 days post discharge to home; assessing for food, transportation, and spiritual needs; assisting

with answering questions regarding adverse signs and symptoms; basic medication questions; encouraging return visit to and when to notify the PCP, in the event of unexpected problems; connecting the patient with support from the congregation; and referring to outside services. A list of countywide resources was developed by the hospital system and made available to the VFB-RN and various congregations. In addition, the VFB-RNs provided spiritual support, which included prayer, meditation, and other coping strategies.

Patient encounters were documented by the VFB-RN, and monthly reports were submitted to the TOC-RN. The reports consisted of aggregate data to protect the privacy of the patients served. The VFB-RN did not receive discharge information regarding his/her patient prior to the first interaction.

Each point of contact or encounter of the VFB-RN and the patient participant was recorded on the *Congregation Transition of Care Encounter* form (see Supplemental Digital Content 2, Figure 2, http://links.lww.com/NCF-JCN/A65). Questions included:

Patient states understanding of discharge instructions that includes:

- Health condition and reason for hospitalization
- Symptoms that necessitate calling PCP/specialist or visit urgent care/emergency room (ER)
- Medication schedule. If responds no—refer to pharmacist or PCP
- Scheduling of any test/labs
- Dietary restrictions
- Activity restrictions
- Follow-up appointment with PCP and/or specialist scheduled
- Medication, transportation, meal, or spiritual needs?

The time spent for the encounter including pretime, the actual call and documentation, were recorded by the VFB-RN, as well as any additional resources required. Each follow-up between the member and the VFB-RN lasted approximately 15 minutes.

Monthly aggregate data were provided to the FCN in the TOC-RN role for evaluation of the CTOC program. Deidentified data were recorded on monthly collection forms, designed to summarize elements of the follow-up between the VFB-RN and the patient.

A 30-day postdischarge phone call from the VFB-RN to the participant was made, with results documented on the *Congregation Transition of Care Encounter* form. Questions used a yes/no format and included adherence to his/her follow-up appointment with PCP and/or specialist. If the member answered "no," the response and reason for not attending the visit were documented. The remaining questions determined an urgent care or emergency department visit and hospital admission in the last 30 days. If the member responded "yes" to these questions, then the VFB-RN documented the reason. The time spent for the encounter, including pretime, the actual call and documentation, were recorded by the VFB-RN, as well as any additional resources required. These interactions between the member and the VFB-RN were approximately 15 minutes.

The Monthly Aggregate Report (Table 1) provided aggregate results of all encounters that occurred monthly. The form included the name of the congregation, VFB-RN submitting the report, as well as the month and year completed. Data included the number of referrals received in the month of the report, as well as the number of participants who received a follow-up from the VFB-RN within 72 hours of discharge. The VFB-RN also documented the number and rationale for any referrals not completed in the expected timeframe. Documentation included the number of members who attended post discharge follow-up with their PCP and those who returned to urgent care, emergency department, or were readmitted within 30 days of discharge. Aggregate data regarding understanding of discharge instructions were also recorded.

ANALYSIS OF DATA

Demographic data were evaluated by the hospital-based FCN (TOC-RN),

Table 1: Congregation Transition of Care Monthly Aggregate Report

Congregation name: _____ Month/Year _____		
Signature of RN completing report: _____		
Number of referrals received this month		
Number of patients without discharge summary		
Number of referrals that were followed-up within 3 days		
Number of patients who had scheduled a follow-up appointment with their healthcare provider		
Number of 30-day encounters		
Number of patients who went to an appointment with their healthcare provider within 30 days post discharge		
Number of patients returned to urgent care or ER within 30 days post discharge		
Number of patients admitted to hospital within 30 days post discharge		
At 30-day encounter, number of patients who state they have a better understanding of discharge instructions after encounter with RN	yes	no
Number of additional encounters (excluding 1st and 30-day encounters)		
Number of TOTAL volunteer congregational RN hours spent this month		

Table 2:
Program Findings (*N* = 44 Participants)

VFB-RN Encounter	*n*	%
72 hours:	43	98
30-day:	41	93
PCP visit:		
Yes	41	93
No	3	7
Readmission rate:		
30-day	1	2.4

Note. VFB-RN = volunteer faith-based registered nurse; PCP = primary care provider

using descriptive statistics. Demographic data included the number of participants, the number who went to their follow-up appointment with their PCP, as well as the number who returned to urgent care, ER, or were hospitalized. The 30-day readmissions were assessed upon monthly reporting provided by the VFB-RN, and the frequencies of readmissions were tallied. The reports are securely stored in the office of the TOC-RN. The percentages of readmissions in the project sample were compared with the aggregate readmission data reported by the identified hospital for calendar year 2016.

Data from the *Congregational Transition of Care Encounter* documentation forms were aggregated and reported on the *Monthly Aggregated Report* by the VFB-RN. The VFB-RN submitted the aggregate report to the FCN in the TOC-RN role. The TOC-RN entered the aggregate results into an Excel database for analysis.

The CTOC program enrolled its first patient on July 26, 2017. A retrospective review of the aggregate data collected between July 26, 2017, and December 31, 2017, revealed 44 participants and 13 VFB-RNs from a total of 16 congregations.

RESULTS

The effectiveness of the VFB-RN in the CTOC program was measured by completion of two phone call interactions with the member post-discharge, and the number of members who saw their PCP within the 30 days of the program. Data support that the VFB-RN completed the 72-hour encounter 98% of the time (n = 43), whereas the 30-day encounter was completed 93% of the time (n = 41). The data further reveal that 93% (n = 41) of participants returned for a follow-up appointment with their PCP within the 30 days post discharge.

Baseline 30-day readmission rate reported by the target hospital was 9.4% for the calendar year 2016, which included 1,534 patients (n = 16,289) who were readmitted within 30 days. In comparison, the readmission rate for the CTOC program was 2.4% (n = 41), with one participant reporting a return urgent care visit. None of the CTOC participants reported a return to the ER or readmission to the hospital, which supports a decrease in 30-day readmission rate for the target hospital population.

Evaluation of the implementation of the CTOC program was measured by the number of participants who completed the entire 30-day program. Completion was defined as participation in the 72-hour and 30-day post discharge phone call encounter with the VFB-RN. Forty-four (44) participants entered the program between July 26, 2017, and December 31, 2017, and 41 (93%) completed the CTOC program (Table 2).

DISCUSSION

Outcomes used in this project are similar to other projects used to measure the effectiveness of FCNs, such as 30-day readmissions (Campbell, 2017; Ziebarth & Campbell, 2016). The role of the FCN is critical to impact the health of many people, and more attention should be given to such an important component of the healthcare team.

The CTOC program was effective, with good participation, supporting Objective 1. The importance of the role of the VFB-RN cannot be overstated in program implementation. Each congregation identified a VFB-RN, who was a trusted member of their faith community and could leverage relationships to encourage the patient to engage in self-care behaviors (Coleman, 2003; Marcum & Hardy, 2015). The VFB-RN was identified and trained by the FCN TOC-RN, and helped participants resolve concerns and answer questions posed by the patient and caregiver (Naylor et al., 2004). Once identified, the VFB-RN attended a comprehensive orientation, which focused on how to offer support and resources spiritually, physically, and mentally. By December 31, 2017, 13 VFB-RNs had completed the training and were fulfilling the role in specific faith communities.

The FCN is critical to impact the health of many people, and more attention should be given to such an important component of the healthcare team.

Project objective 2 also was met. Although not an equivalent comparison, baseline 30-day readmission rates reported by the target hospital were 9.4% for the calendar year 2016 (n = 16,289), and the readmission rate for project participants was 2.4% (n = 41). This shows a positive trend in the decrease in 30-day readmission rates for participants in the CTOC.

Ninety-three percent (93%) of the participants enrolled in the CTOC completed the 30-day program, supporting project objective 3. This showed high engagement on the part of the participants, suggesting that this

type of transitional care model can have successful implementation for a wider audience.

Several project limitations should be noted: a potential for missed congregation members to participate, slow process of gaining congregational commitment to the program, and VFB-RN background check process. The project was impacted due to inconsistent ability to identify potential participants. At the time of registration, the patient identified his/her religious and congregational affiliation, which was entered by a registration clerk into the electronic medical record. Data obtained from these two fields are reported to the FCN in the TOC-RN role. The inclusion criteria for the CTOC program rely on the fact that the congregational member affiliates with a participating congregation. The registration department reported 100% compliance with completed fields. However, it was determined that 78% of the time, registration staff entered terms unknown, no preference, or unable to answer responses into the congregation affiliation data field. This means that up to 78% of all hospital admissions were found to be lacking required information to determine eligibility for participation in the CTOC program. Fields were populated with the member's religion and congregational affiliation, with 22% compliance.

The second identified impact of the project was the difficulty in securing commitment to the program. Data supported the need for an average of 5 contacts with the religious leader of a congregation to ensure willingness to participate. The data further supported enrollment of 15 congregations from July through October 2017, whereas 1 congregation enrolled in the program during November and December. The FCN in the TOC-RN role identified that scheduling meetings with the senior religious leader was difficult, due to the leaders' holiday season responsibilities.

Lastly, there was an unexpected limitation with the role of the VFB-RN. The targeted hospital system approved allowing all VFB-RNs to attain volunteer status within the system. The benefit to the VFB-RN was the availability of liability insurance while practicing in the VFB-RN role. However, the required volunteer background process took up to 4 weeks to complete. This caused a potential delay in a congregation's ability to participate in the program. A meeting was held with the Director of Volunteers to discuss the process. Modifications were made, and it is now possible to finish the process in 2 weeks. Finally, IRB approval was granted to conduct this project using only aggregate data, and no tests of statistical significance were conducted to assess if the project met the objectives.

IMPLICATIONS FOR PRACTICE

This program evaluation showed that participation in the CTOC program was high, and the program was effective in reducing 30-day readmissions. CTOC programs require FCN involvement in planning, networking, and continued evaluation to insure beneficial outcomes. Congregations may start a CTOC program by using the FCN and/or identifying VFB-RNs and gaining support among members, and networking with a hospital-based FCN. Evidence-based interventions exist and can be used to develop a CTOC program (Coleman et al., 2013; Hansen et al., 2011; Hughes et al., 2000; Naylor et al., 2017; Voss et al., 2011; Ziebarth & Campbell, 2017). Building relationships among community hospital contacts, with providers, and in community agencies and home healthcare services can be beneficial to establishing CTOC programs. This CTOC program continues to operate and has expanded to include more members who receive care from the FCN and VFB-RNs.

The CTOC program was successfully implemented in a large Midwestern tertiary hospital system, utilizing the components of proven TOC-M, with interventions focused on the faith-based community. The project found the key element in the success of the CTOC program was the role of the congregation-based VFB-RN. Data revealed a decrease in the 30-day readmission rate, supporting that this type of program could be beneficial to healthcare systems. The conclusions of this evidence-based practice project are only first steps in using research to understand how a CTOC model can be used to impact healthcare outcomes that are meaningful to hospital administrators and payers. Although such conclusions were supported by research, these findings are not generalizable to all healthcare settings. However, the results of this EBP project suggest that further research is warranted to investigate the use of a CTOC model within faith communities.

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