

A Renewed Look at Faith Community Nursing

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

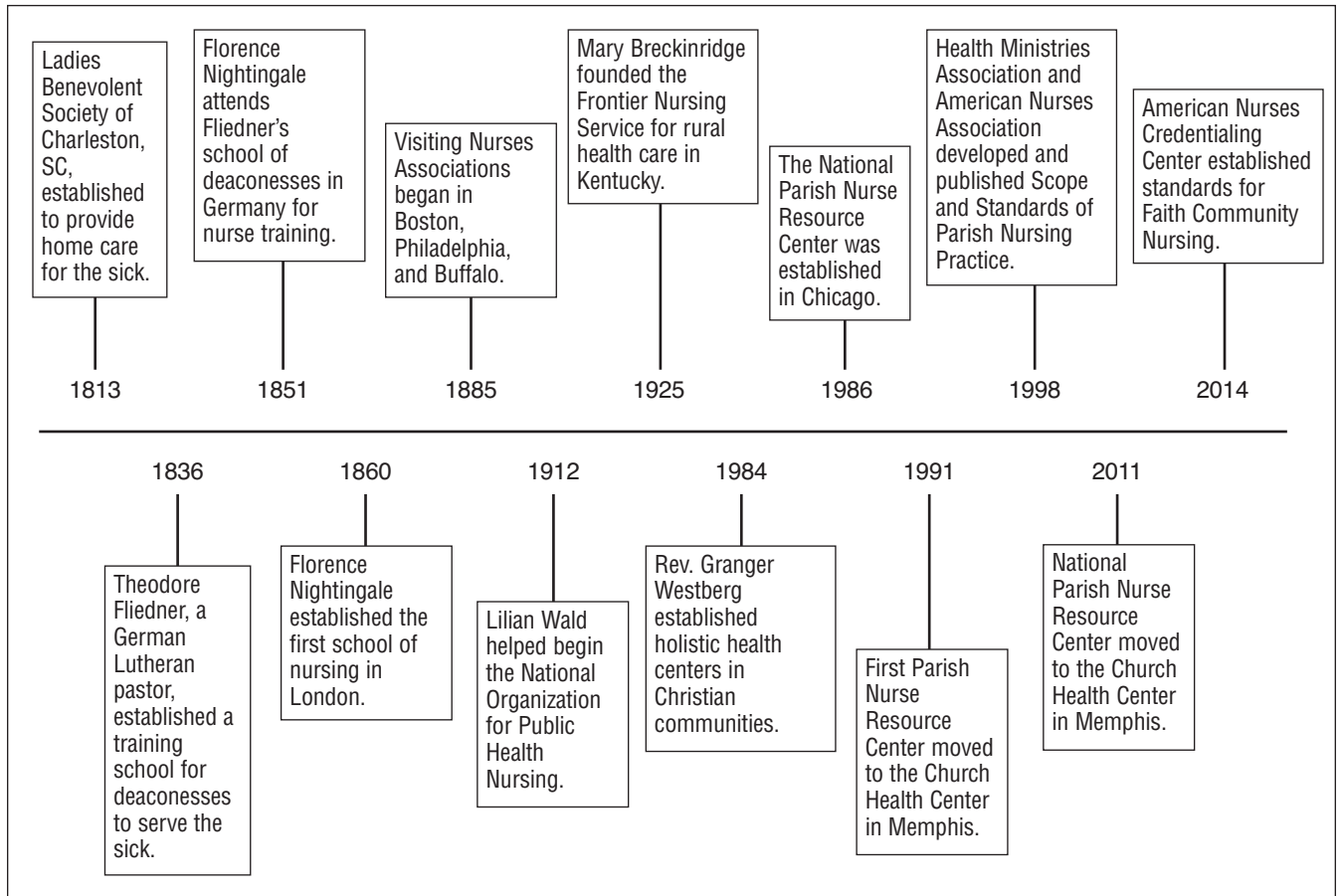
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FIGURE 1.
Education Matters: One Story

Syracuse University teamed with FCNs to develop an obesity-reduction and health-promotion program among low-income, African-American churches. The FCN trained volunteers to hold 12 weekly meetings about obesity, cardiovascular disease, nutrition, and health issues while integrating prayer and Bible study. Findings showed improvement in fitness and food choices, with participants reporting more exercise and weight loss in a 4-month follow-up survey. Participants ate more yogurt, leafy green vegetables, and high-fiber grains while reducing consumption of soda and cheese (Coward et al., 2010).

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).

FIGURE 2.
History of Parish and Community Health Nursing



Source: Harkness, 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 [ANA/HMA], 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 pre-

vention, 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 (ANA/HMA, 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)

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 practice 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.

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 benefit by participating in ongoing education activities and clinical practice to maintain and augment their skills. Because FCNs often work alone, contact with other nursing peers provides support and offers opportunities for personal and professional growth (Harris, 2011).

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 hospital discharge, patients and families often are unequipped to provide self-care, change dressings, manage insulin, or administer medications. Intervention in the home setting can provide better adherence to medical prescriptions and reduce hospital readmissions by 23% (Rytter et al., 2010). A direct correlation exists between appropriate discharge planning and the readmission 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 challenging 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 instructions 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). Attention 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 intervention in the outpatient setting helps avoid rehospitalization (Evdokimoff, 2011). Monitoring the home medication 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 antihypertensive medication soon presented with dizziness and orthostatic hypotension. The FCN contacted the physician to advocate for reevaluation. 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 following 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 disease 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 preparation for the procedure. The FCN encouraged him to undergo the procedure and explained he would be asleep. The individual finally consented to the procedure, 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-

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)

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 with 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 FCNs, gather data concerning long-term medical and cost effectiveness of FCNs in the faith and wider community, and bolster the hospital-FCN coordination during patient transitions from hospital to home. **MSN**

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