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TRANSITIONAL CARE INTERVENTIONS AS IMPLEMENTED BY FAITH COMMUNITY NURSES

by

Deborah Ziebarth

A Dissertation Submitted in

Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

in Nursing

at

The University of Wisconsin – Milwaukee

May 2016

ABSTRACT
TRANSITIONAL CARE INTERVENTIONS AS IMPLEMENTED BY
FAITH COMMUNITY NURSES
by

Deborah Ziebarth

The University of Wisconsin-Milwaukee, 2016
Under the Supervision of Professor Dr. Sally Lundeen

Hospitals are seeking innovative and efficient methods of decreasing avoidable readmissions. Despite the volume of nursing literature exploring the use of advanced practices nurses in providing transitional care, only one study mentions the use of a faith community nurse. The faith community nurse operates in the community and has the skills to provide transitional care. The purpose of this study was to describe transitional care as implemented by faith community nurses using a standardized nursing language: the Nursing Intervention Classification (NIC). A mixed method descriptive design was selected to facilitate a thorough exploration of the interventions implemented by faith community nurses. The findings suggested that the majority of interventions are in the coping assistance, communication enhancement, and patient education Classes of the Behavioral Domain. The most frequently selected nursing interventions in NIC (n=26) were found and validated by the faith community nurse focus group. Results were compared to evidenced-based priority transitional care interventions described in research. In addition, results were compared to previous faith community nursing research describing the practice. Results were also described using the Faith Community Nursing conceptual framework. The results may provide the underpinnings for further testing of transitional care interventions.

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DEDICATION

I would like to dedicate this work to my Lord and Savior first and foremost. And to my dearest husband, and children who gave me the love and support needed to complete my doctoral work. Since beginning my PhD education at UWM, Milwaukee in Fall, 2012, I maintained a job, had two major surgeries, two family weddings, and two new grandchildren. With the help of family, friends, employers, and teachers, I was able to balance a full course load. In addition, while at UWM, I published seven manuscripts. Every time I learned something new, I applied it to faith community nursing…my area of science. I would also like to dedicate this work to faith community nurses everywhere. They are the backbone of faith-based health initiatives improving the quality of lives of people they serve. May they be encouraged by this work. To God be the Glory!

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CHAPTER ONE

INTRODUCTION

Medicare enrollees are disproportionately affected by health care expenditures and hospital readmissions (Cubanski & Neuman, 2010; Stone & Hoffman, 2010). Targeted, time sensitive, nursing interventions provided during the patient's transition from hospital to home, may reduce unnecessary readmissions (Naylor, 2012). Transitional care as implemented by faith community nurses has not been explored in professional nursing literature. The aim of this study is to describe transitional care as implemented by faith community nurses.

Medicare households spend three times more on health expenses than non-Medicare households. Health expenses accounted for 14% of Medicare household budgets in 2012. That is nearly three-times the share of health spending than among non-Medicare households (5%). These shares have remained virtually unchanged over the 10 years from 2002 to 2012, although absolute spending levels have increased (Attanasio, Kitao, & Violante, 2010; Cubanski, Swoope, Damico, & Neuman, 2014). The share of Medicare household spending on payments for health insurance premiums have increased. Health insurance premiums comprised the largest share of average out-of-pocket health care spending among Medicare households in 2012 with nearly two-thirds of overall health spending (Cubanski & Neuman, 2010). On top of standard monthly premiums, "…Medicare enrollees pay a $1,132 deductible for each hospital stay" (p15) and they pay hundreds more when the enrollee has longer hospital stays or are readmitted (Estes, Chapman, Dodd et al., 2013). Medicare enrollees have significant cost above and beyond insurance premiums when hospitalized.

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). In addition to curbing costs, hospitals have a responsibility to their Medicare patients to explore ways to keep them well and safe after discharge in their outpatient environments (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) monitors the fiscal health of the Medicare program and recommends payment policy revisions to contain Medicare cost growth (Stone et al, 2010). The 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 lost 1% of every Medicare payment if the hospital had an excessive 3 day readmission for three specific diagnosis: acute myocardium infraction, congestive heart failure, and pneumonia. The penalty increased to 2% for 2013 and 3% 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 will be added (Centers for Medicare & Medicaid, 2015). It was reported, that less than 799 of more than 3,400 IPPS hospital performed well enough in 2015 to avoid penalties in 2016 (Rice, 2015). These changes in the Medicare reimbursement model have precipitated the need for hospitals to seek innovative and 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).

TRANSITIONAL CARE

Transitional Care is described 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 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).

Nurses have been instrumental in providing transitional care to patients and decreasing avoidable readmissions (Naylor & McCauley, 1999; Naylor, Brooten, Campbell, Maislin, McCauley & Schwartz, 2004; Naylor, Kurtzman, Grabowski, Harrington, McClellan, & Reinhard, 2012; Naylor et al., 2011). Naylor and colleagues (1999; 2004; 2011; 2012) have suggested the use of advanced practice register nurses (APRN) in delivering transitional care

interventions to patients and champions "…enabling advanced practice registered nurses in all states to prescribe medications or essential services such as home health or hospice for this vulnerable group would increase patients' access to care providers and help to prevent unnecessary hospitalizations and re-hospitalizations" (Naylor, 2012, p.1632). Using the APRN is recommended based on the nurse's ability to prescribe medications and provide "essential" services. Despite the volume of nursing literature exploring the use of APRNs in providing transitional care, only one study mentions the use of a faith community nurse (Rydholm, Moone, Thornquist, Alexander, Gustafson & Speece, 2008).

There are best practice transitional care interventions described in literature. Best practice transitional care interventions include the promotion of primary care, individualized care planning, family education and engagement, reliable information flow among older adults, family caregivers, and health care team members, and strong bridges between hospitals and community-based partners (Silow-Carroll, Edwards, & Lashbrook, 2011). FCNs operate in the community and have the skills identified to provide transitional care. In addition, FCNs provide spiritual care interventions (Kuhn 1997; Coenen, Weis, Schank & Matheus, 1999; Tuck, Pullen & Wallace, 2001a; Tuck, Wallace & Pullen, 2001b; Burkhart, Konicek, Moorhead & Androwich, 2005; ANA-HMA 2005, 2012). This is important because 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. In addition, supporting patient's spiritual needs may help patients to cope with illness better (Puchalski, 2001; Balboniet et al, 2007; Paloutzian & Park, 2014).

Faith Community Nursing

Faith community nursing is a "… specialized practice of professional nursing that focuses on the intentional care of the spirit as part of the process of promoting wholistic health and preventing or minimizing illness in [or in partnership with] a faith community" (American Nurses Association (ANA) & Health Ministry Association (HMA), 2012). Faith community nursing was previously referred to as parish nursing (AMA & HMA, 2005). Faith community nurses provide transitional care to their patients (Rydholm et al., 2008). Transitional care, as implemented by faith community nurses, has not been described in literature creating a knowledge gap in the development of a potentially innovative model of transitional care.

Standardized Nursing Languages

A standardized nursing language is a "common language, readily understood by all nurses, to describe care" (Keenan, 1999, p. 12). Standardized nursing languages are used to describe assessments, interventions, and outcomes of nursing care. Benefits of using a standardized nursing language are increased visibility of nursing interventions, improved patient care, enhanced data collection to evaluate nursing care outcomes, greater adherence to standards of care, and facilitated assessment of nursing competency (Rutherford, 2008).

PURPOSE OF THE STUDY

The purpose of this study is to describe transitional care as implemented by faith community nurses (FCNs) using a standardized nursing language, Nursing Intervention Classification (NIC). The description of transitional care as implemented by FCNs will provide insight into what interventions are most implemented during transitional care and the compatibility with most frequently used interventions employed by FCN.

AUTHOR'S BACKGROUND

Early in my nursing career, I was an ICU nurse for 13 years. I saw many patients readmitted due to a worsening or complications of illness. I attended a Faith Community Nursing education program in 1995 and then practiced as a FCN for eight years in a faith community in Waukesha, Wisconsin. This was followed with a position as Community Benefit Manager for a 220 bed hospital for 13 years. In that role, I resourced 26 nurses in 52 community sites. A total of 18 of these settings were faith communities. The FCNs came from a variety of nursing specialties and some had many years of professional experiences. Through extensive data collection, I was able to present evidence of improved patient outcomes regularly to stakeholders. I saw that FCNs brought practice skills from prior knowledge to the role. Attending a FCN Foundation education course was helpful to them, but training specific to transitional care was limited. During staff meetings, discussions regarding which nursing interventions impacted unnecessary readmissions frequently occurred. Continuing education modules were created to increase competence of transitional care knowledge and skills, which led to improved patient outcomes.

The next role I assumed was one of educator in a baccalaureate nursing program. I chaired the community nursing tract for three years. Again, I saw gaps in the curriculum relating to transitional care and created a teaching plan to include this. I have remained current in transitional care literature and want to add to nursing's body of knowledge. Through this study, I hope to identify what are transitional care interventions as implemented by FCNs. In addition, the study may identify interventions that are most often used. It is my bias that regardless of the nurse's past formalized education and professional nursing experiences, attendance at a FCN

Foundation education course and FCN Transitional Care class is important for entering this specialty practice role.

OPERATIONAL DEFINITIONS

The following corresponding operational definitions have been established:

- Faith community nursing: A specialized practice in nursing with attributes of faith integrating, health promoting, disease managing, coordinating, empowering, and accessing health care. Services provided with or in a faith community.
- Faith community nurses (FCNs): Experienced registered nurses with additional training in wholistic health care. Practices with or in a faith community.
- Wholistic health care: Care that is provided by FCNs to help a person function in a state of harmony between body, mind and spirit.
- Wholistic Health functioning: A state of harmony (interacting and functioning together) between body, mind and spirit. The goal of faith community nursing.
- Patient: Person that is targeted for and receives wholistic health care by FCNs.
- Standardized language: Nursing Intervention Classification used by FCNs while implementing transitional care.
- Transitional care: nursing interventions performed by FCNs provided during the patient's transition from hospital to home.

SIGNIFICANCE

This study will add to the body of knowledge of faith community nursing regarding transitional care because: a) There is a lack of knowledge about transitional care as implemented by FCNs. In a literature review of 62 articles describing transitional care, only one mentioned FCNs. In a literature review of 124 articles describing faith community nursing, only one

referred to transitional care; b) hospitals are examining innovative and efficient methods of decreasing avoidable readmissions; c) results can provide the underpinnings for testing FCN transitional care interventions; d) patients that are cared for by FCNs, may experience wholistic interventions leading to positive health outcomes and readmission avoidance; e) since faith community nursing education programs exist, educators can use the results of this study to teach transitional care interventions.

DESCRIPTION OF FAITH COMMUNITY NURSING

The practice of faith community nursing is a recognized and reliable resource of primary health care and wholistic health related services (Peterson, Atwood & Yates, 2002). The FCN is a registered nurse with additional training to provide wholistic health care (Westberg, 1990; Ziebarth, 2014a). Based on a conceptual analysis (n=124) (Ziebarth, 2014b) it was discovered that the FCN:

- Routinely performs intentional spiritual care, spiritual leadership/practices, and integrates health and faith.
- Practices with or in the faith community, home, health institution or other community setting with fluidity and consistency.
- Is a multidisciplinary and interdisciplinary team member, advocating and providing resources on many different levels
- Coordinates, implements, and sustains ongoing activities
- Routinely utilizes and applies results from surveys
- Familiar with and able to implement community and public nursing concepts and practices.
- Familiar with motivational and empowering techniques to encourage lifestyle change.

- Routinely educates and utilizes volunteers
- Practices with the knowledge and skills as a generalist (assessment, prevention, disease processes, procedures, treatments, and end-of-life issues)
- Is accessible (long-term), approachable, professional, good communicator, and culturally sensitive
- Understands the concept of "wholistic health" functioning.

Commonly used faith community nursing interventions are: a) spiritual care, spiritual practices/leadership, and the integration of health and faith; b) both multidisciplinary and interdisciplinary in resourcing and referring; c) coordinates, implements, and sustains ongoing activities; d) routinely utilizes and applies results from surveys; e) trains and utilizes volunteers from the faith community. The nurse practices with or in a faith community with the goal of supporting wholistic health functioning. Interventions occur over time when the client seeks or is targeted for wholistic health care (Ziebarth, 2014c). The delineation of what are commonly used faith community nursing interventions is important, because 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. In addition, supporting patient's spiritual needs may help them to cope with their illnesses (Puchalski, 2001; Balboniet et al, 2007; Paloutzian & Park, 2014). A gap exists in the literature in regards to the description of transitional care as provided by FCNs.

The word wholistic is derived from the root whole and is used to describe whole systems made up of multiple, interacting parts (e.g. body, mind, spirit) that function together (Allen, 2010). Health is described as a state of harmony between body, mind and spirit (Saylor, 2004). The essence of wholistic care is to help a person attain or maintain whole person health (Wolf,

2008). Allen (2010) states that the wholistic health approach for FCNs "…recognizes that God is concerned for the whole of life." (p 4)

A secular health care system divides these parts (body, mind, spirit) into categories, whereas a wholistic health care system [faith community nursing] recognizes that these parts are interacting and functioning together. Ziebarth (2014b) states that the goal of the practice of faith community nursing is wholistic health functioning. She defines wholistic health as "… the human experience of optimal harmony, balance and function of the interconnected and interdependent unity of the spiritual, physical, mental, and social dimensions. The quality of wholistic health is influenced by human development at a given age and an individual's genetic endowments, which operate in and through one's environments, experiences, and relationships" (Ziebarth, 2016, p 30).

Granger Westberg's first used the term of "wholistic health care" to describe care provided by a nurse in a church setting (Westberg & McNamara, 1990). Wholistic health care was recently defined through an evolutionary conceptual analysis as:

> "… the assessment, diagnosis, treatment and prevention of wholistic illness in human beings to maintain wholistic health or enhance wholistic healing. Identified wholistic health needs are addressed simultaneously by one or a team of allied health professionals in the provision of primary care, secondary care, and tertiary care. Wholistic health care is patient centered and considers the totality of the person (e.g., human development at a given age, genetic endowments, disease processes, environment, culture, experiences, relationships, communication, assets, attitudes, beliefs, and lifestyle behaviors). Patient centered refers to the patient as active participant in deciding the course of care. Essential attributes of

> wholistic health care are faith (spiritual) integrating, health promoting, disease managing, coordinating, empowering, and accessing health care. Wholistic health care may occur in collaboration with a faith-based organization to mobilize volunteers to support and promote individual, family, and community health" (Ziebarth, 2016).

Since FCN(s) are recognized as a source of primary health care and have additional training to provide wholistic health 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, 2014e). 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 research questions have been designed based on professional nursing experiences, conversations with practicing FCNs, and current nursing knowledge. The research questions are not addressed in current literature. The research questions can best be answered by analyzing FCN's documentation in an effort to identify nursing interventions and the frequency by which they are performed. The interventions that are performed with frequency may be recognized as essential and may provide an operational definition of transitional care as provided by FCNs. The questions are:

1. What nursing interventions are provided by faith community nurses during transitional care?

2. Which nursing interventions are implemented the most frequently by faith community nurses during transitional care?

ASSUMPTIONS OF THE STUDY

The following three assumptions apply to this study.

1. Faith community nurses implement transitional care interventions.
2. Faith community nurses (participants) document nursing interventions.
3. Documentation reports by the participants were representative of actual experiences.

THEORETICAL DEFINITIONS

CONCEPTUAL MODEL OF FAITH COMMUNITY NURSING

In an evolutionary conceptual analysis of FCN, the practice 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 1: Essential Attributes of Faith Community Nursing.

Table 1. Essential Attributes Faith Community Nursing Manifested (n=124 pieces of literature)

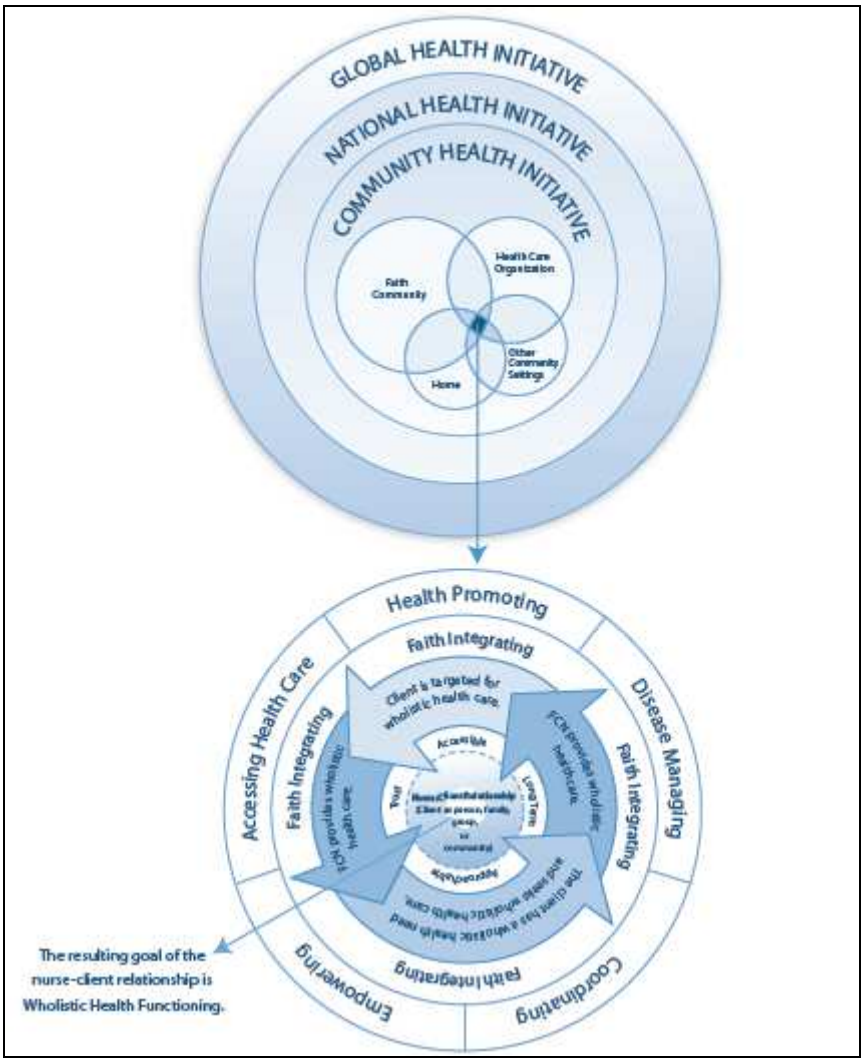
Essential Attributes	Interventions from nurse to patient (Patient as person, family, group or community)
Faith Integrating	Intentional spiritual care and religious interventions: Presence, touch, spiritual and emotional support, prayer and meditation, spiritual growth facilitation, hope and forgiveness 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 Integrating health and faith Health support: Meals, transportation, calls, visits, cards, etc. Case management
Empowering	Capacity building Supporting Encouraging Self-efficacy activities Health Counseling Symptom management Health promoting education Health resourcing Care planning Education Health support services: Meals, transportation, calls, visits, cards, etc. Lifestyle change support Care giver support
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, medical equipment, etc. Advocating Assessment: Individual, family, faith community, community, etc. Policy development Research and literature reviews

Essential attributes are recognized to be intentional manifestations in faith community nursing and confirms situations in which this specialty nursing practice occurs. Ziebarth (2014b), stated that the definition and conceptual model of FCN may be beneficial to researchers to study practice effectiveness and to create applications for practice. The conceptual model of Faith Community Nursing will be used in the study to define and clarify the practice and results. See Diagram 1: Conceptual Model of FCN.

Figure 1: Conceptual Model: Faith Community Nursing: A Method of Wholistic Health Care Delivery (Ziebarth, 2014b).



SUMMARY

With changes in the Medicare reimbursement model, hospitals are examining innovative methods of decreasing readmissions. Medicare patients are disproportionately affected by readmissions. Patients have specific characteristics and nonclinical needs that can affect the way they view, receive, and participate in health care. Supporting a patient's spiritual needs may help them to cope with their illnesses.

The conceptual model of Faith Community Nursing (Ziebarth, 2014b) helps to define the practice. Attributes of faith integrating, health promoting, disease managing, coordinating, empowering, and accessing health care are intentional manifestations of FCN. Since FCNs are recognized as reliable health care practitioners and have additional education to provide wholistic health care, transitional care interventions may look different. This knowledge may be helpful to nursing as it relates to evidence-based practice. Transitional care as implemented by FCNs, has not been described in the literature creating a knowledge gap. The purpose of this study is to describe transitional care as implemented by FCNs using a standardized nursing language, Nursing Intervention Classification (NIC). The thirty classes and seven domains of NIC will be used to describe transitional care interventions as implemented by FCNs.

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this study is to describe transitional care as implemented by faith community nurses (FCNs) using a standardized nursing language. The Nursing Intervention Classification (Bulechek, Butcher, Dochterman, & Wagner, 2013) will be used to describe nursing interventions. Primary topics for this study are transitional care, faith community nursing, wholistic health care, standardized nursing languages, and Nursing Intervention Classification (NIC).

TRANSITIONAL CARE

Factors that lead to hospital readmissions and interventions that reduce them were explored through a review of literature. This exploration is important because patients that have factors that may predispose them for readmission, targeted interventions can be initiated to reduce readmission. Ziebarth, (2015c) collected, compared, and combined a total of 62 articles using a descriptive matrix template (Marsh, 1990) to explore transitional care. 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 lead to hospital readmissions. Second group was interventions that decreased readmissions prior to hospital discharge. The third group was interventions that decreased readmissions post discharge or after hospitalization. Additionally, a review of faith community nursing literature using Nursing Intervention Classification (NIC) is presented (Ziebarth, 2015d).

FACTORS THAT LEAD TO HOSPITAL READMISSIONS

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). The Jencks 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. Patients that are admitted with these conditions and procedures may be targeted for additional transitional care to prevent readmission.

A study of 1,378 patients from nine Veteran Administration Medical Centers examined clinical and patient-centered factors predicting hospital readmission (Smith, 2000). 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. Of the disease variables, COPD increased the most risk for readmission (Smith, 2000). The two patient-centered factors significantly and independently

associated with readmission were lower mental health status and higher satisfaction with access to emergency care.

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 (Parker, Baker, Williams & Nurss, 1995; Gazmararian, Baker, Williams et al., 1999; Boult, Boult, Morishita, Dowd, Kane & Urdangarin, 2001; Wagner, Grothaus, Sandhu, Galvin, McGregor, Artz & Coleman, 2001; Baker, Gazmararian, Williams, Scott, Parker, Green, ... & Peel, 2002; Gazmararian, Williams, Peel & Baker, 2003; Holland, Harris, Leibson, Pankratz & Krichbaum, 2006; Riegel, Moser, Anker, Appel, Dunbar, Grady, ... & Whellan, 2009; Wong, Chan, Chow et al., 2010; LaMantia, Platts-Mills, Biese et al., 2010; O'Reilly, 2011; Gariballa, Forster, Walters et al., 2006; Norman, Kirchner, Freudenreich et al., 2008; Carryer, Budge, Hansen et al., 2010; Mudge, Kasper, Clair et al., 2010; Silow-Carroll, Edwards, & Lashbrook, 2011; Kurek, 2011; Coleman, Austin, Brach et al., 2009; Billings, Dixon, Mijanovich et al., 2006; Boult, Dowd, McCaffrey et al., 1993; Mistry, Rosansky, McGuire et al., 2001; Rodríguez-Artalejo, Guallar-Castillón, Herrera et al., 2006; Strunin, Stone, & Jack, 2007; Cawood, Elia, & Stratton, 2012, Berenson & Shi, 2012; Mark, Tomic, & Kowlessar, 2013). In addition, studies have found that 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 scheduled on five or more medications were found to be at increased risk of adverse event after discharge. In addition, with an increasing number of medications, adherence also decreases (Coleman, Smith, Raha et al., 2005; Forster, Clark, Menard et al., 2004, 2005; Forster, Murff, Peterson et al., 2005; Budnitz, Pollock, Weidenbach et al., 2006; Budnitz, Shehab, Kegler et al., 2007; Oake, Fergusson, Forster et al., 2007).

Allaudeen, Vidyarthi, Maselli, & Auerbach, (2010) 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, Orav, & Jha, (2011), examined hospital characteristics. They found hospitals that are resource poor financially or clinically, public owned, located in counties with low to medium income, without cardiac capability, low nursing staff, and small sized had consistently higher readmission rates (Joynt et al., 2011). In summary, risk factors for readmissions are well documented and include hospital characteristics and a patient's demographics, financial status, medical condition, procedure, multiple medications, nutritional status, mobility, and their ability to maneuver the health care environment. Awareness of these risk factors is important for those providing transitional care. Specific nursing interventions may decrease unnecessary readmissions.

INTERVENTIONS PERFORMED PRIOR TO DISCHARGE

Early Discharge Planning

Preparing the patient for discharge early in the hospitalization is important. Studies have shown that, the earlier discharge planning is addressed in the hospitalization, the better the transitional outcomes (Holland et al., 2006; Silow-Carroll et al., 2011; McCorkle, Ercolano, Lazenby et al., 2011; Desai & Konstam, 2012; Cohen, McGregor, Ivanova et al., 2012). Studies found that discharge planning should start as early as 24 hours after admission (Cohen, Perlstein, Chapline et al., 2006; McCorkle et al., 2011). Writing the anticipated discharge date in the hospital room early was found to offer more opportunities for the patient and family to be involved in discharge planning (McCorkle et al., 2011). In addition, when earlier discharge planning was done, patients were encouraged to take a more active role in care and to assert their preferences (O'Reilly, 2011).

Case Management

Studies suggested case management is important in decreasing readmissions (Watkins, Hall, & Kring, 2012; Naylor, Brooten, Campbell et al., 2012; Fabbre, Buffington, Altfeld et al., 2011). A case manager is often a nurse that provides transitional care incorporating standardize procedures before discharge. Readmissions decrease when case managers begin the discharge process early in the hospitalization and give more opportunities for patient and family to be involved. Naylor, et al (1999; 2004; 2011; 2012) describes the case manager as an advance practice nurse that provides transitional patient care prior or after discharge. Studies described the role of the case manager as performing patient level medication reconciliation prior to discharge (Naylor & McCauley, 1999; Fabbre et al., 2001; Naylor et al., 2012). (Foust, Vuckovic & Henriquez, (2012) stated that a home health nurse can act as a case manager. A review of the

medication lists by a case manager may help identify omitted or indicated medications prior to discharge (LaMantia, Platts-Mills, Biese et al., 2010). Social workers were also identified in literature as assuming the case manager role (O'Reilly, 2011; Watkins et al., 2012; Fabbre et al., 2011). Case managers were described in literature as counselors explaining and writing the discharge plans down for patients so they could understand them (Watkins et al., 2012; Naylor et al., 2012).

Education

Education was found to be another key intervention for reducing unnecessary readmissions (Williams, Parker, Baker et al., 1995; Gazmararian et al., 1999; Baker et al., 2002; Gazmararian et al., 2003). Studies recommended health care providers use the teach-back method to ensure patients understand discharge plans (Mayeaux, Murphy, Arnold et al., 1996; Baker et al., 2002; Gazmararian et al., 2003; Cloonan, Wood, & Riley, 2013). It was also suggested that patient education should be enforced daily and, per Medicare mandate, discharge plans of patients over 65, are shared with patients in writing (Naylor et al., 1999; Piraino, Heckman, Glenny et al., 2012; Cloonan, et al., 2013).

Tools

A patient booklet was developed to be used by nurses prior to discharge 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, 2014d). Halasyamani et al., 2006 found that a check off-list used by hospitalist prior to discharge gave some evidence of increasing readiness for discharge. Other tools mentioned in literature were electronic in nature to promote cross-site communication (Holland et al., 2006).

Collaboration

Collaborative hospital-clinic partnerships have been found to be effective in promoting follow-up appointments post discharge in a timely manner. Studies shared that information sharing through electronic medical records access is important between attending physician and hospital staff (Osei-Anto, 2010; Coleman, 2010; Hernandez, Greiner, Fonarow et al., 2010). Some studies stated that clinics block-out appointments so patients can see a doctor soon after discharge (Coleman, 2010; Hernandez et al., 2010; Naylor, Aiken, Kurtzman et al., 2011). A follow-up appointment is made and written in the patient's booklet prior to discharge (Osei-Anto, 2010; Ziebarth, 2014d).

Diverse Community

Studies looked at interventions such as transitional management programs that started in the hospital and followed patients into the home with calls and/or visits from nurses (Naylor et al., 1999; Fabbre et al., 2010; Naylor et al., 2012; Foust et al., 2012; Ahmad, Metlay, Barg et al., 2013). Jack, Chetty, Anthony, Greenwald, Sanchez, Johnson 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 PERFORMED AFTER DISCHARGE

Follow-up

Follow-up calls are made to patients by hospital staff anywhere from 1-7 days after discharge (Naylor et al., 1999; Dudas, Bookwalter, Kerr et al., 2001; Jha, Orav & Epstein, 2009). 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, Grothaus, Sandhu 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). Patients who were discharged from hospitals that had early clinic follow-up rates had a lower risk of 30-day readmission (Hernandez et al., 2010).

Telehealth

Studies found that telehealth technology allowed for remote monitoring of patients that require higher levels of care (Rich, Beckham, Wittenberg et al., 1995; Bowles, Hanlon, Glick et al., 2011; Looman, Presler, Erickson et al., 2013). More complex types of home telehealth devices were reported to have video capabilities that allowed for visual contact with the patient and/or remote biometric measurements, such as weight, blood pressure, pulse, temperature, pulse

oximetry, electrocardiogram and blood glucose Looman et al, 2013). Other telehealth technology devices included medication reminders and motion and position detectors (Looman et al, 2013).

Community-based Nurses

In a systematic review to identify key components regarding transitional care for older adults, Naylor, Aiken, Kurtzman, Olds, & Hirschman, (2011) found twenty-one randomized clinical trials where patients transitioned from acute care hospitals to other settings, including patients' homes or skilled nursing, rehabilitation, and long-term care facilities. Key components of nearly all nurse-led transitional care models included comprehensive medication reconciliation, case management, and support services for patient self-management. In addition, studies have found that 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 (Naylor et al., 1999; Jha, Orav, & Epstein, 2009; Marek, Adams, Stetzer et al., 2010; Hennessey, Suter, & Harrison, 2010; Conley, Cooray, Vieira et al., 2011; Piraino et al., 2012). Morales-Asencio, Martin-Santos, Morilla-Herrera et al., 2010 found that chronically ill patients that were coached had more primary care visits, but significantly fewer specialty and emergency room visits.

Collaborative hospital-community partnerships are health related programming that is facilitated with or in a community setting by a nurse. Studies have shown that faith community nurses in collaborative hospital-community partnerships may result in improvement of the patient's discharge experience, ensured post-discharge support and reduced re-hospitalization of patients (Rydholm, 1997; Schumacher, Jones, & Meleis, 1999; Nelson, 2000; Carson, 2002; Rydholm & Thornquist, 2005; Rydholm, Moone, Thornquist et al., 2008; Marek et al., 2010; Hennessey et al., 2010; Ziebarth, 2015c; Ziebarth & Campbell 2014e). The FCN effectively

assists older persons to obtain needed health care often, which prevents crisis care or readmissions. The FCN also helps 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. The FCN provides emotional and spiritual support for anxious and isolated elders (Rydholm, Moone, Thornquist et al., 2008).

FAITH COMMUNITY NURSING

The conceptual model of Faith Community Nursing (Ziebarth, 2014b) is used in this study to define and clarify the practice. A systematic review of literature identified attributes of faith integrating, health promoting, disease managing, coordinating, empowering, and accessing health care. These attributes describe the practice and confirm situations in which faith community nursing occur.

Faith Integrating

In faith community nursing classical research, Tuck (1997) reported 89 spiritual interventions, while Sellers and Haag (1998) listed 95 spiritual interventions performed by FCN(s). Types of spiritual interventions described by FCNs are instilling hope, showing compassion, emphasizing the worth of every person, and offering spiritual or emotional support (Kuhn 1997; Coenen, Weis, Schank, & Matheus, 1999; Tuck, Pullen & Wallace, 2001a; Tuck, Wallace & Pullen, 2001b; Burkhart, Konicek, Moorhead & Androwich, 2005; Solari-Twadell, 2006; ANA-HMA 2005; 2012). Integrating faith is seen in the practice as religious rituals such as readings, songs, music, communion, and healing service, spiritual assessments, and spiritual and religious care interventions such as presence, touch, spiritual and emotional support, prayer and meditations, spiritual growth facilitation, hope and forgiveness instillation, humor, resources and referrals, and showing compassion (Mendelson, McNeese-Smith, Koniak-Griffin, Nyamathi

& Lu, 2008; Miskelly 1995; Coenen et al. 1999; Chase-Ziolek & Iris 2002; Bitner & Woodward 2004; Burkhart & Androwich 2004; Burkhart et al. 2005; Mosack et al. 2006; Bard 2006; Ziebarth, 2007; Koenig 2008; Bokinskie & Kloster 2008; Hinton 2009; King & Tessaro 2009; Bokinskie & Evanson 2009; McCabe & Somers 2009; ANA-HMA 2005; 2012).

Tuck et al. (2001) measured spiritual perspective and spiritual well-being in a national sample of 305 FCNs in 34 states. One hundred and nineteen completed surveys were used for data analysis. Spiritual interventions were categorized under four headings. a) "Religious with Praying" was the first heading and described the primary intervention. Offering communion, spiritual service, and discussing spirituality were also included under this heading. b) The second heading was "Interactional", which included interventions that foster the nurse/client relationship and being with, caring, instilling hope, and supporting. c) The third was "Relational". Interventions included listening, visiting, encouraging, and talking. d) The fourth heading was "Professional Services" offered to the client. Professional services included assessing, referring, teaching, assisting, and problem solving.

Health Promoting and Disease Managing

As described in the Faith Community Nursing Scope and Standards of Practice (2005, 2012), health promotion and disease prevention activities are important processes that are linked together. Rethemeyer and Wehling (2004) found that the greatest impact on the health of the congregation as a results of faith community nursing interventions, are regular blood pressure screenings, education about heart disease and eating healthier, health-focused programs, and exercise programs. Blood pressure screenings are the most requested service and studies confirm screenings as important secondary prevention interventions (Armmer & Humbles 1995; Rethemeyer et al, 2004). Some authors identified health educational interventions with

individuals, families, and groups in their research about faith community nursing (Van Loon 1998; Weis, Matheus & Schank, 1997; Coenen et al. 1999; Tuck and Wallace 2000; Tuck et al. 2001a; Wallace, Tuck, Boland & Witucki, 2002; Bitner & Woodward 2004; ANA-HMA 2005; 2012; Burkhart et al. 2005; Koenig 2008). Health promoting is made operational in faith community nursing as health-focused programming (screenings and education), health counseling, health resources, advocacy, end-of-life planning, assessments, surveys, policy development, research, and primary and secondary levels of prevention activities (Weis et al. 1997; Van Loon 1998; Chase-Ziolek and Striepe 1999; Coenen et al. 1999; Tuck & Wallace 2000; Tuck et al. 2001a; Wallace et al. 2002; Chase-Ziolek & Iris 2002; Burkhart et al., 2005: Burkhart et al., 2004; Bitner et al., 2004; ANA-HMA 2005; 2012; Farrell & Rigney 2005; Bard 2006; Koenig, 2008; McGinnis & Zoske 2008; King et al., 2009; Hinton 2009). Disease managing is made operational as symptom management, care planning, disease resources or referrals, disease support services, management or surveillance of therapeutic regime, visits, disease-focused education, disease counseling, advocacy, and tertiary level of prevention activities (Weis et al. 1997; Van Loon 1998; Coenen et al. 1999; Tuck et al., 2000; Tuck et al. 2001; Wallace et al. 2002; Bitner et al., 2004; ANA-HMA, 2005, 2012; Burkhart et al. 2005; Koenig 2008).

Coordinating

Coordinating is made operational in faith community nursing as planning and facilitating ongoing activities (screenings, community health events, education, support groups), recurring meetings (health committee, social concerns, volunteer training), support services (meals, transportation, calls, visits, cards), media (newsletters, bulletins, health displays), and case management (Westberg 1986; Van Loon 1998; Hickman 2006; ANA-HMA, 2005, 2012;

Ministry Health Care, 2006; Bard 2006; Presbyterian Church 2007; Health Ministries Association, 2007; Van Dover & Pfeiffer 2007; IPNRC 2010). Coordinating is also seen in coordinating the health record, data collection, and reports Bergquist & King 1994; Wilson 1997, ANA-HMA 2005, 2012).

Empowering

Solari-Twadell and Westberg (1991) described faith community nursing as helping people to be better partners in the management of their health. Clients find that they are empowered by FCNs to follow through with referrals and maintain lifestyle changes (Wallace et al. 2002). Empowering is seen as capacity building, supporting, encouraging, health support services, surveillance, counseling, self-efficacy activities such as education on how to use the healthcare system, and education techniques such as return demonstration and motivation interviewing (Chase-Ziolek 1999; Brendtro & Leuning 2000; Tuck et al., 2000; Wallace et al. 2002; Burkhart et al., 2004; ANA-HMA, 2005, 2012). Empowering is also seen in serving as preceptors for students (Brendtro et al., 2000; Otterness et al. 2007).

Accessing Health Care

In understanding the client's experience of receiving nursing care in the context of a faith community, clients with at least five contacts stated the nurse educated them about how to communicate more effectively with their physician and referred them to see their physicians regularly. "Rather than replacing other healthcare services, the nursing services in the congregation enhanced the use of traditional care through providing advocacy and increasing accessibility…" (Chase-Ziolek & Gruca 2000, p.181). Accessing health care is observed through the multidisciplinary and interdisciplinary practice within a healthcare team (Pratt 2006; Cheadle, Hsu, Schwartz, Pearson, Greenwald, Beery, et al. 2008; Ziebarth & Miller 2010). On a

national level, The FCN have been involved with health policy development and research that increased healthcare access (Au, Taylor, & Gold, 2009; Ziebarth, Healy-Haney, Gnadt, Cronin, Jones, Jensen & Viscuso, 2012). The practice of faith community nursing is made operational by assisting individuals to access health care by decreasing barriers and navigating healthcare systems (Brendtro et al, 2000; Chase-Ziolek et al 2002; Burkhart et al. 2005; Bard 2006; Patterson 2007; Bokinskie et al., 2008; Bokinskie et al., 2009; ANA-HMA 2005, 2012).

The conceptual model of Faith Community Nursing (Ziebarth, 2014b) identified attributes of faith integrating, health promoting, disease managing, coordinating, empowering, and accessing health care. Since the purpose of the study is to describe transitional care as implemented by FCNs using a standardized nursing language, the attributes of Faith Community Nursing provide a systematic description and confirms situations in which it occurs. Essential attributes help to clarify the practice and will be used to report results.

WHOLISTIC HEALTH

To define the concept of "wholistic health", an evolutionary conceptual analysis was performed (Ziebarth, 2016). A total of 63 resources were used. Essential attributes, antecedents, and consequences were identified, which led to the synthesis of definitions. The definitions presented included: wholistic health care providers, wholistic health, wholistic illness, wholistic healing, patient, wholistic health care, and consequence of wholistic health care. For the purpose of this paper, the definitions of wholistic health, wholistic illness, wholistic healing and wholistic health care are shared to give clarity to the type of care provided by the FCN.

Definition: Wholistic Health

Wholistic health is the human experience of optimal harmony, balance and function of the interconnected and interdependent unity of the spiritual, physical, mental, and social

dimensions. The quality of wholistic health is influenced by human development at a given age and an individual's genetic endowments, which operate in and through one's environments, experiences, and relationships.

Definition: Wholistic Illness

Wholistic illness is the human experience of declining harmony, balance, and/or function of the interconnected and interdependent unity of the spiritual, physical, mental, and social dimensions. Wholistic illness occurring in one dimension impacts other dimensions. Severity of wholistic illness is influenced by human development at a given age and an individual's genetic endowments, which operate in and through one's environments, experiences, and relationships.

Definition: Wholistic Healing

Wholistic healing is the human experience of movement towards optimal harmony, balance and function of the interconnected and interdependent unity of spiritual, physical, mental, and social dimensions. Wholistic healing occurring in one dimension impact other dimensions. Wholistic healing is influenced by human development at a given age and an individual's genetic endowments, which operate in and through one's environments, experiences, and relationships.

Definition: Wholistic Health Care

Wholistic health care is the assessment, diagnosis, treatment and prevention of wholistic illness in human beings to maintain wholistic health or enhance wholistic healing. Identified wholistic health needs are addressed simultaneously by one or a team of allied health professionals in the provision of primary care, secondary care, and tertiary care. Wholistic health care is patient centered and considers the totality of the person (e.g., human development at a given age, genetic endowments, disease processes, environment, culture, experiences,

relationships, communication, assets, attitudes, beliefs, and lifestyle behaviors). Patient centered refers to the patient as active participant in deciding the course of care. Essential attributes of wholistic health care are faith integrating, health promoting, disease managing, coordinating, empowering, and accessing health care. Wholistic health care may occur in collaboration with a faith-based organization to mobilize volunteers to support and promote individual, family, and community health.

STANDARDIZED NURSING LANGUAGES

Interventions of FCNs in this study will be documented using the Nursing Intervention Classification (NIC) (Bulechek, Butcher, Dochterman, Wagner, 2013), a standardized nursing language. A standardized nursing language is defined as a "common language, readily understood by all nurses, to describe care" (Keenan, 1999, p. 12). When a standardized nursing language is used to document practice, effectiveness of care delivered in multiple settings by different providers can be compared and evaluated (Bulechek et al, 2013, p vi). Standardized nursing languages are used to describe assessments, interventions, and outcomes of nursing care. Benefits are increased visibility of nursing interventions, improved patient care, enhanced data collection to evaluate nursing care outcomes, greater adherence to standards of care, and facilitated assessment of nursing competency (Rutherford, 2008).

Since this study aims to describe transitional care as implemented by FCNs using a recognized standardized nursing language, the decision to use the NIC was decided by examining both the OMAHA System (OS) and the NIC. The NIC has two complementary parts that are often linked: North American Nursing Diagnosis (NANDA) (2005) and Nursing Outcomes Classification (NOC) (Moorhead, 2006). The NANDA and the NOC are comprehensive, research-based, standardized classifications of nursing diagnoses and nursing-

sensitive patient outcomes. These classifications provide a set of terms to describe nursing judgments and nursing-sensitive patient outcomes. The NANDA and NOC will not be included as part of this work being that the focus is on nursing interventions.

The International Classification for Nursing Practice (ICNP) was also not included. It is considered to be a Unified Nursing Language System, which contains existing taxonomies such as the OS and NIC. It also uses very broad nursing terms to represent the global nature of nursing and the cultural variation in practice (Coenen, Marin, Park & Bakken, 2001; Goossen, 2006; Coenen & Kim, 2010).

The OS (Martin, Elfrink, & Monsen, 2005) and the NIC (Bulechek et al., 2013) are both recognized as meeting the American Nurses Association (ANA) criteria for recognition and are included in Metathesaurus of the Unified Medical Language System of the US National Library of Medicine (UMLS) (Rutherford, 2008). The OS was developed in 1992 (Martin & Scheet 1992). The NIC was also published in 1992 (McCloskey & Bulechek 1996a). In a review of nursing literature, there was a lack of faith community nursing research using the OS or the ICNP. No articles were found, which may suggest a gap with exploratory potential. There were three faith community nursing research studies utilizing the NIC. The presence of research presenting FCNs successfully using the NIC, may suggest familiarity with this taxonomy and its ability to describe faith community nursing interventions. Since the aim is to describe transitional care as implemented by FCNs, using a recognized classification that has been tested in the specialty is important. The NIC was chosen to define nursing interventions in this study due to previous testing in the area of faith community nursing.

NURSING INTERVENTION CLASSIFICATION

The NIC was developed at the University of Iowa and out of the College of Nursing's Center for Nursing Classification & Clinical Effectiveness (McCloskey & Bulechek, 1994; McCloskey et al, 1996a). The NIC describes treatments that nurses perform, respectively, in various settings, specialties, and populations. The website at the University of Iowa, College of Nursing's Center for Nursing Classification & Clinical Effectiveness states that NIC is "…useful for clinical documentation, communication of care across settings, integration of data across systems and settings, effectiveness research, productivity measurement, competency evaluation, reimbursement, and curricular design" (Website: para 1). The use of NIC can facilitate the analysis of the impact of activities on patient outcomes (Lundberg, Warren, Brokel, et al, 2008). Each intervention includes a definition and a unique numeric code that can be used for reimbursement of nursing interventions (Lundberg, et al, 2008). The NIC codes are also used to facilitate computer use.

The NIC is used in electronic health record implementation of plans of care, critical pathways, order sets, patient education and data sets for the evaluation of care at the individual or unit level (Cullen, Greiner, Greiner, Bombei, & Comried, 2005; Lundberg et al, 2008). The use of the NIC in an electronic health record has facilitated the appropriate selection of nursing interventions used to demonstrate the impact of nursing by communicating nursing interventions to other health care providers (Lundberg et al, 2008). This allows communication with other coded systems, such as SNOMED, NANDA and NOC and mapped into the ICNP. The NIC is recognized by the ANA and is included as one data set that meets the uniform guidelines for information system vendors in the NIDSEC (Kim, Coenen, Hardiker et al, 2011). The NIC is

included in the CINAHL and the Joint Commission recognizes NIC as meeting the standards of uniform data (Kim et al, 2011).

The NIC is updated in an ongoing process with practice feedback, research, and practice guidelines. The NIC was first published in 1992, the second edition in 1996, the third edition in 2000, the fourth edition in 2004, the fifth edition in 2008, and the sixth edition in 2013 (Bulechek et al, 2013). A research team works to construct, validate, and implement NIC as a standardized language for nursing interventions using a variety of qualitative and quantitative methods including content analysis, expert surveys, hierarchical analysis and multidimensional scaling (Bulechek et al, 2013). This team of researchers has been testing the usefulness of NIC and its implementation in growing numbers of client populations, information systems and educational programs (Bulechek et al, 2013). In addition, the NIC is based on standards of care from various professional organizations. For example, the NIC intervention of electronic fetal monitoring: intrapartum (McCloskey-Dochterman & Bulechek, 2004) is supported by publications of expert authors and researchers in the field of fetal monitoring and by standards of care from the Association of Women's Health, Obstetric and Neonatal Nurses (Johnson, Posner, Biermann et al, 2006; Macones, Hankins, Spong et al, 2008).

The NIC is used in a variety of settings, nationally and internationally. It has been translated into Chinese, Dutch, French, German, Portuguese, Japanese, Korean, and Spanish (Lundberg et al, 2008). The NIC has been tested in acute care, intensive care units, home care, hospice care, parish nursing, long term care, primary care, and in all nursing specialties (Lee & Mills, 2000).

In the specialty of Advanced Practice Register Nursing (APRN), NIC consistently measured interventions in two separate studies. In the first study, O'Connor, Hameister, &

Kershaw (2000) used NIC to collect interventions from 19 APRN students. Three years later Haugsdal & Scherb, (2003) surveyed 1,190 APRN in Minnesota. The two studies found that the results were almost identical.

Cavendish, Lunney, Luise et al, (2001), surveyed sixty-four members of the National Association of School Nurses to describe the nursing interventions of elementary school children. In 2008, Kreulen, Bednarz, Wehrwein et al, used NIC to describe school nursing interventions in 1,279 school nurse contacts and 769 student nurse contacts. Again, the results from the two studies were similar.

Three studies using NIC in the specialty of faith community nursing were found (Weis, Schank, Coenen et al, 2002; Burkhart et al., 2004; Solari-Twadell, 2006; Solari-Twadell & Hackbarth, 2010). The largest sample was a survey sent to nurses who had attended the standardized *Basic Parish Nurse Training* program. Respondents (n = 1,161) represented all major religious denominations in 47 states (Solari-Twadell, 2006; Solari-Twadell et al., 2010). The NIC (3rd Ed.) was used. Of the 486 possible nursing interventions listed, 417 were reported as used and were mostly clustered in the Behavioral domain. Fifty nursing interventions accounted for 80% of the most frequently used interventions. The top 30 interventions appeared in a pattern measuring daily, weekly, and monthly frequencies. Solari-Twadell et al., (2010) considered these interventions to be ‘‘core’’ to faith community nursing were defined as care that supports psychosocial functioning and facilitated lifestyle changes. Solari-Twadell (2006) also presented a combined list of 32 interventions from the most frequently used interventions on a daily, weekly and monthly basis. The most frequently used interventions from that list are communication enhancement, coping assistance, and patient education. Respondents reported the most frequently used interventions to be active listening in the communication class and

presence, touch, spiritual support, emotional support, spiritual growth facilitation, hope instillation, humor, and counseling in the coping assistance class. Religious ritual enhancement, truth telling, and values clarification, as well as assisting a person to gain self-awareness and support in decision-making were also prominent coping assistance interventions. The class of patient education was also identified with emphasis on health education and teaching disease management (Solari-Twadell, 2006; Solari-Twadell et al., 2010).

Health System was the second prominent domain and is defined as care that supports effective use of the healthcare delivery system. Frequently used interventions included documentation, telephone consultation, and telephone follow-up. The third domain identified was Family, defined as care that supports the family unit, and included the intervention of caregiver support. Within the Safety domain, interventions were defined as care that supports protection against harm and community was defined as care that supports the health of the community. Frequently used interventions included health screening and vital sign monitoring. Program development was an intervention identified from the Community domain (Solari-Twadell, 2006; Solari-Twadell et al., 2010).

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 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). The 7 domains are: Physiological: Basic, Physiological:

Complex, Behavioral, Safety, Family, Health System, and Community. The Physiological Basic domain is defined in NIC as care that supports physical functioning. Classes in this domain include management and facilitation of activity and exercise, elimination, immobility, nutrition, physical comfort, and self-care. The Physiological: Complex domain is defined in NIC as care that supports homeostatic regulation. Classes in this domain include management of electrolytes and acid-base levels, drugs, neurologic status, perioperative care, respiratory status, skin and wounds, thermoregulation, and tissue perfusion. The third domain is Behavioral, defined by NIC as care that supports psychosocial functioning and facilitates lifestyle changes. It includes the classes of behavior therapy, cognitive therapy, communication enhancement, coping assistance, patient education, and psychological comfort promotion. The fourth domain is Safety, defined by NIC as care that supports protection against harm. Relevant classes are crisis and risk management. The fifth domain, Family, is defined by NIC as care that supports the family unit. Relevant classes include childbearing care and lifespan care. The sixth and final domain is Health System, defined by NIC as care that supports effective use of the healthcare delivery system. Three classes constitute this domain, namely, health system mediation, health system management, and information management (Bulechek et al., 2013. Even though, NIC has been used to describe the practice of faith community nursing, citations are not current (within the last five years) and studies do not describe specific transitional care interventions.

SUMMARY

Disease variables, certain conditions such as physical and/or psychological illnesses increase 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 included Medicare and Medicaid payer status, markers of frailty and elderly with complex medical, social and financial needs. Lack of caregiver or social support, poor health literacy, 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 have coached patients after discharge.

Faith integrating, health promoting, disease managing, coordinating, empowering, and accessing health care are essential attributes that are shown to operationalize the concept of faith community nursing. Essential attributes are recognized to be intentional manifestations. Essential attributes help to clarify the practice.

The NIC is an ANA recognized standardized nursing language and describes what the nurses do in a variety of specialties and settings both nationally and internationally. The NIC is considered a separate classification from its counterparts, NANDA and NOC. The NIC has ongoing research activities for future revising and reliability. Components of the NIC have descriptors, which give clarity. The author did not find literature to support the use of one standardized language over another in the specialty of faith community nursing. The presence of research with FCNs successfully using the NIC, suggest familiarity with this taxonomy and the ability to describe interventions. Since this study will describe transitional care interventions as implemented by FCNs, using a recognized classification that has been tested in the specialty is advantageous. The NIC has been used to describe the practice of faith community nursing. To describe transitional care interventions as implemented by FCNs, the thirty classes and seven domains of NIC will be used.

CHAPTER THREE

METHODS

The plan for implementing a qualitative descriptive study of transitional care interventions as implemented by faith community nurses (FCNs), is presented in this chapter. The plan includes a) the rationale for the study design, b) the target population and sampling criteria, c) methods for protecting human subjects, d) recruitment, e) data collection, and f) analysis. The appendices include: screening questions (Appendix A), the consent form (Appendix B), and focus group questions (Appendix C).

RESEARCH DESIGN

A mixed method descriptive design will be used to describe transitional care interventions as implemented by FCNs. A mixed method descriptive design was selected in order to facilitate a thorough exploration of the research questions. 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). The description and operationalization of transitional care as implemented by FCNs may provide the underpinnings for further testing of the variable. 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" (Clark & Lang, 1992, p. 109). Naming transitional care interventions performed by FCNs is the first step towards understanding its impact and implications. A qualitative descriptive method will operationalize and define the variables regarding transitional care interventions performed by FCNs. A quantitative descriptive design will be used to count nominal categories of documented nursing interventions. In describing transitional care as provided by FCNs, factors may be identified

which might influence behaviors. Further quantitative research may show correlation among these factors.

The collection and thematic exploration of transitional care interventions documented by FCNs using the Nursing Intervention Classification (NIC) will be undertaken in Phase 1 of the study. In addition, nominal categorical analysis will present frequencies of most often used nursing interventions in NIC. Following completion of data analysis, Phase 2 will consist of the qualitative analysis of a focus group conducted with study participants to ensure that the description of transitional care as implemented by FCNs is rich, robust, comprehensive, well-developed, and validated (Denzin, 1978; Patton, 1999).

SETTINGS

Data will be obtained through a collaboration between a community hospital and an associated Church Health Center. The hospital is located in central Florida and serves a large urban city. It has 160 beds and employs three FCNs who provide transitional care. Each nurse works in a faith community setting in the community surrounding the hospital. The Church Health Center (CHC) has a "business associate" contract with this employing hospital to collect nursing intervention documentation data for research purposes. The CHC houses the International Parish Nurse Resource Center (IPNRC), which provides curriculum, education, and practice resources for FCNs. They host the annual Westberg Symposium, which serves as the research conference for FCNs. The IPNRC routinely engages in faith community nursing research. They are supportive of this research study to identify transitional care interventions as implemented by FCNs.

SAMPLE

All FCNs in the study are employees of a hospital and perform transitional care for patients transitioning from hospital to home. The hospital has a formalized business agreement with CHC and works closely with CHC staff in hiring and training FCNs to perform transitional care. For this study, the hospital will share FCNs anonymized documentation to a PhD prepared nurse employed by CHC. All FCNs in the study will be asked to participate in a focus group following the analysis of their documentation. The FCNs have attended both the Faith Community Nurse Foundation's course and Faith Community Nurse Transitional Care training provided by the CHC. This Faith Community Nurse Transitional Care education program was created and facilitated by the author of this study.

Documentation

Data will be received in one or more of four forms: a) narrative nursing intervention documentation in paper format written freehand in pen, b) narrative nursing intervention documentation typed into Word format electronically, c) electronic documentation with nursing interventions transposed into NIC format, and d) electronic documentation with nursing interventions presented in a narrative format. Participants may use 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). There is also a narrative component where FCNs can documents electronically. There is a cost to use the system, which may present a financial hardship for many FCNs and limit its use in general as many FCNs are unpaid.

Faith Community Nurse Foundation's Course

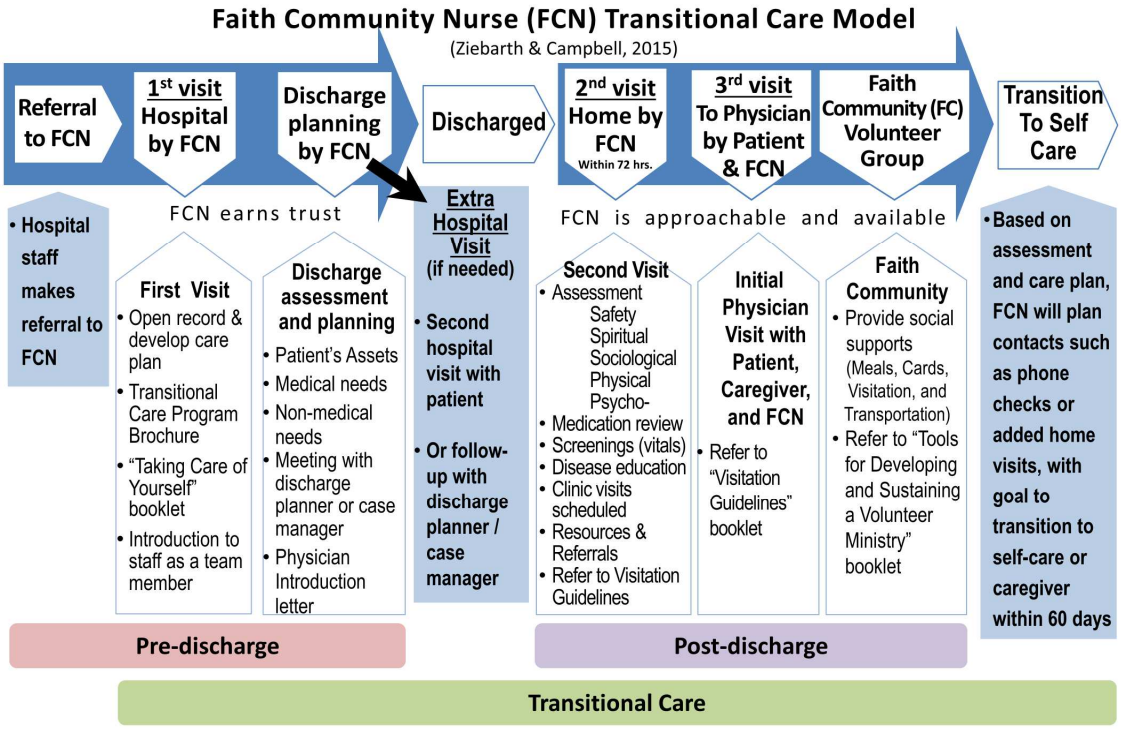
The Faith Community Nurse Foundation's course is designed to introduce and prepare registered nurses for the specialty practice of faith community nursing (IPNRC, 2014: Jacob, 2014). The current version (2014) has 19 module authors and 10 reviewers, all considered experts in the field. Module authors 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. They have varying lengths from two to four hours for total contact hours of 38 to 40.5 hours and include such topics as spiritual care, prayer, self-care, ethical issues, documenting practice, behavioral health, health promotion, life issues of violence, suffering and grief, assessment and care coordination. 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 will attend the Faith Community Nurse Transitional Care education program. This occurs 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; 2016). The goals of the program are to a) endorse wholistic health by using FCN(s) 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. Four standards of practice are reviewed: a) Leadership- standard #12; b) Communication- standard #11; c) Collaboration- standard #13; and d) Coordination of Care- standard #5A. In addition, a model of transitional care is shared (Ziebarth & Campbell, 2014; 2016).

Figure 2: Faith Community Nurse Transitional Care Model



Resources such as: Faith Community Nurse Visitation Guidelines. (2014), Taking Care of Myself, and a program brochure are available to participants to use in their contact with the patient. The booklet, "Tools for Developing and Sustaining a Faith Community Volunteer Ministry Group (Ziebarth, 2014) is offered to participants to guide them in their contact with faith communities. In addition, FCNs can use any resources that they want in their professional role as registered nurses.

SAMPLE SIZE

In qualitative research, the sample size is flexible (Burns & Grove, 2005). The general rule is that data will be collected until a point of saturation is reached (Sandelowski, 1995). Each FCN participant can care for four to six patients at one time and averages three visits per patient over the 30 days post discharge. Sample size is dependent upon the purpose of the study (Creswell, 2003). The purpose of this study is to describe transitional care as implemented by FCNs. To do this, it is estimated that no less than three and no more than five FCN study participants will be sought. Documentation will be collected from each nurse over a three month period. It is estimated that a 60 documentation pieces/records will be needed in this study.

DATA RIGOR, CREDIBILITY AND CONFIRMABILITY

After collection, the documentation will be ascertained for a thematic analysis to describe transitional care as implemented by FCN(S). The goal in rigorous research is to accurately represent the participant's experiences (Speziale, Streubert, & Carpenter, 2007). In this study, the participant's experiences performing transitional care will be captured in their documentation of nursing interventions. In an effort to describe transitional care as implemented by FCNs, certain variables may limit data collected. These variables include the ability of the FCN to document reliable information and the ability of the researcher to interpret nursing interventions (Merriam, 1998).

To limit variables that could influence the credibility of study, four strategies have been used to enhance accurate data collection and ensure credibility and rigor: (a) The FCN study participants have received the same education. All participants have attended both the Faith Community Nurse Foundation's course and have received Faith Community Nurse Transitional Care education program. The same individual, the researcher, teaches the Faith Community

Nurse Transitional Care education program; 2) A PhD prepared nurse at the CHC will audit the data trail and examine the coding process, thus sharing the accountability and encouraging confirmability (Creswell, 2003; Sandelowski, 1995); 3) a focus group will be conducted in Phase 2 to obtain feedback from the FCN participants, concerning the accuracy of results to ensure credibility; and 4) the practice of faith community nursing is fully described in rich details using the Conceptual Model of Faith Community Nursing (Ziebarth, 2014). The Conceptual Model of Faith Community Nursing (Ziebarth, 2014) presents essential attributes of faith community nursing to describe the practice and roles. Additionally, the study's assumptions are explained in Chapter 1 of the study. The study's descriptions of transitional care as implemented by FCNs may enable applicability of research findings to other similar situations, however that is not the intent of this qualitative study.

DATA COLLECTION PLAN

During the FCN Transitional Care Training, FCNs will be invited to volunteer to share anonymous nursing documentation by the PhD prepared employee of the CHC. The study procedure will be explained to each volunteer by the researcher in private following the education. If the volunteer is interested in participating, a series of preliminary screening questions, using Appendix A, will be asked by the researcher. If the volunteers meet eligibility criteria, the consent form will be presented. The consent form (Appendix B) will cover their agreement to share anonymous nursing intervention documentation in a timely manner and to participate in the focus group. It will inform them of the intent and benefits of the research study and detail the expectations of their participation (Burns & Grove, 2005, p.192). The participation section includes instructions about where to send their password protected anonymous documentation. They will also be informed that data from this study will be used by the

researcher in partial fulfillment of her requirements for a PhD in Nursing from the University of Wisconsin- Milwaukee.

The study participants' employing hospital has a business agreement with the CHC. 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 (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 will have no patient identifiers. The data set will only have transitional care interventions performed by FCNs.

A PhD prepared nurse at the CHC will initially receive the nursing intervention data in the form of documentation from participating FCNs and forward it to the researcher. This person will ensure that data is anonymous and also audit the data trail. The researcher will describe and demonstrates the analysis of the data to a PhD prepared nurse to audit the data trail. Data will be collected from each participant over a period of three months and represent nursing interventions provided during a period of thirty-day post hospitalization. The amount of documentation will vary based on the FCNs patient load, referrals, and number of visits. All data will be saved on an encrypted USB jump drive. The jump drive and all raw data will be protected in a locked file drawer only accessible to the researcher and destroyed seven years after the completion of the research study per UWM Records Retention/Disposition Authorization policy (p 3).

PROCEDURE FOR DATA ANALYSIS OF FCN DOCUMENTATION

The researcher will engage in an active and rigorous analytic process throughout all phases of the research. Narrative documentation coding will include three steps:

Step One: Data Reduction

Data reduction refers to the process of selecting, focusing, simplifying, abstracting, and transforming the data (Miles & Huberman, 1994). "Not only does the documentation need to be condensed for the sake of manageability, it also has to be transformed so it can be made intelligible in terms of the issues being addressed" (Miles et al., 1994, p 16). Data reduction forces choices about which aspects of the assembled data should be emphasized, minimized, or set aside completely for the purposes of the project at hand. There are two parts to the reduction process: 1) Ocular scanning or reading the documentation and underlying key phrases or descriptors of interventions and 2) Template analysis (Polit & Beck, 2006), which involves a second look at the data for themes.

Sandelowski (1995, p 373) observed that coding of texts begins with "proofreading the material and simply underlining key phrases". Ryan and Bernard (2000) refers to this as the ocular scan method, otherwise known as ocular scanning or "eyeballing." Bogdan and Biklen (1982) suggested reading the text at least twice before underlining key phrases.

Boyatzis (1998) describes template analysis as recognizing important moments or themes in the data prior to interpretation. Themes describe an outcome of coding and consist of ideas and descriptions that can be used to explain causal events (Riessman, 2008) or in this case, nursing interventions. Theme recognition is guided by the study questions: 1) What interventions are provided by faith community nurses during transitional care? 2.) Which interventions are most implemented by faith community nurses during transitional care? Selectivity of themes

include examination of all the relevant data sources to extract a description of what they say about nursing interventions. The researcher will read the documentation and underline descriptors of interventions. A second look at data for nursing interventions will occur. Text that describe nursing interventions, will be highlighted with computer generated highlight colors to represent similar nursing interventions.

Step Two: Interpretation through Data Display

Data display goes a step beyond data reduction to provide "an organized, compressed assembly of information that permits conclusion drawing..." (Miles et al., 1994, p10). Data display is a new way of arranging and thinking about the more textually embedded data and allows for extrapolation of enough data to begin to discern systematic patterns and interrelationships. In this step, additional, higher order categories or themes may emerge from the data that go beyond those first discovered during the initial process of data reduction. The researcher will display data using Microsoft Excel® software. The standardized nursing language, Nursing Intervention Classification (NIC) (6th ed.), will serve as a coding framework (Bulechek, et al, 2013).

The NIC includes the interventions that nurses do on behalf of patients. While each nurse will have expertise in a limited number of interventions reflecting on the specialty, the NIC captures the expertise of all nurses. The 554 interventions in NIC (6th ed.) are grouped into thirty classes and seven domains for ease of use. The NIC is used in a variety of settings, nationally and internationally and is recognized by the American Nursing Association.

The thirty NIC classes will be entered into a Microsoft Excel® program first. The interventions from the coding template that align with NIC classes will then be cut and pasted in aligning cells. In addition, the Microsoft Excel® columns will be used to paste supporting

verbatim descriptive text. Another column will be used to collect “additional knowledge” related to transitional care. Some data collected may already be reduced to NIC format as some participants may use the Henry Ford Macomb’s electronic tool (Girard, 2013) to document nursing interventions. In that case, NICs will be collected, counted, and aligned to nominal categories of Classes and Domains.

Step Three: Translation and Validation

Translation and validation is the third element of qualitative analysis. Conclusion drawing involves stepping back to consider what the analyzed data mean and to assess its implications for the research questions (Patton, 1990). Verification, integrally linked to conclusion drawing, entails revisiting the data as many times as necessary to cross-check or verify these emergent conclusions. "The meanings emerging from the data have to be tested for their plausibility, their sturdiness, their ‘confirmability’ - that is, their validity" (Miles et al, 1994, p. 11). Validity means the conclusions being drawn from the data are credible, defensible, warranted, and able to withstand alternative explanations. The thirty classes and seven domains of NIC will be used to answer the research questions: 1) What nursing interventions are provided by faith community nurses during transitional care? 2.) Which nursing interventions are most implemented by faith community nurses during transitional care? Answering the research questions about transitional nursing care will go beyond enumerating a list of interventions to also probing the reasons for believing which interventions are more often used and which are considered to be essential. This inquiry will occur in the focus group when the researcher shares with FCNs the most frequently performed nursing interventions in an effort to validate results. Apart from exploring the specific content of the respondents' views, the researcher will take note

of the relative frequency with which issues are raised, as well as the intensity with which they are expressed. This will be done with numerical descriptors.

PROCEDURE FOR DATA ANALYSIS OF FOCUS GROUP

Focus group data were collected, transcribed, simplified, and coded. Recorded data and field notes collected in the focus group were anonymous without names and were transcribed by a hired transcriptionist into typed text within a month after the focus group was conducted. The transcript was read again by the researcher while listening to the taped recording of the focus group to verify the accuracy of the transcription.

Step 1: Key-Words-in-Context

Key-words-in-context is a type of analysis that identifies key words and concepts and then systematically searches the data to find all instances in a document (Spradley, 1972). Pawing through texts and marking the narrative up with different colored highlighter pens is recommended. This is a cyclical process going back and forth during data analysis as needed until you are satisfied with the final themes (Braun & Clarke, 2006).

Step 2: Identifying Possible Themes

By pawing through the text, key words and key concepts in verbatim statements were identified and color coded using the highlighting tool on Microsoft Office Windows 8. By color coding key words and key concepts in the narrative, themes were identified from the data. A theme represented a level of patterned response or meaning from the data that related to research questions, keeping in mind that themes need to provide an accurate understanding of the big picture (Saldana, 2009). Themes can be identified at semantic and latent levels (Boyatzis, 1998). This thematic analysis focused on the sematic level. Semantic themes attempt to identify the

explicit and surface meanings of the data. The researcher color coded explicit responses of the focus group members to questions such as, “What do you think about the results of the study?”

Step 3: Comparing and Contrasting Themes

The interpretation step includes comparing theme frequencies, identifying theme co-occurrence, and graphically displaying relationships between themes in a matrix (Guest, MacQueen, Namey, 2012).The researcher used a descriptive matrix to further reduce, contrast, and compare the totality of findings (Marsh, 1990). Ziebarth and Miller (2010) used a matrix to reduce data and inserted “Example of Descriptive Matrix” (p 276) in their published manuscript. The matrix uses conceptual space to collect and code main points or meanings of the actual statements of the participants. The matrix has horizontal rows and vertical columns, much like a table. The researcher inserted themes of related concepts and supporting descriptive narratives into the rows of the matrix. The researcher then compared and contrasted these themes. The compare and contrast approach is based on the idea that themes represent the ways in which texts are either similar or different from each other. Glazer and Strauss (1970, pp 101) refer to this as the "constant comparison method." During this step some existing themes may collapse into others (Braun et al, 2006).

Step 4: Report

After themes were reviewed, conveying the story in a report was the next step. The researcher presented themes, followed by interpretations. This was followed by the verbatim statements of the focus group found in text. The focus group data analysis validated the study’s results and brought related issues to light. The focus group provided construct validity in the description of transitional care as provided by FCNs and the factors that might influence behaviors. If the focus group narrative did not validate the initial analysis, then the findings

would have been reported as research results. In addition, a review of the initial analysis would have occur.

PROTECTION

Prior to the study being initiated, the researcher obtained approval from the Internal Review Board at the University of Wisconsin, Milwaukee. The IRB application was submitted and has been approved. As is consistent with IRB guidelines, participation in this study is voluntary. Due to the nature of the study there was minimal risk to participants. Participants signed a consent form (Appendix B) that informed them of the intent and benefits of the research study and detailed the expectations of their participation. They were informed that data from this study would be used in partial fulfillment of the requirements for a PhD in Nursing from University of Wisconsin, Milwaukee. Participants were informed that they could withdraw from the study at any time and their data would be destroyed. The verbal and written permission of participants were documented on the consent form and will be kept in a locked file, only accessible to the researcher for a period of seven years. All volunteers were adults, over the age of 18 years, and currently registered as a nurse. Participants were all practicing as a FCN and attended both the Faith Community Nurse Foundation's course and the Faith Community Nurse Transitional Care education program. Nursing intervention documentation did not have any identifying information or links; thus, anonymity was afforded.

The benefits of participating in this study was explained to participants. An opportunity for questions was provided. One benefit is that this study may generate new knowledge influencing the education of future faith community nursing and subsequently influencing the provision of quality nursing care to community clients. The findings from this study may be presented at nursing conferences and published in nursing literature.

SUMMARY

A mixed method design was used to fully describe the phenomenon of transitional care interventions as implemented by FCNs. Participants were sought that fit the criteria. Study participants were asked to sign a consent form that contains content and intent of the research study and details the expectations of their participation. Participants were asked to share their anonymous nursing intervention documentation that was collected during the period when transitional care was provided. A thematic analysis reduced, interpreted, and translated data. Peer examination of the coding process of data encouraged internal validity.

Volunteers were asked to participate in a focus group. Focus group data was collected, transcribed, simplified, and coded. The focus group provided validity in the description of transitional care as provided by FCNs and the factors that might influence behaviors. The conceptual model of Faith Community Nursing (Ziebarth, 2014b) was used in the study to define, clarify, and operationalize the practice. The model was used to understand attributes of the practice, such as faith integrating, health promoting, disease managing, coordinating, empowering, and accessing health care. These are intentional manifestations that confirm situations in which faith community nursing occur. The thirty Classes and seven Domains of NIC was used to describe transitional care interventions as implemented by FCNs. The study generated new knowledge that can be used to influence future faith community nursing education and subsequently effect the provision of quality nursing care to community clients. Chapter three appendices included Appendix A: Preliminary Screening Questions, Appendix B: Consent Form, and Focus Group questions (Appendix C).

CHAPTER FOUR

RESULTS

The purpose of this mixed method descriptive research study was to describe transitional care as implemented by faith community nurses (FCN) using a standardized nursing language, Nursing Intervention Classification (NIC) (6th ed) (Bulechek, Butcher, Dochterman et al, 2013). The qualitative and quantitative descriptive design of this study was selected because it allowed for thorough exploration of FCN documentation in describing transitional care nursing (Polit & Beck, 2006). The study was performed in two phases.

In Phase 1, nursing interventions documented by FCNs while facilitating transitional care were collected in two documentation forms: 1) NICs captured electronically and 2) nursing notes. A thematic analysis of nursing notes was done using NIC as a coding framework. The research questions served as a guide. The research questions were:

1.) What interventions are provided by faith community nurses during transitional care?

2.) Which interventions are most implemented by faith community nurses during transitional care?

In Phase 2, a focus group consisting of FCNs who had participated in the study was conducted to seek confirmation of the Phase 1 results. Focus group data were thematically coded for themes. The results of the study describing transitional care interventions as documented by FCNs and the focus group themes will be presented in this chapter following the description of participants and how the documentation was managed.

PARTICIPANTS

The three FCN participants in this study were employees of one hospital located in central Florida. Each FCN works with a faith community in providing transitional care. The

hospital has a business agreement with Church Health Center, which allowed data sharing. The FCNs each attended the FCN Foundation's Course and FCN Transitional Care training provided by Church Health Center. The FCNs signed consents and institutional review board approval was obtained. All three FCNs provided nursing care to patients transitioning from hospital to home and documented their interventions. Each FCN shared their documentation of nursing interventions over a three month period.

The FCNs participated in a focus group following the analysis of their documentation as a means to validation study results. The focus group provided an opportunity to collect limited demographic information on study participants. Table 2 presents the FCN's ages, years of experience in faith community nursing and previous professional nursing experiences.

Table 2: Faith Community Nurses

Participants	Age	Years of FCN experience	Types and years of previous nursing experiences
1	36	1	Neuroscience Nursing 2.5 years
2	63	5	Missionary Nursing 12 years
3	62	13	Cardiac Nursing 24 years

HANDLING OF THE DOCUMENTATION: DATA COLLECTION AND MANAGEMENT

Patient visits were provided by the FCN either in person or by phone. The FCNs were instructed by their hospital managers to use the Henry Forbes McCombs (HFM) program for nursing intervention documentation. The 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 is an American Nursing Association

(ANA) recognized standardized nursing language that describes what nurses do in a variety of specialties and settings. 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).

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. It was estimated by nurse caseload and referrals that to achieve a point of saturation that the researcher would analyze the documentation records representative of 60 FCN patient visits. A total of 73 nurse documentation records representing 73 FCN patient visits during the three month study period were analyzed. The FCNs documented anywhere from two to six nursing interventions which had occurred during each patient visit. Each visit averaged three (3) nursing interventions. A total of 210 nursing interventions were documented.

A PhD-prepared nurse employed by Church Health Center 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 conducted by this researcher, a Microsoft Excel® spread sheet was created to align thematic themes, which were nursing interventions, into the thirty Classes of

NIC. This method of analysis was insufficient for this study as the analysis needed to occur at the individualized nursing intervention level of NIC. The goal of this study was to collect and describe transitional care as provided and documented by FCNs. Therefore, the researcher worked with a computer programmer to develop a Microsoft Excel® software program, currently referred to as the Nursing Intervention Classification Analysis Program (NICAP). This data management program was created specifically for this study. The NICAP provides the capacity to collect and organize large numbers of individual nursing interventions as coded by NIC into a manageable database for the ease of analysis.

In preparation for NIC collection, analysis, and translation, 554 non-duplicated NICs (6th ed.) (Bulechek, Butcher, Dochterman et al, 2013) and 91 duplications (n= 645) were manually entered into the NICAP by the researcher. 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. Even though the NICAP development was very time consuming, it is anticipated that it will prove useful in future nursing intervention studies. All NICs documented electronically by FCNs were entered into the NICAP.

Nursing interventions were also documented in nursing notes by FCNs. There were 22 nursing notes available for analysis. Each nursing note averaged 125 words. The nursing notes 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. Since the NICs identified in the nursing notes were similar to those in the list of NICs received electronically, it was assumed that FCNs sometimes documented certain interventions both electronically and through narrative means. The focus group participants confirmed that nursing notes were used to describe interventions and provide context. After confirming with the focus group, it was decided that these interventions would not be added to the Microsoft Excel® software program for analysis.

FINDINGS

A Microsoft Excel® software program, NICAP, was developed to collect and analyze the quantitative nursing intervention data (NICs) collected in the study. Each nursing intervention in the NIC represents a set of nursing activities. There are a total of 13,000 nursing activities that define the standardized nursing interventions. The NICAP aligned each nursing intervention to a numeric code, class and domain and generated infographic displays based on the aggregate data entered. Out of the 554 possible nursing interventions, 52 (9.4%) were reported to have been used at least once with a total of 210 interventions documented. Table 3 highlights a list of the 26 NICs that describe the bulk of transitional care interventions provided by FCNs. Table 3 contains 26 listed in order of the most frequently selected NICs. The numeric codes, to the left of the nursing intervention in Table 3, 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).

Table 3: Frequently Selected Nursing Interventions

Order of frequency	Code	Standardized Nursing Intervention	Standardized Nursing Intervention Definition	#

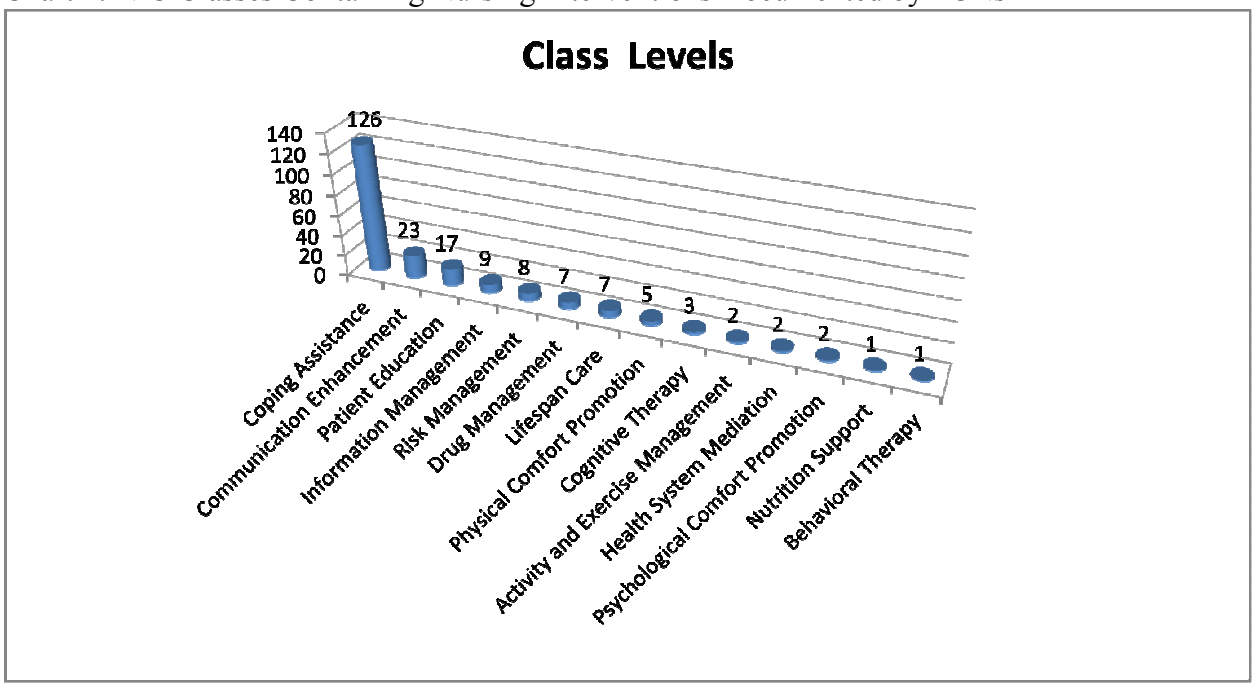
1	3R-5270	Emotional Support	Provision of reassurance, acceptance, and encouragement during times of stress	63
2	3R-5420	Spiritual Support	Assisting the patient to feel balance and connection with a greater power	39
3	3Q-4920	Active Listening	Attending closely to and attaching significance to a patient's verbal and nonverbal messages	15
4	2H-2380	Medication Management	Facilitation of safe and effective use of prescription and over-the-counter drugs	12
5	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	10
6	4V-6490	Fall Prevention	Instituting special precautions with patient at risk for injury from falling	6
7	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	5
8	6b-8190	Telephone Follow-up	Providing results of testing or evaluating patient's response and determining potential for problems as a result of previous treatment, examination, or testing, over the telephone	5
9	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	4
10	3R-5250	Decision-Making Support	Providing information and support for a patient who is making a decision regarding health care	4
11	3S-5520	Learning Facilitation	Promoting the ability to process and comprehend information	3
12	3S-5606	Teaching: Individual	Planning, implementation, and evaluation of a teaching program designed to address a patient's particular needs	3
13	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	3

14	5X-7140	Family Support	Promotion of family values, interests, and goals	3
15	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	3
16	1E-1400	Pain Management	Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient	3
17	1E-6482	Environmental Management: Comfort	Manipulation of the patient's surroundings for promotion of optimal comfort	2
18	3Q-5100	Socialization Enhancement	Facilitation of another person's ability to interact with others	2
19	3R-5210	Anticipatory Guidance	Preparation of patient for an anticipated developmental and/or situational crisis	2
20	3R-5310	Hope Instillation	Enhancing the belief in one's capacity to initiate and sustain actions	2
21	3R-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	2
22	3R-5340	Presence	Being with another, both physically and psychologically, during times of need	2
23	3R-5440	Support System Enhancement	Facilitation of support to patient by family, friends, and community	2
24	3S-5618	Teaching: Procedure/Treatment	Preparing a patient to understand and mentally prepare for a prescribed procedure or treatment	2
25	1A-0180	Energy Management	Regulating energy use to treat or prevent fatigue and optimize function	2
26	1A-0200	Exercise Promotion	Facilitation of regular physical activity to maintain or advance to a higher level of fitness and health	2

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

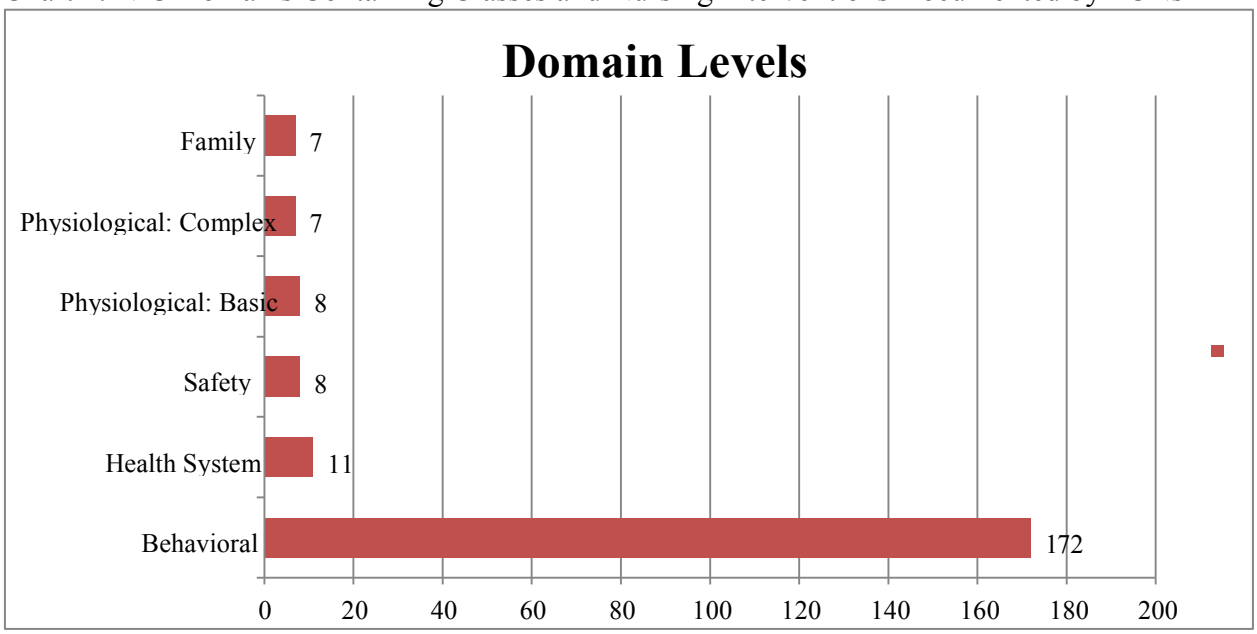
code that represents the primary Class (Bulechek et al, 2013, p 2). A stacked cylinder chart presents all 14 Classes containing nursing interventions documented by FCNs while providing transitional care. The most frequent Classes of NIC were Coping Assistance, Communication Enhancement, Patient Education, Medication Management, Risk Management, Drug Management, Lifespan Care, Physical Comfort Promotion, Cognitive Therapy, Activity and Exercise Management, Health System Mediation, Psychological comfort Promotion, Nutrition Support, and Behavioral Therapy. The three Classes containing the most frequently reported interventions (77%) were Coping Assistance, Communication Enhancement, and Patient Education.

Chart 1: NIC Classes Containing Nursing Interventions Documented by FCNs



The NIC Domains contain the Classes in which nursing interventions are aligned. The NICs documented by FCNs were found in six out of seven Domains as seen in the clustered bar chart below. The majority of interventions used while FCNs provided transitional care belonged to the Behavioral Domain.

Chart 2: NIC Domains Containing Classes and Nursing Interventions Documented by FCNs



Out of the 554 possible nursing interventions in NIC (6th ed.) (Bulechek, Butcher, Dochterman et al, 2013), 210 were reported to have been used by FCNs in this study while providing transitional care. Although this coding demonstrates the breadth of nursing interventions used by FCNs, the majority of interventions provided belonged to 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 FCNs documented emotional support, spiritual support, coping enhancement, decision-making support, support enhancement, hope facilitation, and forgiveness facilitation as the most frequently used interventions in the Coping Assistance Class. Active listening and listening visits were the most frequently selected nursing interventions in the Communication Enhancement Class. The Class of Patient Education was also frequently used with an emphasis on health education, learning facilitation, and individual learning interventions.

Table 4: Behavioral Domain

172	Behavioral Domain	Class	NIC Label
	1	Behavioral Therapy Class	
		1 3O-4480	Self-Responsibility Facilitation
	3	Cognitive Therapy Class	
		1 3P-4680	Bibliotherapy
		1 3P-4820	Reality Orientation
		1 3P-4860	Reminiscence Therapy
	23	Communication Enhancement Class	
		15 3Q-4920	Active Listening
		1 3Q-4978	Communication Enhancement: Visual Deficit
		2 3Q-5100	Socialization Enhancement
		5 3Q-5328	Listening Visits
	126	Coping Assistance Class	
		2 3R-5210	Anticipatory Guidance
		4 3R-5230	Coping Enhancement
		3 3R-5250	Decision-Making Support
		63 3R-5270	Emotional Support
		1 3R-5280	Forgiveness Facilitation
		1 3R-5290	Grief Work Facilitation
		2 3R-5310	Hope Instillation
		1 3R-5320	Humor
		2 3R-5328	Listening Visits
		2 3R-5340	Presence
		1 3R-5350	Relocation Stress Reduction
		39 3R-5420	Spiritual Support
		1 3R-5424	Religious Ritual Enhancement
		1 3R-5426	Spiritual Growth Facilitation
		2 3R-5440	Support System Enhancement

		1	3R-5480	Values Clarification		
	17	Patient Education				
		6	3S-5510	Health Education		
		3	3S-5520	Learning Facilitation		
		1	3S-5602	Teaching: Disease Process		
		3	3S-5606	Teaching: Individual		
		1	3S-5614	Teaching: Prescribed Diet		
		1	3S-5616	Teaching: Prescribed Medication		
		2	3S-5618	Teaching: Procedure/Treatment		
	2	Psychological Comfort Promotion				
		1	3T-5820	Anxiety Reduction		
		1	3T-6040	Simple Relaxation Therapy		

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). In the Information Management Class, frequently used interventions were telephone follow-up and telephone consultation. The third domain identified as significant was Safety. The Safety Domain is defined as "Care that supports protection against harm" (Bulechek et al, 2013, p.40). In the Risk Management Class, fall prevention and health screening were the most frequently documented nursing interventions. The fourth prominent Domain was Physiological: Basic. 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. Nursing interventions used most in these Classes were pain management, environmental management: comfort, and nutritional counseling. The Domains of Physiological: Complex and Family were tied for the fifth most frequently used Domains. Physiological: Complex is defined as "Care that supports homeostatic regulation"

(Bulechek et al, 2013, p.40). The only Class used in this Domain was drug management. Medication management is the most frequently used nursing intervention in the Drug Management Class. The Family Domain is defined as "Care that supports the family unit" (Bulechek et al, 2013, p.40). Caregiver support and family support were the most often selected interventions in the Class of Life Span. There were no 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.

Focus Group

Infographic results generated by the NICAP were used as a visual display to elicit focus group feedback from the FCN participants. Infographic results include: 1) Table 3. Frequently Selected Nursing Intervention Classifications, 2) Chart 1. NIC Classes Containing Nursing Interventions Documented, 3) Chart 2. NIC Domains Containing Classes and Nursing Interventions Documented, and 4) Table 4. Behavioral Domain. In addition, a summary of the results in narrative format was provided. The FCNs were given time to review these results. The focus group participants were then asked the following questions:

1. What do you think about the results of the study?
2. Do the results describe transitional care as implemented by faith community nurses?
3. The most frequently implemented nursing interventions were… Do you consider these essential? Why?

Follow up questions to elicit further discussion were used. The FCN focus group discussion was collected using a micro-recorder and transcribed by a transcriptionist into typed text. Semantic

themes were sought to represent the explicit meanings of the data. Patterned key words and concepts that related to the focus group questions were identified as the sematic themes. In addition, other related concepts were identified in verbatim statements. A matrix was developed to graphically display relationships between themes. The researcher organized the themes as headers with the supporting descriptive narratives in vertical columns. During further comparison, themes were collapsed. The final matrix is presented which represents the themes, interpretation, and the supportive verbatim statements from the focus group participants (Focus Group Results). The FCNs in the group agreed that the results presented represented the interventions they had used. They also agreed that some of the variances in documentation could have occurred due to how nursing interventions were chosen, the NIC taxonomy, and the HFM documentation tool. The FCNs reported that documented interventions were chosen based on the time spent performing the intervention. Interventions were documented that were not performed by home health or other health care providers. Nursing interventions were documented that were perceived as priority and routine. Participants also expressed that a nursing intervention in NIC can represent multiple activities. For instance, Decision-Making Support could include a decision to notify a health-care provider as well as the support to make the decision. The FCNs had been instructed by their manager to collect all hospital and clinic referrals in another documentation system (not the HFM tool) making them unavailable for analysis in this study. In inquiring to the essentiality of the 26 most often used interventions, verbal descriptors such as "core", "important", and "intentional" were used. The FCN participants confirmed that the codes presented in the results represented the interventions they provided.

Matrix 1: Focus Group Results

Results	How interventions were chosen	About interventions
Yes, the data reflects what we	By the bulk of time spent.	One intervention can represent multiple

did... (x3)		things [activities] I am doing.
Descriptors of the 26 most frequent interventions: core; important; takes time; routine; intentional	Not repeated by home health. (x3) Not wanting to repeat or copy what others were doing. (x3)	Checking meds is routine, vitals are routine, but spent the most time solving a problem or what was most important… listening.
…feel good that I am doing what others are doing. (x3)	…significance or priority. Focused on what needs to be done to solve [immediate] problem.	…community nursing skills with spiritual care added. …we integrate faith in everything we do.
Does not surprise me that most of our interventions are emotional and spiritual. Just shows that there are such needs…	…did [transitional] interventions that we talked about [training] but I still did everything I usually do… It is just routine…	Get a scale, phone calls, medication reconciliation, and keeping their appointments… Family support given… A lot of one-on-one education…
	...another place to document referrals back to hospital system or the clinic.	Emotional and spiritual interventions take more time… (x3) Spiritual care is intentional at every visit. (x3)

CONCLUSION

The study sought to describe faith community nursing interventions used in transitional care. A description of faith community nursing interventions used in transitional care in the study setting has been presented. Out of the 554 possible NICs, 52 were reported to have been used at least once with a total of 210 interventions documented. A list of 26 NICs that describe transitional care as facilitated by FCNs was created. The three Classes containing the most frequently interventions (77%) were Coping Assistance, Communication Enhancement, and Patient Education. The majority of interventions used while FCNs provided transitional care belonged to the Behavioral Domain. The Behavioral Domain includes Classes of interventions such as Coping Assistance, Communication Enhancement and Patient Education. The focus group validated the study's results and brought related issues to light, such as the faith community nurse role and the patient.

CHAPTER FIVE

DISCUSSION

Medicare enrollees have significant cost above and beyond insurance premiums when hospitalized. Hospital readmissions affect over 80 percent of all Medicare enrollees (Stone & Hoffman, 2010). Nearly one-fifth of Medicare patients discharged from the hospital are readmitted within 30 days. In addition to curbing costs, hospitals have a responsibility to their Medicare patients to explore ways to keep them well and safe after discharge in their outpatient environments (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 is the reduction in hospital readmissions (Cutler, Davis, & Stremikis, 2010; Cauchi, 2012). The Independent Payment Advisory Board 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 lost 1% of every Medicare payment if the hospital had an excessive 3 day readmission for three specific diagnosis: acute myocardium infraction, congestive heart failure, and pneumonia. The penalty increased to 2% for 2013 and 3% 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 will be added (Centers for Medicare & Medicaid, 2015). It was reported, that less than 799 of more than 3,400 IPPS hospital performed well enough in 2015 to avoid penalties in 2016 (Rice, 2015). These changes in the Medicare

reimbursement model have precipitated the need for hospitals to seek innovative and efficient methods of decreasing avoidable readmissions when patients return to the hospital soon after their previous stay, specifically within 30 days.

Studies have shown that the rate of avoidable hospital readmission can be reduced by improving transitional care for patients from discharge to their homes (Boutwell & Hwu, 2009; Burke, Kripalani, Vasilevskis, & Schnipper, 2013). Nurses have been instrumental in providing transitional care to patients and decreasing avoidable readmissions (Naylor & McCauley, 1999; Naylor, Brooten, Campbell, Maislin, McCauley & Schwartz, 2004; Naylor, Kurtzman, Grabowski, Harrington, McClellan, & Reinhard, 2012; Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). Naylor and colleagues (1999; 2004; 2011; 2012) have suggested the use of advanced practice nurses in delivering transitional care. Despite the volume of nursing literature exploring the use of advanced practices nurses in providing transitional care, only one study was found that mentions the use of a faith community nurse (FCN) in this role (Rydholm, Moone, Thornquist, Alexander, Gustafson & Speece, 2008).

There are best practice transitional care interventions described in literature. Best practice transitional care interventions include the promotion of primary care; individualized care planning, family education and engagement, reliable information flow among older adults, family caregivers, and health care team members, and strong bridges between hospitals and community-based partners (Silow-Carroll, Edwards, & Lashbrook, 2011). The FCNs operate in the community and have the skills identified to provide transitional care. In addition, FCNs provide spiritual care interventions (Kuhn 1997; Coenen, Weis, Schank & Matheus, 1999; Tuck, Pullen & Wallace, 2001a; Tuck, Wallace & Pullen, 2001b; Burkhart, Konicek, Moorhead & Androwich, 2005; ANA-HMA 2005, 2012). This is important because 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. In addition, supporting patient's spiritual needs may help patients to cope with illness better (Puchalski, 2001; Balboniet et al, 2007; Paloutzian & Park, 2014).

DISCUSSION

The purpose of this study was to describe transitional care as implemented by FCNs using a standardized nursing language, the Nursing Intervention Classification (NIC). A standardized nursing language is a "common language, readily understood by all nurses, to describe care" (Keenan, 1999, p. 12). Nursing interventions (NICs) describe treatments that nurses perform, respective of various settings, specialties, and populations. The NIC was chosen because there has been previous testing in the area of faith community nursing using this classification system (Weis, Schank, Coenen et al, 2002; Burkhart et al., 2004; Solari-Twadell & Hackbarth, 2010).

Transitional care as implemented by FCNs, has not been described in the literature, thus creating a knowledge gap. The description of transitional care as implemented by FCNs may provide insights into what interventions are most frequently used by FCN(s) during transitional care.

The research questions were:

1. What nursing interventions are provided by faith community nurses during transitional care?

2. Which nursing interventions are implemented the most frequently by faith community nurses during transitional care?

METHODOLOGY

A mixed method design was chosen to describe transitional care interventions as implemented by FCNs. A descriptive design using both quantitative and qualitative methods was selected to facilitate a thorough exploration of the phenomenon. The methods chosen for the study were able to answer the study questions. The design supported that certain variables existed and that there is construct validity (agreement). In addition, the variables could be counted. Since it is the intent of the researcher to perform future research on the same phenomenon, the descriptive method provided operationalized definitions of variables to be tested.

SUMMARY OF FINDINGS

The Relationship of the Results to the Research Questions

A total of 73 nursing documentation records were collected representing 73 FCN patient visits over a three month period. Patient visits were provided by the FCN either in person or by phone. Each patient visit averaged three nursing interventions coded by the FCN. Each standardized nursing intervention represented up to 100 possible activities (Bulechek et al, 2013, p. 39). Only standardized nursing interventions, Classes and Domains were used to describe transitional care as provided by FCNs. Out of the 554 possible nursing interventions in the Nursing Intervention Classification (NIC)s, 52 (10.6%) were reported to have been used at least once by a FCN with a total of 210 interventions documented over a three month period.

The 26 most frequently recorded NICs by FCNs in the HFM program were Emotional Support, Spiritual Support, Active Listening, Medication Management, Health Education, Fall Prevention, Listening Visits, Telephone Follow-up, Coping Enhancement, Decision-Making Support, Learning Facilitation, Teaching: Individual, Caregiver Support, Family Support,

Telephone Consultation, Pain Management, Environmental Management: Comfort, Socialization Enhancement, Anticipatory Guidance, Hope Instillation, Listening Visits. The FCN focus group participants confirmed these interventions to be "core", "important", and "intentional" to providing transitional care. Since transitional care as provided by FCNs has not be described in nursing literature, these nursing interventions are useful in provided the underpinnings for future testing.

Focusing on the most frequent NICs for FCNs is consistent with recommendations from the Iowa Intervention Project Research Team. The team suggests that "the list of core interventions of any specialty be short, preferably less than thirty" (Tripp-Reimer, Woodworth, McCloskey, & Bulechek, 1996, p. 7). Eight of the nursing interventions represented 73% (n=155) of the 210 NICs documented by FCNs. The eight interventions were Emotional Support, Spiritual Support, Active Listening, Medication Management, Health Education, and Fall Prevention.

The researcher found the frequency pattern of NICs to be of interest since many nursing interventions recorded by FCNs represented those recorded by advanced practice registered nurses (APRN) in previous studies (Naylor et al 1999; 2004; 2011; 2012). In addition to these APRN interventions, emotional and spiritual support interventions were also recorded by FCNs. The FCN focus group participants stated that emotional and spiritual support interventions are "intentionally" performed at each visit.

Relationship of the Study Results to Faith Community Nursing Research

Interventions. The results of the study are consistent with previous faith community nursing research that used NICs to describe what FCNs do. In the Solari-Twadell, (2006) study, the top 32 interventions used several times daily, weekly, and monthly were selected for the

comparison. Many of the same interventions were identified as the most frequently performed NICs in the current study and considered to be "core", "important", and "intentional" by the FCN focus group participants (n=14). See Table 5 for the comparative findings of the two studies.

Table 5: Transitional Care NICs Aligned with Faith Community Nursing NICs.

Top ranked 32 NICs describing Faith Community Nursing (Formerly called Parish Nursing) (n = 977 returned surveys) (Solari-Twadell, 2002; Solari-Twadell et al., 2010)	Top ranked 26 NICs describing Transitional Care as performed and documented by Faith Community Nurses (n =75 patient visits) The * indicates those NICs that were not in the Solari-Twadell study (2002).
Learning Facilitation	Emotional Support
Learning Readiness	Spiritual Support
Active Listening	Active Listening
Presence Emotional	*Medication Management
Touch Presence	Health Education
Spiritual Support	*Fall Prevention
Emotional Support	*Listening Visits
Spiritual Growth Facilitation	Telephone Follow-up
Humor	Coping Enhancement
Hope Instillation	Decision-Making Support
Counseling	Learning Facilitation
Decision-Making Support	Teaching: Individual
Self-Esteem Enhancement	Caregiver Support
Support System Enhancement	*Family Support
Religious Ritual Enhancement	Telephone Consultation
Self -Awareness Enhancement	*Pain Management
Truth Telling	*Environmental Management: Comfort
Values Clarification	*Socialization Enhancement
Coping Enhancement	*Anticipatory Guidance
Health Education	Hope Instillation
Teaching Disease Process	*Listening Visits
Teaching: Individual	Presence
Health Screening	Support System Enhancement
Vital Signs Monitoring	*Teaching: Procedure/Treatment
Caregiver Support	*Energy Management
Documentation	Exercise Promotion
Telephone Consultation	
Telephone Follow-up	
Consultation	
Program Development	
Energy Management	
Nutrition Counseling	

This study revealed that out of the most frequently used NICs (n=26) describing transitional care, there were ten interventions that were not in the top ranked NICs (n=32) describing the most frequently selected intervention used several times daily, weekly, and monthly in a previous study (Solari-Twadell, 2006). These NICs included Medication Management, Fall Prevention, Listening Visits, Learning Facilitation, Teaching: Individual, Family Support, Pain Management, Environmental Management: Comfort, Socialization Enhancement, Teaching: Procedure/Treatment, and Energy Management.

One of the interventions identified in this study, Listening Visits, was not among the 486 NICs that were available for selection at the time of the Solari-Twadell study (Solari-Twadell, 2006). In addition, it is captured twice: once under the Class of Communication Enhancement and the Class of Coping Assistance. The nursing intervention, Listening Visits is defined as "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" (p. 388). The nursing intervention, Listening Visits was documented with frequency in the current study (n=7). The fact that this NIC was not available to select in the Solari-Twadell, (2006) study may explain why it is missing from the top 32 interventions used several times daily, weekly, and monthly to describe Faith Community Nursing in previous work.

When comparing the most frequently used NICs (n=26) describing transitional care to those interventions as determined as essential to Faith Community Nursing, there were only eight that were not in the top ranked NICs (n=32) (Solari-Twadell, 2006). The NICs included Medication Management, Fall Prevention, Listening Visits, Learning Facilitation, Teaching:

Individual, Pain Management, Environmental Management: Comfort, Socialization Enhancement, Teaching: Procedure/Treatment, and Energy Management.

The difference in the two findings may be explained by sample size (n = 977) in the Solari-Twadell (2006) study and research design. The Solari-Twadell (2006) study used a survey tool to collect all interventions that FCNs perform daily, weekly, and monthly. The intent of this study was to describe interventions that FCNs perform while providing transitional care using their documentation. One would expect a difference in the nursing interventions collected from FCNs in the two studies. In addition, the difference in the two findings may be explained by targeted care to prevent re-hospitalization and the additional education the study participants had received regarding transitional care. The goal of the education was to provide practical education and resources to equip FCNs for transitional care (Ziebarth & Campbell, 2014; 2016).

Relationship of the Study Results to Transitional Care Research

In the literature review presented in Chapter 2, post discharge interventions to reduce readmission included follow-up calls, post clinic visits, telehealth interventions, and community-based nursing visits where specific interventions were performed (Silow-Carroll, Edwards, & Lashbrook, 2011). Priority nursing interventions performed post discharge were: medication reconciliation, support services for patient self-management, caregiver support, and education. Case management was also identified as a nursing intervention. Case management is defined as coordinating care with targeted interventions to keep patients healthy and out of the hospital (Boling, 1999).

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 6. 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).

The types of spiritual interventions described by FCNs reported in the professional literature include instilling hope, showing compassion, emphasizing the worth of every person, and offering spiritual or emotional support (Kuhn 1997; Coenen, Weis, Schank & Matheus, 1999; Tuck, Pullen & Wallace, 2001a; Tuck, Wallace & Pullen, 2001b; Burkhart, Konicek, Moorhead & Androwich, 2005; ANA-HMA 2005; 2012). Spiritual care interventions can also include religious rituals (Mendelson, McNeese-Smith, Koniak-Griffin, Nyamathi & Lu, 2008; Miskelly 1995; Coenen et al. 1999; Chase-Ziolek & Iris 2002; Bitner & Woodward 2004; Burkhart & Androwich 2004; Burkhart et al. 2005; Mosack et al. 2006; Bard 2006; Ziebarth, 2007; Koenig 2008; Bokinskie & Kloster 2008; Hinton 2009; King & Tessaro 2009; Bokinskie & Evanson 2009; McCabe & Somers 2009; ANA-HMA 2005; 2012).

In Table 6, 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 in this study. 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, and education interventions. 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 (Dyes, 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 30). 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.

Table 6: Transitional Care NICs Aligned to Previous Transitional Care Research Interventions.

Transitional care research suggest these priority interventions	Top ranked NICs (26) performed by study participants (FCNs) while performing transitional care	Aligned NIC Definitions (Bulechek, Butcher, Dochterman, & Wagner, 2013)	Possible number of activities in NIC
Follow-up calls and home visits	1. Telephone Consultation	1. Eliciting patient's concerns, listening, and providing support, information, or teaching in response to	1. 35 (p 388)

	2. Telephone Follow-up	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 telephone	2. 15 (p 389)
	3. Active Listening	3. Attending closely to and attaching significance to a patient's verbal and nonverbal messages	3. 17 (p 72)
	4. Listening Visits	4. 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	4. 25 (p 248)
Medication Reconciliation	Medication Management	1. Facilitation of safe and effective use of prescription and over-the-counter drugs	1. 36 (p 264)
Case management and patient self-management	1. Pain Management	1. Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient	1. 43 (p 285)
	2. Environmental Management: Comfort	2. Manipulation of the patient's surroundings for promotion of optimal comfort	2. 19 (p 177)
	3. Energy Management	3. Regulating energy use to treat or prevent fatigue and optimize function	3. 50 (p 175)
	4. Fall Prevention	4. Instituting special precautions with patient at risk for injury from falling	4. 65 (p 188)
	5. Exercise Promotion	5. Facilitation of regular physical activity to maintain or advance to a higher level of fitness and health	5. 24 (p 182)
Education	1. Learning Facilitation	1. Promoting the ability to process and comprehend information	1. 45 (P. 244)
	2. Health Education	2. Developing and providing instruction and learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities	2. 35 (p 210)
	3. Teaching: Individual	3. Planning, implementation, and evaluation of a teaching program designed to address a patient's particular needs	3. 29 (p 373)
	4. Teaching:	4. Facilitation of support to	4. 28

	Procedure/Treatment	patient by family, friends, and community	(p 382)
Clinic visits and caregiver support.	1. Caregiver Support	1. Provision of the necessary information, advocacy, and support to facilitate primary patient care by someone other than a health care professional	1. 31 (p 113)
	2. Family Support	2. Promotion of family values, interests, and goals	2. 36 (p 193)
	3. Support System Enhancement	3. Facilitation of support to patient by family, friends, and community	3. 14 (p 362)
	4. Socialization Enhancement	4. Facilitation of another person's ability to interact with others	4. 23 (p 351)
	5. Anticipatory Guidance	5. Preparation of patient for an anticipated developmental and/or situational crisis	5. 18 (p 83)
	6. Decision-Making Support	6. Providing information and support for a patient who is making a decision regarding health care	6. 17 (p 139)
Other	1. Coping Enhancement	1. Facilitation of cognitive and behavioral efforts to manage perceived stressors, change, or threats that interfere with meeting life demands and roles	1. 52 (p 133)
	2. Emotional Support	2. Provision of reassurance, acceptance, and encouragement during times of stress	2. 17 (p 174)
	3. Spiritual Support	3. Assisting the patient to feel balance and connection with a greater power	3. 29 (p 353)
	4. Hope Instillation	4. Enhancing the belief in one's capacity to initiate and sustain actions	4. 18 (p 218)
	5. Presence	5. Being with another, both physically and psychologically, during times of need	5. 16 (p 311)

Relationship of the Study Results to Theory

The conceptual model of faith community nursing (Ziebarth, 2014) provides some specificity as to the specialty of faith community nursing and the role of the FCN. The definition states:

> "Faith community nursing is 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, 2014, p).

Table 7 links the top ranked nursing interventions (n=26) documented by FCNs to the essential attributes of the faith community nursing conceptual model (Ziebarth, 2014). The researcher was able to align each top ranked NIC (n=26) with five out of six essential attributes from the conceptual framework. Transitional care interventions that were documented by FCNs did not fall in the attribute of "Coordinating". The "Coordinating" attribute is similar to the NIC "Community Domain" in which on-going activities such as support group, health screenings, and meetings are captured. Since many of transitional care interventions are done with the patient directly, one would not expect the need for coordination of community on-going activities. The ability to align each top ranked NIC with an essential faith community nursing conceptual model attribute speaks to the range of activities in the conceptual model. In addition, it would appear that the conceptual model's essential attribute headings and the NIC's Domain headings may have similar characteristics inherent in the components.

Table 7: Transitional Care NICs Aligned to the Theory's Essential Attributes.

Essential attributes of the Faith Community Nursing Theory (Ziebarth, 2014).	Operationalized definitions of the Faith Community Nursing Theory (Ziebarth, 2014).	Top ranked nursing interventions in NIC (n=26) performed by FCNs while performing transitional care.
Faith integrating/ Spiritual	Religious rituals such as	• Emotional Support

	readings, songs, music, communion, and healing service, spiritual assessments, and spiritual and religious care interventions such as presence, touch, spiritual and emotional support, prayer and meditations, spiritual growth facilitation, hope and forgiveness instillation, humor, spiritual resources and referrals, and showing compassion.	• Spiritual Support • Hope Instillation • Presence
Disease managing	Symptom management, care planning, disease resources or referrals, disease support services, management or surveillance of therapeutic regime, visits, disease-focused education, disease counseling, advocacy, and tertiary level of prevention activities.	• Pain Management • Environmental Management: Comfort • Energy Management • Fall Prevention • Exercise Promotion
Health promoting	Health-focused programming (screenings and education), health counseling, health resources, advocacy, end-of-life planning, assessments, surveys, policy development, research, and primary and secondary levels of prevention activities	• Learning Facilitation • Health Education • Teaching: Individual • Teaching: Procedure/Treatment
Coordinating	Planning and facilitating ongoing activities (screenings, community health events, education, support groups), recurring meetings (health committee, social concerns, volunteer training), support services (meals, transportation, calls, visits, cards), media (newsletters, bulletins, health displays), and case management. Coordinating is also seen in coordinating the health record, data collection, and reports.	
Empowering	Capacity building, supporting, encouraging, health support services, surveillance, counseling, self-efficacy activities such as education on how to use the healthcare system, and education techniques such as return demonstration and motivation interviewing. Empowering is also seen in serving as preceptors for students.	• Coping Enhancement • Caregiver Support • Family Support • Support System Enhancement • Socialization Enhancement • Anticipatory Guidance • Decision-Making Support

Accessing Health Care	Multidisciplinary & interdisciplinary resources/referrals. Health policy development and research that increased or addressed healthcare access. Assisting individuals to access health care by decreasing barriers and navigating healthcare systems.	• Telephone Consultation • Telephone Follow-up • Active Listening • Listening Visits

Relationship of the Study Results to Faith Community Nursing Research

Classes and Domains. A NIC Class contains a standardized group of nursing interventions. 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). In this study, Listening Visits were collected under the two Classes of Coping Assistance and Communication Enhancement. See Table 3. There are 14 Classes, out of thirty containing NICs documented by FCNs while providing transitional care. See Chart 1. The 14 classes are Coping Assistance, Communication Enhancement, Patient Education, Medication Management, Risk Management, Drug Management, Lifespan Care, Physical Comfort Promotion, Cognitive Therapy, Activity and Exercise Management, Health System Mediation, Psychological comfort Promotion, Nutrition Support, and Behavioral Therapy. The three Classes containing the most frequently interventions (77%) were Coping Assistance, Communication Enhancement, and Patient Education. This is consistent with what FCNs do as defined by Solari-Twadell and Hackbarth (2010). They found that most interventions describing what FCNs do were in the Classes of "…Communication Enhancement, Coping Assistance, and Patient Education" (p 75).

The interventions documented by FCNs in this study represented six out of the seven NIC Domains. See Chart 2. The majority of interventions used while FCNs provided transitional care are in to the Behavioral Domain. See Table 4. The Behavioral Domain is defined as "Care that supports psychosocial functioning and facilitates life-style changes" (Bulechek et al, 2013, p.40).

The second prominent domain used by FCNs while facilitated transitional care 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 Safety. The Safety Domain is defined as "Care that supports protection against harm" (Bulechek et al, 2013, p.40). The fourth prominent domain was Physiological: Basic. Physiological: Basic is defined as care that supports physical functioning" (Bulechek et al, 2013, p.40). The Domains of Physiological: Complex and Family were tied for the fifth most frequently used domains. Physiological: Complex is defined as "Care that supports homeostatic regulation" (Bulechek et al, 2013, p.40). The Family Domain is defined as "Care that supports the family unit" (Bulechek et al, 2013, p.40). There were no interventions selected in the Community Domain as expected since transitional care occurs in a one to one relationship with the patient or caregivers. As noted earlier, community interventions be helpful in keeping patients well in their home and reducing unnecessary hospitalizations.

Again, this confirms with what other studies have found related to what FCNs do. In the largest FCN sample (n = 977), a survey was sent to those who had attended the Foundations Faith Community Nursing education program and asked to select interventions they perform (Solari-Twadell and Hackbarth, 2010). The nursing interventions were mostly clustered in the Behavioral Domain (Solari-Twadell and Hackbarth, 2010). Health System was the second prominent Domain. The third Domain identified was Family. The fourth Domain was Safety and the fifth was that of Community. Program development was an intervention identified from the Community Domain (Solari-Twadell et al., 2010). The NIC provides the interventions, Classes, and Domains categories to capture both what FCNs do daily, weekly, and monthly and what FCNs do for patients transitioning from hospital to home.

Limitations

Since faith community nursing is relatively new to the overall practice of nursing, and many FCNs are non-paid, limited research was available and some referenced information was derived from non-research literature. Since the researcher was the instructor of the transitional care education course, a bias related to the success of this study could have occurred. It is important to note that this instruction occurred prior to the research study. The FCN focus group participants shared that some uncontrolled variables, such as how NICs were chosen, the NIC taxonomy, and the use of the data collection tool, could have caused some variances in the documentation of interventions. The documented interventions were reportedly chosen by each FCN based on (a) the bulk of time spent; (b) interventions not performed by home health or other health care providers; (c) significance or priority; and (d) per routine, in which case, may not have been captured in NIC consistently. Subjective reasons for choosing interventions may vary among the FCNs. Participants also expressed that a NIC can represent multiple activities. For instance the NIC, Decision-Making Support, could include a decision to notify a health-care provider that may not be captured as a referral. Finally, participants were instructed by their manager to collect all hospital and clinic referrals in another area of the documentation. These referrals may not have been captured in NIC.

Rigor, Credibility, and Confirmability

Variables that could influence the credibility of study were controlled for by using five different strategies. The five strategies were used to enhance accurate data collection and ensure credibility and rigor: (a) The study participants received the same education. All participants attended the *Foundation of Faith Community Nursing* course. In addition, they all attended the *Faith Community Nursing Transitional Care* education program. The same individual, the

researcher, taught the transitional care education. (b) The study participants used the same documentation system, Henry Forbes McCombs, thus ensuring construct validity. (c) A PhD prepared nurse at the church health center audited the data trail and examined the coding process, thus sharing the accountability and encouraging confirmability (Creswell, 2003; Sandelowski, 1995). (d) A focus group was conducted to obtain feedback from the FCN participants, concerning the accuracy of results to ensure credibility; and (e) the practice of faith community nursing is fully described in rich details using the Conceptual Model of Faith Community Nursing (Ziebarth, 2014).

Assumptions

For the purpose of this study the researcher assumed that: (a) FCNs implement transitional care interventions; (b) FCNs document nursing interventions; and (c) documentation reports by the participants were representative of actual experiences. The FCN focus group participants indicated that some documentation variances may have existed from what actually occurred. An example of this is how interventions were chosen. The FCNs reported that nursing interventions were coded based on the length of time spent performing the intervention or by other criteria such as those interventions not performed by home health or other health care providers. In addition, the FCNs were instructed to document some referrals to another documentation tool therefore making them unavailable for analysis. Since saturation was met, there is no evidence to suggest that the assumptions are not true or results would have changed due to loss data. There was concentration of interventions into 14 classes. The three Classes containing the most frequently interventions (77%) were Coping Assistance, Communication Enhancement, and Patient Education. This is consistent with what FCNs do as defined by Solari-Twadell and Hackbarth (2010). In addition, the 26 most often used interventions were described

as “core”, “important”, and “intentional”. Variances in documentation or loss data may not have changed the results due to the concentration of data into the Classes of NIC.

IMPLICATIONS

Implications: Nursing Practice

This study has implications for all of community-based nursing practice, most obviously, faith community nursing. As identified in Chapter 2, FCNs are 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) documented nursing interventions in NIC that are standardized and aligned with those nursing interventions that are documented in previous studies (Solari-Twadell, 2006; Solari-Twadell et al., 2010); (b) the interventions reflected could be described using the conceptual model of Faith Community Nursing (Ziebarth, 2014); and (c) 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.

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). Dyes, (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 care to patients transitioning from hospital to home.

Implications: Nursing Education

Since the faith community nursing is an important source of health care for patients transitioning from hospital to home and the ANCC has credentialed the specialty, formal nursing education should consider inclusions of the FCN role as part of a population-based aggregate 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.

Faith community nursing education is only "recommended" in the Scope and Standards of Faith Community Nursing (ANA & HMA, 2012). The FCNs in the study attended both the *Faith Community Nursing Foundation* course and the *Faith Community Nursing Transitional Care* education program. Mandatory education by employing health care organizations would set

a practice standard expectation, however, it is not the role of the ANA or the ANCC to recommend any specific continuing education programs.

The adoption of state-wide educational objectives could standardize faith community nursing preparations. Standardized educational objectives could lead to content driven basic practice competencies, which in turn could be tested. Currently Wisconsin is the only state that has standardized educational objectives for FCNs (Ziebarth, 2015). It requires all Faith Community Nursing education programs to meet certain criteria and endorses the use of the evidenced based *Faith Community Nursing Foundation course*. Other states should follow Wisconsin's lead.

Implications: Theory

The conceptual model of *Faith Community Nursing* (Ziebarth, 2014) is a framework which facilitates understanding of faith community nursing in a community, national, or global environment. This study used the conceptual model to understand the context of the practice, roles and essential attributes of faith community nursing. It was not the intent of this study to test the conceptual model of *Faith Community Nursing* (Ziebarth, 2014), but the framework's essential attributes of Faith Integrating, Disease Managing, Empowering, and Accessing Health Care were easily applied to describe what FCNs do when providing transitional care. Based on the study's findings, the most frequently used nursing interventions in NICs (n=26) were aligned to five out of six of the framework's essential attributes. As author of the framework, an addition of environment under the operational definition of Accessing Health Care is recommended to include situations when the environment creates a barrier. The conceptual model of *Faith Community Nursing* (Ziebarth, 2014) application in this study is supported to guide future studies relative to the specialty's operational definitions, model, and essential attributes. While providing

transitional care, the most frequently used nursing interventions in NIC were aligned with the framework's essential attributes.

Implications: Research

Since describing FCN implemented transitional care, using a standardized nursing language has not been documented before in the literature, this study provided new information. The findings revealed that the description of transitional care as implemented by FCNs using a standardized nursing language is of value in gaining insight into what interventions are most often used. The study's findings may provide the underpinnings for future research relating to faith community nursing and transitional care. The purpose of this study was to describe transitional care as implemented by FCNs using a standardized nursing language, the Nursing Intervention Classification (NIC). Results were presented in nominal frequencies of interventions, Classes, and Domains. The use of a focus group resulted in achieving credibility of results. Results were presented using comparisons to previous faith community nursing interventions (Solari-Twadell, 2006; Solari-Twadell et al., 2010) and to evidenced-based transitional care interventions (Ziebarth, 2015). Results could be described using the *Faith Community Nursing* conceptual model (Ziebarth, 2014).

In future studies, it is recommended that researchers explore more fully the concept of transitional care as facilitated by FCNs. Barriers and resolutions are important to identify. There were barriers or uncontrolled variables identified in this study. The documented interventions were reportedly coded by each FCN based on (a) the bulk of time spent; (b) interventions not performed by home health or other health care providers; (c) significance or priority; and (d) per routine, in which case, they may not have been captured in NIC consistently. Subjective reasons for choosing to document interventions may vary among the FCNs. Participants also expressed

that a NIC can represent multiple activities. For instance the NIC, Decision-Making Support, could include a decision to notify a health-care provider that may not be captured as a referral. Finally, participants were instructed by their manager to collect all hospital and clinic referrals in another area of the documentation, therefore,these referrals may not have been captured in the NICs available for analysis in this study. These variables could have caused some variances in the documentation of interventions. It is suggested that future studies address these.

Future studies are recommended to further investgate the role of FCNs in transitional care. A quantitative design could test the concept of transitional care as provided by FCNs. A quasi experimental design could test the effectiveness of using FCNs as compared to another provider group for transitional care, such as APRNs. A larger sample size is desirable to establish statistical significance. An experimental research design could test the impact of FCNs providing transitional care as it relates to the additional or "other" interventions provided and relate this to outcomes.

The Microsoft Excel® software program, NICAP, was created for this study when a suitable data management program was not found. When trying to align and analyze multiple components of a large and complex nursing taxonomy, the ability to reduce and manage data sets is important. The NICAP has the potential to be useful in future nursing research studies. It has the capacity to collect and organize large numbers of individual nursing interventions in NICs into a manageable database and to produce infographics. Future research to expand the NICAP to include the North American Nursing Diagnosis (NANDA) (2005) and the Nursing Outcomes Classification (NOC) (Moorhead, 2006) is planned. It is the goal of this researcher to seek copyright ownership and to explore the marketability of the NICAP as a tool to support the work of other nursing researchers.

Significance

The results of this study added to the body of knowledge of faith community nursing regarding transitional care. Significant findings include: 1) There was a lack of knowledge about transitional care as implemented by FCNs. In a literature review of 62 articles describing transitional care, only one mentioned FCNs. 2) Hospitals are examining innovative and efficient methods of decreasing avoidable readmissions. 3) Results can provide the underpinnings for testing FCN transitional care interventions. 4) Patients that are cared for by FCNs, may experience wholistic interventions leading to positive health outcomes and readmission avoidance. 5) Since faith community nursing education programs exist, educators can use the results of this study to teach 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. The most frequently selected nursing interventions in NIC (n=26) were validated by the focus group as "core", "important" and "intentional". Comparisons were made to previous faith community nursing interventions and to evidenced-based "priority" transitional care interventions. Results were consistent with the essential attributes of the Faith Community Nursing conceptual model (Ziebarth, 2014) and lended credibility to the framework. 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 little research exploring transitional care as provided by FCNs. Concepts such as faith integrating, disease managing, health promoting, coordinating, empowering, accessing health care (Ziebarth, 2014) helped to further describe the most frequently performed nursing interventions.

The findings will be helpful for FCNs, educators, coordinators, and health care leaders in understanding the nursing interventions in NIC performed and documented by FCNs while performing transitional care. This study may ultimately provide the underpinnings for further research in the area of transitional care. 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 data sets in application format may impact future nursing research.

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Appendix A: Preliminary Screening Questions

1. Are you currently working as a Faith Community Nurse/ Parish Nurse and performing nursing interventions with patients transitioning from hospital to home?
2. What kind of preparation (course and training) did you have for your role?
3. Would you be willing to share your nursing intervention documentation in aggregate format for a qualitative study to describe nursing intervention performed during transitional care?
4. Would you be willing to participate in a focus group following the analysis of the documentation?
5. Does your employing hospital have a business agreement with Church Health Center?

*** If volunteer does not meet the criteria, will say: “You do not meet the criteria for the study. Thank you for taking the time to inquire about the study”.

Appendix B: Consent Form

Introduction

I am Deborah Ziebarth, a doctoral candidate at the University of Wisconsin, Milwaukee. I am conducting a study related to transitional care nursing interventions as delivered by Faith Community Nursing. Volunteers, who are practicing as a faith community nurse/parish nurse, attended the International Parish Nurse Resource Center's Faith Community Nurse Foundations Course and attended the International Parish Nurse Resource Center's Faith Community Nurse Transitional Care Class will be asked to share nursing intervention documentation.

Procedure

I will ask you to send your anonymous documentation electronically or in paper format to a PhD prepared nurse employed by Church Health Center. A business agreement (data sharing agreement) is needed between your employing organization and Church Health Center. In addition, I will ask you to participate in a focus group that will be audio taped for later transcription and analyzed verify or not verify study results. All data will be analyzed and the results presented and shared in anonymous aggregate format with University of Wisconsin, Milwaukee faculty and professional colleagues. Your participation is kept confidential.

Risks and Benefits

I will be the only individual to know the participant's identities. Documentation will be anonymous as to nurse or patient. Documentation and focus group data will be kept separate. Your documentation will not have any identifying information or links to volunteers or patients; thus, anonymity will be afforded to actual nursing interventions. All word documents will be received on a password protected hard drive and downloaded to a jump (USB) drive. The jump

drive and all raw data will be protected in a locked cabinet file drawer only accessible to the researcher. All tapes, transcripts, jump (USB) drives will be destroyed after seven years.

The benefit in participating is that the data derived from this study may be used to assist in the preparation of faith community nurses-parish nurses by educators and coordinators.

Freedom to Withdraw from Research

Participation in this study is voluntary. If you wish to withdraw from this study at any time, you are free to do so without prejudice or penalty, and the information collected up to that point will be destroyed.

Researcher contact information

Deborah Ziebarth at C-414-315-5456 or ziebart2@uwm.edu

If you have any questions about the conduct of this research study contact:

Dr. Lundeen at the University of Wisconsin, Milwaukee.

If you have any concerns about your treatment as a participant in this research study contact (Institutional Review Board Chairperson)

Note: All complaints are kept confidential

I have received a satisfactory explanation of the study and I agree to participate. I understand that participation in this study is voluntary.

_____ (Name)

_____ (Date)

This research has been approved by University of Wisconsin, Milwaukee Institutional Review Board for the Protection of Human Participants for a period of 12 months.

Appendix C: Proposed Focus Group Question Guide

The main research questions are:

1. What nursing interventions are provided by faith community nurses during transitional care?
2. Which nursing interventions are implemented the most frequently by faith community nurses during transitional care?

Focus Group Question Guide

1) What do you think about the results of the study?

2) Do the results describe transitional care as implemented by faith community nurses?

3) The most frequently implemented nursing interventions were… Do you consider these essential? Why?

Field Notes

_____

_____

_____

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Appendix D: Contact information

Focus Group Name_____

Date of contact_____

Curriculum Vitae

Licensures, Certifications, Training

- Registered Nurse in State of Wisconsin - Current
- Board Certified FCN through ANCC (2014- 2016)
- FCN Foundations Faculty Course Training (2013)
- Work Force Analytics Leadership Training (2010)
- "Just Culture" for Leaders Training (2010)

Awards

- 2013 Received Herzing University (Brookfield Campus) 2013 Academic Scholarship Award for Excellence in Academia
- 2012 Received Herzing University 2012 National Academic Scholarship Award for Excellence in Academia
- 2012 Received Herzing University (Brookfield Campus) 2012 Academic Scholarship Award for Excellence in Academia
- 2011 Received Herzing University (Brookfield Campus) 2011 Academic Scholarship Award for Excellence in Academia
- 2010 Received Wisconsin Nursing Association (WNA) 2010 "100 Faces of Nursing over 100 years" Award
- 2008 Received Volunteer Hospital Association (VHA) 2008 "Best in Class" Award for Community Health Programming
- 2006 Received the American Hospital Association (AHA) 2006 "Nova Award" for Community Health Programming

Professional Memberships and Board Positions

- ANCC FCN CEP Since 2013
- Wisconsin Nurse Association (WNA) since 1999
    - Wisconsin FCN Coalition (WNA MIG)
        - Education Chair since 2003-2014
- Saint Joseph's Free Clinic, Waukesha Foundation Board (Coordinator of Fund Development) – 2011-2013
- Susan G. Komen Foundation Board (Grant's Committee) - Southeastern Wisconsin Affiliate 2009-2011
- Medical College of Wisconsin Academic/Community Advisory Board and Translational Research Committee (2005-2011)
- National Children Study Advisory Board Member (2008-2011)
- Healthiest Wisconsin 2020 Implementation Board Member- Madison, Wisconsin (2010-2011)
- Federal Funded Health Clinic Project Development and Implementation Committee (2008-2011)
- American Hospital Association (AHA) Association of Community Health Initiatives (ACHI) 1999 - 2011
- Wisconsin Public Health Association (WPHA) 2009- 2013
- Westberg Institute
    - Content Expert Curriculum Reviewer 2013
    - Continuing Education Module Development Chair 2007
    - HMA/ANA Task Force Member to update Faith Community Nurse Scope and Standards of Practice 2010-2011

- Carroll University Hispanic Nursing Project Board Member (2005-2009)
- WCTC Adult Education Board Member (2006-2010)
- Waukesha Hispanic Collaborative Network (Chair from 2004-2008)

Published Works (or in press)

Research

- Ziebarth, D. (2016) Altruistic and Economic Measurements Used for Prevention Health Services. *Journal of Evaluation and Planning*. In Press.
- Ziebarth, D. (2016) Moving Towards a Virtual Knowledge Platform for Nurses. *Journal of Computers, Informatics, Nursing*. In Press.
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Articles

- Ziebarth, D. (2014). Evidence-Based Practice: Faith Community Nurse Transitional Care Program. *Perspectives*. 13 (3), 6-9.
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- Ziebarth, D. (2008, February). Quality Education Provided. Wisconsin STAT. 7(1), 3-4.
- Ziebarth, D. (2007, January). Specialty Celebrates 10 Years of Caring. *Nursing Matters,* 18(1), 4, 21.
- Ziebarth, D. (2004, February). Exceptional Community Care as Evidenced by Clinical Outcomes. Wisconsin STAT, 3(1), 5-6.
- Ziebarth, D. (2005, December). Introduction to Shared Governance. Wisconsin STAT, 4(4), 5-6.
- Ziebarth, D. (2005, August). Community Automatic External Defibrillator Policy. Wisconsin STAT, 4(3), 5.
- Ziebarth, D. (2005, May). Developing a Blood Pressure Policy. Wisconsin STAT, 4(2), 4-5.
- Ziebarth, D. (2002, July). Blood Pressure: Part II [I]. Wisconsin STAT, 1(3), 5-7.
- Ziebarth, D. (2002, April). Six-Month Blood Pressure Outcomes. Wisconsin STAT, 1(2), 4-5.

State Nursing Education Standards

- Ziebarth, D. (2010). Wisconsin Minimum Set of Basic Parish Nurse Education Outcomes and Behavioral Objectives. (pp. 1-69). Madison, Wisconsin. Wisconsin Nursing Association.

Nursing Textbook Chapter

- Ziebarth, D. (2005). Policies and Procedures for the Parish Nursing Practice. In P. Solari-Twadell & M. McDermott (Eds.), Parish Nursing: Development, Education, and Administration (pp. 257-282). St. Louis, MO: Elsevier Mosby.

Published Papers/Presentations

- Ziebarth (2016, April) FCN Transitional Care. Westberg Symposium, Skokie, Ill.
- Ziebarth (2015, April). FCN Transitional Care. Westberg Symposium. Memphis, Tenn.
- Ziebarth (2015, April). Evolutionary Conceptual Analysis: Faith Community Nursing. Westberg Symposium.
- Ziebarth (2014, Dec). Transitional Care. IHI Conference, Orlando, Fl.
- Ziebarth, D. (4-25-2014) Helen Westberg Memorial Lecture Panel Session: Transitional Care Models. Presented at the Westberg Symposium, Olive Branch, Mississippi.
- Healy-Haney, N. & Ziebarth, D. (2011, September). Reducing Cardiac Risk in Hispanic Families: A Collaborative Approach. Presented at the Public Health Conference. Stevens Point, Wisconsin.
- Healy-Haney, N. & Ziebarth, D. (2011, February). Reducing Cardiac Risk in Hispanic Families: A Collaborative Approach. Presented to Southern Wisconsin LEAP Professionals at quarterly meeting. Waukesha, Wisconsin.
- Ziebarth, D. (2010, Oct.). Wisconsin Minimum Set of Basic Parish Nurse Education Outcomes and Behavioral Objectives. Wisconsin Nursing Association Conference.
- Ziebarth, D. (2009, Sept). Research: Exploring Parish Nurses' Perceptions of Parish Nurse Training. Paper presented at the 23rd Annual Westberg Symposium. Saint Louis, Missouri.
- Ziebarth, D. (2005, Sept. 30-Oct. 2). Promoting Leadership and Professionalism through the Implementation of a Shared Governance Model. Paper presented at the 19th Annual Westberg Symposium, (pp. 115-128). St. Louis, Missouri.

Abstracts/Posters

- Ziebarth (2015, April). Transitional Care Model. Westberg Symposium. Memphis, Tenn.
- Ziebarth (2014, Dec). Transitional Care Model. IHI Conference, Orlando, Fl.
- Ziebarth, D. (2010, Oct). Research: Exploring Parish Nurses' Perceptions of Parish Nurse Training. Poster presented at the 100th Anniversary of the Wisconsin Nursing Association Annual Convention. Madison, Wisconsin.
- Ziebarth, D. (2010, Oct). Project: Wisconsin Minimum Set of Basic Parish Nurse Education Outcomes and Behavioral Objectives. Poster presented at the 100th Wisconsin Nursing Association Annual Convention. Madison, Wisconsin.
- Ziebarth, D. (2004, Sept. 29-Oct. 1). Hypertension Identification with Blood Pressure Control & Heart Disease risk Identification and Lifestyle Change. Poster presented at the 18th Annual Westberg Symposium, (p. 279). St. Louis, Missouri.
- Ziebarth, D. & Wisnefske, K. (2005, Sept. 30-Oct. 2). A Strategy to Promote Leadership, Professionalism and Scholarship through a Partnership with a State Nursing Association. Poster presented at the 19th Annual Westberg Symposium, (p. 214). St. Louis, Missouri.

Curriculum (Published/Unpublished)

- Ziebarth, D. & Campbell, K. (2014) Faith Community Nurse Transitional Care Curriculum. Church Health Center. Memphis, Tenn.
- Ziebarth, D. (1998; 2013). Health Ministry Mentoring Curriculum (p.1-360).

Published Booklets

- Faith Community Nurse Visitation Guidelines. (2014). Church Health Center, Memphis, Tenn.
- Tools for Developing and Sustaining a Faith Community Volunteer Ministry Group. (2014). Church Health Center, Memphis, Tenn.