While medical-surgical nurses often help acutely ill individuals in a hospital or medical setting, one aspect of nursing is re-emerging to bridge the transition of patient care from hospital to home. Under the 2020 Healthy People objectives, nursing care is focused on holistic care, prevention, and wellness (HealthyPeople.gov, 2015). Faith community nursing is poised uniquely to meet health care challenges of older adults, a group projected to increase even more as baby boomers age. An estimated 89 million Americans will be over age 65 by 2050, double the number in 2010 (Centers for Disease Control and Prevention [CDC], 2013a).

Recent changes in health care laws also attempt to reduce repeated patient readmission for the same medical condition. Hospitals can be penalized if Medicare patients are readmitted soon after discharge, with a projected 3% withholding for 2015 fiscal year reimbursements (James, 2013). To avoid this, hospital leaders are taking direct steps to ensure patients follow discharge instructions and receive supportive care in the community. Early attention to post-hospitalization complications decreases readmission and provides considerable cost savings (Evdokimoff, 2011; Glendenning-Napoli, Dowling, Pulvino, Baillargeon, & Raimer, 2012). Community-supported early release cuts hospital costs and benefits patients who prefer to recover in their own homes (Bernard & Foss, 2014). Faith community nurses (FCNs, also known as parish nurses) can help increase use of preventive medical and social services, increase patient adherence to treatment regimens, build a supportive network in the congregation, and reduce readmissions to allow patients to thrive in their homes (see Figure 1). When medical-surgical nurses and FCNs work together, they can provide continuity of care with long-term patient benefits.

Reaching Beyond the Hospital Door

An alliance among hospitals, FCNs, and other nursing agencies in the community can enhance patient outcomes by improving patient understanding and adherence to treatment plans following hospital discharge. Without appropriate follow up and education, 1 in 5 patients experiences an adverse event; 62% of these adverse events are preventable though follow-up care (Dilwali, 2013). When the medical-surgical nurse and FCN collaborate before a patient’s hospital discharge, the FCN can provide medical guidance during the critical transition from the hospital to home. FCNs often can reach populations that typically lack medical and spiritual support, including low-income individuals, homeless persons, and single mothers. These people tend to present with multiple chronic health conditions that are worsened by their lack of consistent primary care (Balint & George, 2015). For example, Emory University provides an excellent outreach into the larger community in which FCNs teamed with Gateway Center, a community-based, multi-partner service center, to provide spiritual and nursing services for the homeless (Connor & Donohue, 2010). Although Gateway serves 500 persons a day, many with multiple complex health problems, follow up was not possible due to the confidentiality protocol and the difficulty of tracking homeless individuals. In this project, FCNs encouraged spirituality to improve health, educated patients about major diseases and health behaviors, and improved access to care. In a similar situation, University of Texas Medical Branch provided case management after discharge for uninsured individuals with hypertension, diabetes, and heart disease to prevent hospital readmission and improve access to primary care. When community nurses visited patients in their homes and enrolled clients in community health programming, acute outpatient encounters decreased 62% and inpatient admissions decreased 53% (Glendenning-Napoli et al., 2012).
Faith Community Nursing Defined

The terms parish nursing and faith community nursing often are used interchangeably and have the same meaning. Faith community nursing is defined as “the specialized practice of professional nursing that focuses on the intentional care of the spirit as part of the process of promoting holistic health and preventing or minimizing illness in the faith community” (American Nurses Association and Health Ministries Association [ANAHMA], 2012, p. 108). FCNs typically offer minimal direct medical care; instead they provide and facilitate health screenings, patient education concerning disease processes, and spiritual counseling, and teach exercise and nutrition classes (Dandridge, 2014). When nursing care is integrated within the spiritual ministry of the parish, patients demonstrate improved physical, mental, and spiritual well-being (Dandridge, 2014; Dyess & Chase, 2012). Community nursing outreach programs, including home visits and case management after hospital discharge, can increase primary care use by 162% among uninsured patients (Glendenning-Napoli et al., 2012; Shores, 2014). While community nurses and FCNs advocate broad health promotion and disease prevention, the spiritual dimension is considered a core emphasis (Dyess, Chase, & Newlin, 2010; Shores, 2014). Because FCNs are integrated into the local community, they are suited ideally to team with hospital staff to improve patient understanding and adherence following hospital discharge while supporting patients’ spiritual needs and desire to stay in their community.

Development of Faith Community Nursing

Because faith communities traditionally have seen nursing care of the sick, elders, and young as a religious duty, faith community nursing has a long history (see Figure 2). Holistic health is based on the concept human beings strive for completeness in their relationships with God, themselves, their families, and communities. This focus is a core aspect in faith community nursing today (ANAHMA, 2012). FCNs typically are employed by medical facilities to serve targeted aging or impoverished people or by faith communities to serve congregant members and provide outreach in the community (Connor & Donohue, 2010; Yeaworth & Sailors, 2014).

The American Nurses Credentialing Center (ANCC)
announced certification standards for faith community
nursing in 2014. Certification through the ANCC
entails additional training beyond the baccalaureate
degree (see Table 1). Similar to other nurses, FCNs be-

TABLE 1.
Faith Community Nursing Certification
Eligibility Requirements

- Hold a current, active RN license
- Complete 30 hours of professional development
  requirements in faith community nursing in the past 3
  years
- Complete 1,000 hours of faith community nursing prac-
  tice in the past 3 years
- Practice 2 years full time as a registered nurse
- Fulfill two professional development categories
  - Academic credits
  - Presentations
  - Publication or research
  - Preceptor
  - Professional service

Source: ANCC, 2014.

Implications for Nursing Practice

Transitions from hospital to home can be difficult for
patients. Because patients often go home with drains,
venous access devices, wounds, pain, and multiple other
needs, acute care staff and FCNs can coordinate post-
hospital care to decrease patient vulnerability. After hos-
pital discharge, patients and families often are un-
equipped to provide self-care, change dressings, man-
age insulin, or administer medications. Intervention in
the home setting can provide better adherence to med-
ical prescriptions and reduce hospital readmissions by
23% (Rytter et al., 2010). A direct correlation exists
between appropriate discharge planning and the read-
mission rate (Coffey & McCarthy, 2012). Despite well-
established discharge oversight, patients report they are
confused and overwhelmed by the multiple available
resources (Bernard & Foss, 2014). When FCNs are
included in the discharge process, patients cite less stress
and anxiety and show greater adherence to health care
measures (Shores, 2014).

The transition from hospital to home can be chal-
lenging when patients do not hear well, are visually
impaired, or have difficulty remembering discharge
instructions (Yeaworth & Sailors, 2014). When present
during discharge, FCNs can reinforce discharge instruc-
tions with the patients in their homes to increase clarity
and adherence. Because FCNs are well grounded in their
communities, they have a deep understanding of the
area’s health care literacy, nonverbal signals, and cul-
ture/language differences (Cooper & McCarter, 2013;
Nigolian & Miller, 2011).

If the patient does not transition successfully to the
home environment, hospital readmission often occurs
within a few days or weeks. Because 1 in 5 Medicare
patients are readmitted to the hospital within 30 days of
discharge, readmission costs exceed $26 billion a year;
$17 billion of that is preventable (James, 2013). Atten-
tion to transition following hospital discharge can
decrease rehospitalization among Medicare patients by
12%, so many hospitals have assigned specific nursing
staff to facilitate post-hospital care and adherence to
prevent readmission for the same health problem
(Evdokimoff, 2011). A small issue can result in a cascade
of negative health events across all of a patient’s chronic
conditions. Older individuals who are isolated from the
community and do not have family support are three
times more likely to regress (Coffey & McCarthy, 2012).

When the FCN identifies the patient’s declining
health condition or complications, an early interven-
tion in the outpatient setting helps avoid rehospital-
ization (Evdokimoff, 2011). Monitoring the home medica-
tion regimen for effectiveness and adherence can
improve patient outcomes at home. When hospitals
partner with churches, patients improve adherence and
communication after hospitalization (Anaebere &
DeLilly, 2012; Morris & Miller, 2014). In one case study,
a patient who had been prescribed a new antihyper-
tensive medication soon presented with dizziness and
orthostatic hypotension. The FCN contacted the physi-
cian to advocate for revaluation. The FCN interaction
prevented hospitalization due to potential overdose or a
possible fall (Brown, Coppola, Giacona, Petriches, &
Stockwell, 2009), avoiding possible costs of $35,000 fol-
lowing a fall injury (CDC, 2013b).

Coordinator of Services

The health and wellness of congregant members can
be improved when the FCN collaborates with other
agencies and volunteers (Cooper & McCarter, 2013;
Dandridge, 2014). Because nurses work directly with
older adults and families, they see the immediate needs
of elders and can identify gaps in service use through a
working knowledge of medical support available in the
community. Thus the FCN is the ideal person to help
the patient connect with services through hospitals,
doctors’ offices, nonprofit resources, and therapists.
Further, accessing health care resources early in the dis-
ease process can prevent more serious health issues from
developing (Joo & Huber, 2014; Morris & Miller, 2014).
One patient who consistently refused to undergo a
screening colonoscopy was afraid of the pain and prepa-
ration for the procedure. The FCN encouraged him to
undergo the procedure and explained he would be
asleep. The individual finally consented to the proce-
dure, during which numerous precancerous polyps were
removed. This prevented possible hospitalization for
surgery and colon cancer (Brown et al., 2009). By
encouraging preventive screenings for cancer, hyperten-
sion, or diabetes, an FCN can help parishioners obtain timely medical care, adhere to treatments, and prevent long-term medical costs. Through collaboration with medical centers, universities, health departments, and community resources, the FCN can strengthen the reach and success of the work (Joo & Huber, 2014; Tanner, 2010).

Conclusion

The FCN’s greatest strength is the consistency and trust built between parishioners and the faith community. As a health team member, the FCN can collaborate with the entire congregation to provide care for a beloved member of their community (Morris & Miller, 2014). The FCN also can provide clarification regarding physician orders or hospital discharge instructions. Better adherence to these instructions will reduce readmission and promote health (Coffey & McCarthy, 2012; Joo & Huber, 2014; Rytter et al., 2010). Furthermore, the FCN can be instrumental in ensuring individuals disconnected from the medical system receive appropriate screenings and services, thereby improving outcomes for the community (Joo & Huber, 2014; Shores, 2014).

Traditionally, FCNs have been successful in identifying additional medical, physical, emotional, and health needs in the congregations they serve and seeing these needs are met while addressing spiritual needs (Whisenant, Cortes, & Hill, 2014). Ultimately, the FCN can connect parishioners and community members with local resources and the parish volunteer network.

Current research concerning medical benefits of faith community nursing has focused on small projects and often lacks follow-up research that can address wider implications for the continuity of nursing and health care after patients’ hospital discharge (Bernard & Foss, 2014; Coffey & McCarthy, 2012; Monay, Mangione, Sorrell-Thompson, & Baig, 2010). For faith community nursing to reach its potential, more research is needed to define the present role of the FNCs, gather data concerning long-term medical and cost effectiveness of FNCs in the faith and wider community, and bolster the hospital-FCN coordination during patient transitions from hospital to home. MSN

TABLE 2.
Additional Resources

- American Nurses Credentialing Center: Faith Community Nursing (www.nursecredentialing.org/FaithBoardCert)
- Church Health Center (www.parishnurses.org)
- Episcopal Health Ministries (www.episcopalhealthministries.org)
- Health Ministries Association (www.hmassoc.org)
- Lutheran Deaconess Association (www.thelda.org/resources/parishnurse.php)
- Scope and Standards of Practice: Faith Community Nursing (www.nursesbooks.org/Main-Menu/Standards/A—G/Faith-Community-Nursing.aspx)
- United Church of Christ Parish Nurse Network (www.ucc.org)

REFERENCES


