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Faith Community Nurse Care Transitions Intervention Feasibility Project

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Abstract

Background: A major national-to-local healthcare quality and safety goal is to reduce hospital readmissions, which are considered preventable patient harm. While the literature shows the impact of using care transitions programs to reduce readmissions, few studies have utilized faith community nurses (FCNs) within care transition programs. An FCN-integrated care transitions program potentially could help fill the gap in community clinical support for chronic illness care. Saint Alphonsus Regional Medical Center (SARMC), a Catholic hospital in Boise, Idaho, sponsors an FCN network within many Southwest Idaho faith communities. This presented a local opportunity to create and test the feasibility of an FCN-integrated care transition pathway, using an evidence-based practice model such as the Care Transitions Intervention (CTI), to impact patient experience and outcomes post-discharge. The purpose of this project was to evaluate the feasibility of using FCNs as hospital CTI Transition Coaches and illuminate facilitators and barriers to their work.

Methods: Three FCNs trained to intervene with a targeted group of orthopedic patients, using the CTI model and protocol resources for Care Transitions Coaches, which included a 30-day patient engagement of a hospital contact, a home visit, and three phone calls. Primary outcomes were to implement an FCN-integrated CTI program, to evaluate both the effectiveness and satisfaction of the FCNs as Transition Coaches, and to quantify adequacy of the hospital support in fulfilling the CTI work and give voice to the facilitators and barriers to FCN-CTI care delivery.

Results: Feasibility evaluation was determined by if the CTI model could be implemented using FCNs. Over the time period of August 2015 to January, 2016, 24 patients, aged 65 and older, having total hip or knee surgeries, were enrolled as participants in the project. The FCNs completed the 30-day CTI follow-up protocol with 18 patients (75%) with 100% of the protocol documentation completed (18/18 checklist forms), 100% protocol visits accomplished (90/90), and

100% of Patient Activation Assessments were performed (72/72). FCNs reported 99% of the time

(71/72 assessment visits) having the resources needed for Coaching. Key facilitators for effective

Coaching included a project coordinator to help the FCNs navigate the hospital system and

effective communication strategies with staff and providers. Barriers highlighted by the FCNs

included poor usability of the personal health record tool, confusing discharge instructions, and

challenges with coordinating hospital visits before discharge. The FCNs appeared satisfied that the

Transition Coach role falls within FCN scope and standards of practice. They also found the

stipend to be a beneficial incentive.

Conclusions: Healthcare delivery is transforming from hospital-focused care to community-based

care. Providing care transitions resources to ensure healing after hospital discharge and prevent

unnecessary readmissions benefits patients and hospitals. This project demonstrated that FCNs can

be effective Transition Coaches and successfully implement the CTI model. Although often in

unpaid roles in faith communities, the FCNs in this project were remunerated with a stipend.

FCNs performing care transitions should be compensated for this value-based work, a trend that

will likely be more common as reimbursement for care transitions grows in payer practices.

Keywords: faith community nurse, parish nurse, care transitions, care transitions intervention

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Problem

National and local healthcare quality and safety goals are focused on reducing preventable readmissions. Readmissions are one of many outcomes considered a "patient harm." This is an important focus in the Centers for Medicare and Medicaid Services (CMS, 2014) *Partnership for Patients*, in payer-based value-based purchasing initiatives, and in simply doing what is right for patients. Readmitted patients are most often older patients managing several health conditions (Condeius, Edberg, Jakobsson & Hallberg, 2008). There is a gap in health services in the transition from hospital to home of seniors with chronic illness. Care transitions programs in the literature have shown an impact in reducing readmissions (Health Research & Educational Trust [HRET], 2010), but there is still ample opportunity to journey with patients to help them stay healthy in the community after hospital discharge, especially among community-dwelling older adults living with chronic illness (Rydholm, Moone, Thornquist, Gustafson, & Speece, 2008). Faith Community Nurses (FCNs) are a potential resource for providing such transitional care.

Problem Change

This project tested the innovative use of a unique specialty of nursing, faith community nursing, within an established model of care transitions, the Care Transitions Intervention (CTI) Program. The purpose of this project was to determine the feasibility of implementing an FCN-delivered hospital care transition pathway for active follow-up with targeted patients to help them thrive post-discharge and prevent poor outcomes. FCNs, as Transition Coaches, can help provide spiritually-centered and clinically supportive care in a way that gives support to hospital discharge team goals, improves the patient's experience of care, and reduces likelihood of readmission. Appendix A displays the care pathway created for the project.

Background

Few studies have utilized FCNs within care transition programs. Faith community nurses are valuable resources of health expertise, love, spiritual counseling, and caring for their congregational members in all their life stages and health journeys, and they are particularly in tune with shepherding parishioners into wholeness within the context of faith communities (American Nurses Association & Health Ministries Association [ANA & HMA], 2012). At Saint Alphonsus Regional Medical Center (SARMC), there is a sizeable volunteer FCN network that provides care within many Southwest Idaho faith communities. While faith community nursing work prior to the Scholarly Project had not been integrated with the Saint Alphonsus hospital care delivery system, this project integrated the FCN into patient care processes during the patient hospital stay and after discharge.

The literature review sought and yielded articles from both the care transitions and FCN literature (see Appendix B). Best evidence demonstrates that care transitions models such as the CTI can improve outcomes for this population (HRET, 2010). The CTI is a 4-week care transitions model used with patients being discharged from a hospital who have a high risk of readmission (Parrish, O'Malley, Adams, Adams, & Coleman, 2009). A trained Transition Coach in this model can be a nurse, other health care professional, or a trained community worker. In this project, an FCN performed the Transition Coach role. The Transition Coach helps patients develop an ability to manage their condition independently in the community. Although other care transitions models are described in the literature (HRET, 2010), the CTI model was chosen for two reasons. First, the Northwest Parish Health Ministry project (Marston, 2012) reported success with FCNs using the CTI model. Second, the CTI is a known evidence-based practice and dissemination model (Coleman, Rosenbek, & Roman, 2013).

Eric Coleman, the designer of the CTI model, is a lead or co-author in all of the referenced CTI studies. This and other care transitions models as a whole have shown effectiveness in multiple communities nationally in decreasing 30-day readmissions (Brock et al., 2013). Successful implementation of the CTI program requires: (1) sustainability of the CTI model in organizations (Parrish et al., 2009), and (2) patient perception of caring by the Transition Coach as integral to the model (Parry, Kramer, & Coleman, 2006). It is this deeper connection of caring, as perceived by the patient, which makes the Transition Coach role effective when delivering the four pillars of the model.

The FCN literature is known to be weaker in relation to outcomes (Dyess, Chase, & Newlin, 2010), which made it difficult to find peer-reviewed literature in this field. Baig, Mangione, and Miranda (2010) conducted the only randomized controlled trial found in the FCN literature. These study findings described how FCNs can intervene in the community in chronic disease (e.g. high blood pressure) follow-up and facilitate the care transition to a primary care provider as needed. Another study revealed the ways in which FCNs identify patient issues of concern in the community (Rydholm et al., 2008). For the purpose of this project, an article shared by the Northwest Parish Nurse Ministries (Marston, 2012) proved most relevant. It reported a project where FCNs used the CTI model to successfully reduce readmissions in a quality improvement initiative in a rehabilitation center.

The evidence suggests that models of care transitions, specifically the CTI model, are effective at preparing patients for self-care in the community (Coleman et al., 2004), coaching patients for successful transitions home (Parrish et al., 2009), and reducing readmissions (Parry, Min, Chugh, Chalmers, & Coleman, 2009). The literature related to FCNs describes their role in assessment of patient chronic and urgent health needs (Rydholm et al., 2008), in providing follow-up care in the community (Baig et al., 2010), and in helping patients move from inpatient acute-

care to self-care at home (Bay, 1997). This is the crux of the literature synthesis: the intertwining of FCN and CTI scholarly work that inspires this project as a synergistic opportunity for improving care in the community.

<div align="center">**Implementation Process Analysis**</div>

The Saint Alphonsus Institutional Review Board (IRB) reviewed the project proposal, implementation plan, and all related tools and documents. The IRB decided this project was officially exempt from further IRB review and also provided a support letter for the project allowing the use of Saint Alphonsus' name and logos in the final report (see Appendix C).

Setting and Target Population

Setting. The Care Transitions Intervention protocol was implemented in August 2015 in the inpatient setting of Saint Alphonsus Regional Medical Center in Boise, Idaho. Saint Alphonsus is a Catholic, faith-based healthcare organization and is part of Saint Alphonsus Health System, a regional system with hospitals and clinics extending from Boise to Baker City, Oregon, serving about 700,000 people in a rural and urban area. This regional health system is also part of the second-largest national Catholic healthcare system, Trinity Health. FCNs were recruited and trained to perform CTI 30 days follow-up on patient participants discharged to home (see Appendix A). The Transition Coach met the patient in the hospital before discharge and then performed in-person follow-up in the patient's home after discharge, followed by three telephone calls to the patient's preferred phone number over the 30 day period. The FCNs had a toolkit of materials for implementing the CTI protocol with patients. FCNs performed some of the preparation work and telephone calls for their coaching encounters from their private church offices or homes.

Faith community nurses. The population of interest for this Scholarly Project was the FCNs who engaged in this 30-day journey with patients upon hospital discharge. The Saint

Alphonsus FCN Network has more than 100 FCNs in over a dozen Catholic and non-Catholic faith communities. Organized through the Saint Alphonsus volunteer program, most FCNs are unpaid volunteers for their churches, but receive education, liability insurance, and other support through the Saint Alphonsus program. FCNs have their own specialty *Scope and Standards of Practice* (ANA & HMA, 2012). These nurses traditionally offer health resources to their churches such as home visiting, health education, grief counseling, referrals, blood pressure checks, and other non-invasive health coaching types of activities.

Three FCNs were recruited and trained as CTI Transition Coaches. They were current and active volunteers in the Saint Alphonsus FCN Network. Although they were volunteers, in this project the FCNs received a nominal stipend of $100 per patient followed. This incentive structure was borrowed from the Northwest Parish Nurse Ministries (2013) program model which continues to offer remuneration. The FCNs were from two different Catholic churches and one Episcopalian church. The particular faith background of each FCN was not a required criterion for participant assignment; each FCN acted in a non-denominational manner in their Coach role.

Patients. The recruited patients were 65 years and older. While the CTI is often implemented across many chronic disease categories, and this was considered during the original proposal, the project scope was narrowed to total hip and total knee surgery patients. This scope change allowed the nurses to gain experience with one disease category, to focus on a scheduled patient group, and to give and receive feedback from a smaller group of physicians and support staff. The patient sample for this project was partly defined by a payer (insurance) category – Medicare patients; the patients were also limited to the Treasure Valley region: Boise, Meridian, Nampa, Eagle, and Kuna. The goal was to recruit a minimum of 20 patients, with each FCN following 1-3 new patients per month, allowing a range of 12 to 36 patients

total. Patients were identified and vetted by the project coordinator who reviewed weekly

surgery schedules and daily admission reports for likely candidates. Patients were assigned to

available FCNs. Some patients discharged with rehabilitation and home health referrals were

recruited; these patients became incomplete cases and, upon reflection, should have been

excluded from the beginning of the project.

Implementation Strategies

Implementation strategies key to the successful completion of the project included:

1) engaging Saint Alphonsus hospital care transitions work stakeholders and organizational

leaders for project endorsement, alignment, and guidance; 2) engaging nursing leaders and case

managers for support and assistance during project implementation; 3) training FCNs on the CTI

model to have a qualified, competent Transition Coach team; 4) obtaining grant funding for the

project operations budget; and 5) establishing key contacts in patient care setting such as social

workers, unit clerks, and the orthopedic joint program coordinator.

Program Outcomes

This was a feasibility project to determine if the CTI model could be effectively

implemented using FCNs as Transition Coaches. The main outcomes were to:

- determine if the CTI model can be implemented in the hospital using FCNs,

- determine if FCNs are effective as Transition Coaches in the CTI model,

- understand hospital facilitators and barriers to FCN delivery of CTI care, and

- evaluate FCN satisfaction with the Care Transitions Coach role in relation to their
  scope of practice.

Economic, Social and Political Environment

Saint Alphonsus Regional Medical Center is a Catholic hospital part of local and national

Catholic healthcare systems. Catholic healthcare entities consider healthcare to be a faith-based

ministry of the healing work of Jesus Christ, not just brick-and-mortar locations for healing bodies. Catholic healthcare has done much to grow and support the specialty of faith community nursing, formerly known as parish nursing. Faith community nursing is one of many coordinated community benefit programs at Saint Alphonsus. Saint Alphonsus was ready and excited to use FCNs in such an innovative outcomes-focused endeavor. The project aligned perfectly with the mission, values, and community benefit work of the organization. The project also aligned with the Saint Alphonsus and Trinity Health strategy to transform healthcare from fee-for-service hospital-based care to community-based population healthcare. Payer incentives and reimbursement penalties implemented after *the Patient Protection and Affordable Care Act* (PPACA, 2010) have done much to encourage the growth and innovation in care transitions work. While Saint Alphonsus leadership was supportive of the FCN Scholarly Project, the infrastructure for seamless care coordination into the community is in its infancy as Saint Alphonsus moves towards improved population health management and better care for patients before admission and after discharge. Still, Saint Alphonsus had already adopted CTI as one of its primary care transitions support models; it has one CTI-trained Transition Coach nurse who performs the protocol with patients 65 and older in certain disease categories.

Project Evolution

This project has evolved since the initial proposal in the Fall of 2013, and in some ways since final proposal approval, as should be the case with a quality improvement project. In the beginning the project focus was to create a process or mechanism to connect and integrate FCNs into hospital care of the patient. The original proposal was difficult to articulate, so the project evolved into the current focus, testing the feasibility of using FCNs in providing hospital-integrated follow-up care in the community. Still, nested within the current project is the critical, original work of creating the connecting mechanism(s) for integrating the FCNs into the hospital

processes. Prior to implementation, the project was adapted to focus on elective total hip and knee surgeries for ease of scheduling the FCN work. This also allowed the FCNs to develop expertise in one hospital unit for this project. Initially the proposed stipend was $50, and after reflection on time required for follow-up and travel, the stipend was increased to $100 for each patient followed to protocol completion; it was prorated for incomplete cases. Patients with a discharge referral for rehabilitation and home health were not excluded, but after a few failed experiences in follow-up they were no longer recruited.

Business Plan Analysis

The business plan analysis for this project was based mainly on targeted activities, budget, and congruency with established timeline. The project activities and expenses tracked as planned and were supported by grant funding. The FCNs were trained, and support materials were purchased, organized and distributed to the nurses. Mileage and stipend were budgeted into the project plan. The data collection phase was delayed slightly from late spring to later summer 2015. Activities that took additional time prior to data collection included providing adequate shadowing opportunities for the FCNs, a change in the participant identification process, allowing for summer plans of the FCNs, and getting appropriate communication of the project to providers, orthopedic unit manager, and orthopedic staff. Despite the delay in project start date to August, there was ample time to accomplish significant patient recruitment and meaningful data collection over 5 months.

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Results/Outcome Analysis

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Data Collection Analysis

This project was a feasibility (Bowen et al., 2009) and quality improvement project, in which a model was selected (CTI), adapted (using FCNs), and evaluated as a nursing intervention. Select FCNs were trained to intervene with a targeted group of orthopedic

patients, using the CTI model and protocol resources for Care Transitions Coaches. Appendix A shows an overview of the FCN Transition Coach process during each 30-day patient engagement. The project logic model (see Appendix D) shows various overlapping perspectives on the project investments, activities, objectives, outcomes, and predicted impact.

The primary data collection tools were used to: 1) determine FCN effectiveness in CTI Transitions Coach Role; 2) understand hospital facilitators and barriers to FCN delivery of CTI care; and 3) evaluate FCN satisfaction in the CTI Transitions Coach role. Three instruments were used for collecting data: 1) a client Contact Checklist tool (see Appendix F); 2) the CTI Patient Activation Assessment (PAA) tool (see Appendix G); and the FCN satisfaction survey (see Appendix H). A detailed description of the data sources is listed in the project evaluation plan (see Appendix E).

The nurses utilized the first two instruments during hospital and home visits. One contact checklist form was used for each patient recruited. The CTI PAA tool was completed during each nurse-patient coaching session over the 30-day follow-up period. The FCNs provided ongoing feedback after each patient encounter regarding if they had the resources to do the role effectively and if the patient was reaching self-care goals along the way. The FCN satisfaction survey was completed by each FCN at the conclusion of the project as part of the evaluation. Descriptive statistics were used to evaluate the project outcomes. Answers to a few open-ended questions were collected in the FCN satisfaction survey (see Appendix H) to provide a understanding of the FCNs experience, from their point of view, as part of the final analysis (Wholey, Hatry, & Newcomer, 2013). In the end all data were collected and analyzed to help answer the overall feasibility project question – if this model could be successfully implemented.

Indicators for Project Outcomes

Success of the project was evaluated using the stated project outcomes. Major outcomes were to determine if the CTI model could be implemented effectively using FCNs and if the FCNs found satisfaction in the Transition Coach role. Also, because of the project's quality improvement focus, facilitators and barriers to coaching were illuminated to continually improve the program for the hospital. Each of these measures is addressed in the following discussion.

Determine feasibility of implementing CTI model in the hospital using FCNs. A total of 24 patients were enrolled in the project, and the FCNs completed 30-day follow-up on 18 (75%) of enrolled patients (see Appendix I). Of the 18 patients who completed the CTI program, 10 (56%) were followed by one of the FCNs, seven (39%) patients, and the third FCN completed one patient 30-day follow-up. The FCN with one patient also had paid employment and had to balance her job and the work in this project. Each FCN had a couple of patients who did not complete the 30 day follow-up. At least four of six (83%) incomplete cases had discharge dispositions that conflicted with CTI; in these cases the surgeon referred the patient to home health or rehabilitation after the patient had been enrolled and visited by an FCN. While home health and rehabilitation dispositions were not initially project exclusion criteria, the overlap with Transition Coaching felt confusing and redundant for the patient and the FCN. One other incomplete case was a patient who should have been excluded initially as he was under 65 years old.

Determine FCN effectiveness as Transition Coaches in CTI model. Three of three (100%) FCNs completed official CTI model training in Denver, CO. This training was followed by all three FCNs (100%) completing shadowing experiences with the Saint Alphonsus employed hospital CTI Coach. Effectiveness in the role was assessed by accounting for if the FCN *contacted* the patient five times (hospital, home, three phone calls) and then also *assessed* the patient using the Patient Activation Assessment four times (home and during three phone calls).

Completing the full CTI protocol of five visits was an important goal and metric for evaluating

effectiveness of the FCN in the Coach role: greeting in the hospital, meeting in the home, and

completing three telephone calls. The CTI Contact Checklist tool (see Appendix F) was used to

record these five visits. If any encounters were not completed, the FCN documented why it did

not occur, which helped with evaluating barriers. Both percent of Contact Checklist tools

completed and percent of CTI protocol visits completed were measured as quantitative metrics.

The FCNs returned Contact Checklist forms on 100% (18/18) of patients recruited and followed in

the project. The percent of CTI protocol visits completed was 100%; of the 18 patients who

completed the 30-day protocol, the FCNs completed 100% (90/90) of all scheduled visits with the

patients, including a hospital visit, home visit, and three phone calls. In several cases additional

phone calls were included as extra support for patients.

The Patient Activation Assessment (PAA) tool was used by the FCNs. It is a key

Transition Coach tool and is part of the required training with Coleman's Care Transitions

Intervention Program (Coleman, 2014). This tool quantifies patients' uptake of skill and

knowledge in self-care along the four pillars of the CTI model: (a) medication management, (b)

red flags, (c) medical care follow-up, and (d) the personal health record. The FCN Coach helped

activate patients along the four pillars of the CTI protocol and documented patient progress on the

PAA tool. The Coach evaluated each patient during four patient encounters: the home visit and

each of the three phone calls. Percent of PAA tools completed was measured as a quantitative

metric. The FCNs assessed patient activation using the PAA form for 100% of encounters; of the

18 patients who completed the 30-day protocol, the FCNs completed 100% of assessments

expected (72/72 encounters). One FCN suggested an improvement to this process that was

implemented part way through the project to allow the nurse to simply update the original PAA

form or document a new PAA form when there were changes to the assessment numbers. In many

cases the patient assessment scores remained the same from the initial visit. The assessment was still performed at each encounter and any changes documented.

Understand hospital facilitators and barriers to FCN delivery of CTI care. As seen in Appendix G, the original CTI PAA form was adapted by adding questions to determine if the FCN had the necessary resources for each visit and to list ways the hospital helped and/or created barriers for an effective patient coaching visit. These questions were added in an effort to evaluate facilitators and barriers to the work performed by FCNs. Although the adaptations to the PAA were not validated pieces of the tool, they served the intentions of this local evaluation. The FCNs reported hospital facilitators and barriers on the PAA form during any given follow-up event with patient. Appendix J has tables highlighting reported facilitators and barriers during the project. Often the reported barriers were temporary and served to make improvements in the project in real-time.

Evaluation of hospital facilitators. FCNs were asked if they had the resources they needed for each patient encounter. Of the 18 patients who completed the intervention, which included 72 or more assessment visits with the Coaches, 99% (71/72) of the time the FCNs reported having at least the basic resources for supporting the patients during the follow-up experiences. In one instance a pair of gloves was desired, which inspired including gloves in the FCN toolkit for future home visits.

There were many facilitating items, people, and actions that helped the FCNs perform their Coach role effectively and efficiently. Key was the common feedback of the importance of having a coordinator in the hospital. The project coordinator created seamless recruitment of patients, preparation of materials for FCNs, and relationship-building among all the hospital staff and providers involved with the patient and FCN. She naturally bridged the connection between patient and FCN and was the person who connected the program and documentation with the

physicians' offices. Additionally smartphone technology allowed for efficient communication, with texting, faxing and emails between the FCNs and the coordinator. Patient privacy and confidentiality was emphasized and maintained in communications. The FCNs felt that their work was also supported by having project collateral such as hospital identification with badge and Coach title, hospital business cards, and a program information sheet with their photos on it (see Appendix Q)

The FCNs appreciated having a known and clear relationship with the hospital unit staff and the patient's providers. This created comfort and patient safety for all involved in the patient's care, especially in the hospital setting. Because of this relationship-building, the nursing staff extended themselves in helpful ways such as wayfinding when they noticed the FCNs on the unit. The physician offices became so comfortable with the program that on several occasions they called the coordinator in advance to ensure their patient would be seen by an FCN Transition Coach. The providers also were open to phone calls directly from the FCNs and helped answer questions in a timely manner. It was discerned that lunchtime was a mutually good time for both patient and FCN to meet at the hospital. The FCNs felt the discharge paperwork was very organized, a facilitator, but also reported that the discharge instructions were often confusing to the patient, a barrier.

Evaluation of hospital barriers. The FCNs identified the Personal Health Record (PHR) tool as the main barrier to performing the CTI work effectively. One of the pillars of the CTI model is to ensure the patient understands the importance of such a record and that they take it with them to each health encounter. The one provided by Saint Alphonsus is aesthetically pleasing at first glance, but served as a poor tool for the nurses because it was not well-adopted by patients.

Discharge paperwork and instructions were provided and organized well for the patient. Still there were some discharge items that proved vexing for the patient and nurses. For example,

things patients sometimes found confusing included the following: 1) exercises; 2) pain control

options; 3) constipation treatment; 4) follow-up appointment with providers; 5) infection

definition; and 6) diet post-discharge. These issues provided extra validation for the value and

helpfulness of having a Transition Coach available for questions and clarification.

The following additional barriers identified by the FCNs provide guidance for potential

improvements in the next iteration of the program. There was lack of parking near the hospital

entrance for FCN ease of access. Once in the hospital, there was no one single place for the

coordinator to transfer the patient file to the FCN efficiently and assuredly, although it always was

transferred to them. The discharge disposition was not always known in time for the FCN

assignment and hospital visit with a patient, which led to including rehabilitation and home health

patients who eventually became incomplete cases. Finally, there were patient candidates in rural

and remote areas who could have benefitted from the program but were beyond this project's

scope.

Evaluate FCN satisfaction in CTI Coach role. A brief satisfaction survey (see Appendix

H) was administered to the three FCNs at the conclusion of the project. They completed a

quantitative survey that included a few open-ended questions. This was not designed for statistical

strength but was important in the descriptive analysis and storytelling which complemented the

other quantitative data. The survey was followed by a group conversation with the three FCNs to

clarify insights from the survey. Appendix K documents the FCN responses to each of the survey

questions. All three FCNs (100%) completed the survey.

Regarding the FCN perception of the Transition Coach role, the three FCNs had

overlapping insights. One nurse said, "Being a Transition Coach means getting involved. You

learn [the patient's] health goals, what they want to get back to, you get to know their family, and

you become a part of their healthcare team, if only for a little while." This comment revealed a

mutually enriching benefit of being a Transition Coach. Also noted was that the Coach role

provided guidance and coaching, facilitated personal goal-setting, and empowered patient self-

advocacy; also emphasized was how the Coach gets to be a caring presence, guide, and companion

on a person's healing journey. Interestingly, while at least one FCN though they would implement

the Coach role almost exactly as she had learned it, the actual practice and performance of the role

was different than expected, with great emphasis on patient self-reliance and instilling patient

confidence.

When answering the question about the Coach role and fit within FCN practice, 100%

(3/3) agreed that it does. While the FCN *Scope and Standards* (ANA & HMA, 2012) recognizes

and legitimizes that transitional care is an emerging professional trend in faith community nursing,

it was validating to hear directly from FCNs that their experience in this project resonates with this

practice assertion. FCNs have been doing home visits as part of their practice before it was called

"care transitions." One FCN expressed that the CTI model would be a good framework for FCN

practice even if they didn't participate formally in hospital follow-up work. Another FCN also

shared that she felt a couple of her patients may have actually needed a higher level of care, such

as rehabilitation or home health, because of the intensity of the need expressed during the home

visit. This highlighted the need to continually evaluate patient needs and consider practice

boundaries in the Coach role. At least two nurses detailed specifically, with examples, of how the

Coach role fit each of the six FCN practice standards of assessment, diagnosis, outcomes

identification, planning, implementation, and evaluation. Finally, in follow-up conversation with

the FCNs, they shared that they did not get to exercise one of their greatest strengths – spiritual

support – of their CTI patients, and that would be an opportunity in future FCN-CTI projects.

The FCNs were asked if they would recommend the role for other FCNs, and 100% (3/3)

FCNs said they would do so. One FCN recognized that FCNs working in a faith community

already follow their congregation members as needed, and this role is a definitive way to help

prevent poor outcomes and prolonged recovery. Another FCN recognized the synergy between

FCNs as caregivers and health educators who naturally want to support independence and self-

actualization of the patient to the extent possible. The third nurse noted that while she would

recommend it, she would share that the formal Coach role with the hospital is different than other

FCN roles; FCNs interested in such a formal role should shadow other Coaches before committing

to formal training and taking patient cases.

The FCNs shared their insights on the impact of a stipend. All three FCNs (100%)

appreciated having costs covered such as mileage for a car, and one commented that being

compensated offered a sense of value to the work. One FCN also shared that having a stipend is

not a requirement for participating in care transitions Coaching, but the more limiting factor, as an

FCN, is balancing competing work and personal priorities. Another FCN emphasized that the

stipend is very important to the CTI Coach role; if FCNs take on hospital-directed Coach roles,

and positively impact hospital quality and financial goals, then some compensation is a natural and

expected part of the FCN-hospital care transitions relationship.

When asked to name one change that would improve the FCN experience as a hospital

Transition Coach, several practical ideas emerged: 1) implement a different personal health record

that is easy to use and amenable to patient adoption; 2) include pill organizers as part of home-visit

tool for patients; 3) design a way to give more lead time in identifying and pairing an FCN with a

patient participant, even if it is before the surgery or hospital visit, and 4) keep working to improve

clear discharge instructions for patients. The FCNs were also asked to share a story from their

Transition Coach experience that they will never forget. In their patient stories, the nurses

reflected on: 1) the learning and joy they experienced as the patient learned and mastered

managing their healing process; 2) the prevention of patient harm they were able to achieve; and 3) the synergy they shared as an FCN team to ensure the most at-risk patients were coached well.

In summary of the FCN satisfaction survey, the FCNs described their satisfaction and alignment with the Coach role in relation to the scope of practice for faith community nursing (ANA & HMA, 2012). They appreciated the stipend for their valuable work. The survey results revealed that the FCNs agree that care transitions is relevant and part of the faith community nursing scope of practice, and that the CTI is a good model for traditional FCN home visiting (Church Health Center, 2014) in general. Still the FCNs seemed to agree that an FCN should be well-informed about the details of transitions work and possibly do some shadowing before committing to the intense and expensive training. Additionally, there appears to be opportunity to highlight with patients the spiritual care background of an FCN Transition Coach so that the FCN can naturally and adeptly offer this special FCN expertise as part of the 30-day follow-up experience.

Inferences Relating to Project Objectives

The results reported in the prior section showed that FCNs can deliver the CTI model to patients effectively. From their satisfaction survey responses there seems to be a great deal of flexibility in how an FCN can deliver the program as long as they maintain at least the core elements (pillars) of the model. FCNs are presumed to be natural coaches by their very competency and practice. The Transition Coach role is a seemingly great fit, and would be more so if the FCNs were encouraged to exercise their spiritual care skills in tandem. Their passion and commitment to caring deeply for their patients encourages FCN Coaches to go above and beyond the strict protocol, becoming available for additional follow-up with the patient within reason. All three nurses had patients with whom they voluntarily followed-up with additional calls because they felt it was important to the Coach-patient relationship and wanted to ensure a good patient

outcome.

The Personal Health Record (PHR) pillar gained a lot of attention from the nurses in this project. They felt the tool employed by Saint Alphonsus failed the nurse, the patient, and the model. In order for Coaches to meet the objectives of the CTI model fully, a better tool would need to be provided. It may be ideal to offer options for PHR tools depending on patient preference, such as an online health system portal or an improved hardcopy tool.

The FCNs did not have access to the electronic record, so could not review it for additional information and could not record data into it, so providers and patients have a less than complete record. If adequately connected to health system access, FCNs might manage health issues even more effectively. In this project essentially no information was recorded in the patient medical record; minimal information was faxed to the surgeon (See Appendix Q, fax sheet), and no information was sent to primary care providers. Data management and data access are opportunities for improvement. Electronic communication was effectively used between the FCNs and the coordinator; protected health information is a critical issue in the transmittal of information between hospital and community caregivers.

The FCNs were effective in delivering the CTI as volunteers with a stipend for compensation. The formal structure of the CTI model and intensity of follow-up may be a barrier to truly volunteer-based work. Volunteers, with or without a stipend, must balance their personal schedules with the requirements of the model. Additionally in this project, there was minimal lead time in inviting an FCN into a possible case assignment. In best case scenarios there were only 24 to 36 hours to plan an FCN hospital visit, and in some cases, only a couple of hours lead time. A possible improvement would be to bring the Coaches in earlier in the patient scheduling process, allowing for FCNs to meet with patients pre-operatively. Transition Coaching also may infringe on the natural autonomy of the FCNs' normal duties to their congregations. If the program grows

and formalizes, FCNs may need to be professionally paid.

Gaps and Effectiveness

The results showed that the FCNs effectively delivered CTI-based follow-up care, found it meaningful and relevant to their practice, and helped ensure its successful implementation in the hospital setting. The faith tradition of each FCN was not required to match the patient's religious background which allowed more flexibility in patient assignments. The Coaching process and materials were standardized to best support the FCNs in the project for maximum effectiveness (Storm, Siemsen, Laugaland, Dyrstad, & Aase, 2014).

Gaps were few but meaningful and provided opportunities for improvement. Data flow from the community setting back to the hospital, primary care office, and surgeon clinic was not accomplished easily. For care transitions to perform best for the patient, communication with all stakeholder providers must be fluid with full access to all care documentation. Documentation flow, sharing, and archiving must be complete, secure, and available to all care providers when possible.

FCNs in this project did not explicitly exercise support from their faith tradition, nor were they paired with patients from their church, faith tradition, or who were even necessarily spiritual in any way. FCNs typically focus on serving the people of their church, and FCN Transition Coaches may prefer to work primarily with their church members or at least patients of their shared faith tradition, given the choice. The project essentially discouraged FCN faith identification in the Coach role, which helped in recruiting and pairing them with any patient in the short project timeline, but also limited the potential benefit of FCNs providing intentional spiritual support of patients.

Another gap was that many patients excluded as project candidates could certainly benefit from having an FCN Transition Coach, including remote or rural patients, underinsured patients,

patients under 65 who are at-risk for readmission, and some patients discharged with rehabilitation or home health. The Bellingham, WA CTI work (Marston, 2012) performs work exclusively from rehabilitation facilities, so there is opportunity for helping these patients when a CTI Coach pathway is well-defined for the rehabilitation population.

Appendix I documents how the FCNs had varying available dedicated time for scheduling Transition Coaching assignments. All three nurses were actively engaged: 1) the FCN with the most cases was devoted 100% to volunteer FCN work in the community; 2) the one with the fewest patients also had a part-time job; and 3) the FCN with the middle load also had a newer separate part-time grant-funded role in the community. This simply highlights the gap that exists in ease of scheduling FCNs for CTI assignments. The cases assigned must be matched to the available time of any given FCN, including natural fluctuations in a person's day and life.

Unanticipated Consequences

This project evaluated how FCNs may be effectively utilized, using a care transitions model of post-discharge follow-up, to help patients thrive after discharge. One unintended positive consequence was that the program became a victim of its own success: 1) physicians actively referred their patients to the program instead of being recruited by coordinator based on project criteria; 2) the hospital orthopedic Joint Coordinator actively referred patients to the program as well; and 3) the orthopedic service line director wanted to expand the program.

The impact to faith community nursing practice can be positive and negative. The positive results of this project and others like it could shift the traditional practice of faith community nursing and launch it deeply into the world of outcomes-based care. While the spiritual care intention of this specialty would remain intact, this movement could disengage retired nurses who desire a simpler commitment in their FCN practices. Still the FCNs voiced that even if not

performing as a formal CTI, the CTI model could provide a great framework for FCNs who are

conducting home visits for their congregations.

Additionally, while 99% of the Saint Alphonsus FCNs are unpaid volunteers, this project

could fuel a local movement to compensate, at a professional level, those FCNs performing

transition coaching. While there is a savings in using volunteer-based nurses, the work creates an

argument for paying them too; one would still find a return on investment (see Appendix P).

Future financial analysis work could evaluate potential in deriving savings in actively managing

the care of a congregation.

Financial Analysis

The simple per case cost of delivering the 30-day follow-up per patient is in Appendix L,

with a patient assignment cost of approximately $120 for stipend and mileage. A project

operating budget is detailed in Appendix N. It represents the first 2 years of the 5-year budget

and cost of the Scholarly Project. The revenue, assets, and expenses are simple and

straightforward with the SARMC Foundation grant ($15,000 Revenue), CTI Training

Scholarship ($3000 In-Kind from CTI Center), training stipend for three FCNs, and materials

cost making up the bulk of the expenses. The long-term budget (see Appendix O) estimates the

final 3 years of the 5-year budget. Although the FCNs were technically volunteers, for the

purposes of this project work, a small stipend was budgeted for each 30-day follow-up

engagement ($100). The long-term budget extrapolated on the initial budget, showing the

expenses for increasing the number of trained nurses from three to 15 to 35 FCNs over time. The

long-term budget also assumes a future foundation grant award.

A cost-benefit analysis (CBA) in Appendix P demonstrates the financial advantage of

using FCNs in hospital care transitions, with a positive cost-benefit ratio for every year,

especially when considering grants in the first two phases of the work. Readmission reductions

and their related savings have already been well researched (HRET, 2010); this was not the focus

of the analysis provided. Readmission reduction was not part of the primary evaluation;

evaluated were the opportunities found in using FCNs as Transition Coaches. Appendix P shows

costs of volunteer (stipend-only) FCN Transition Coaches and reveals savings compared with

using paid workforce nurses, a positive financial evaluation of this singular intervention.

Assuming paid or volunteer nurses would produce the same results in a Transition Coach role,

volunteer, stipend-paid FCNs can yield a financial advantage. While reimbursement pathways

for care transitions interventions are minimal, eventually there may be more as healthcare

transforms payment models. When that occurs, the payment structure for the FCNs and CBA

will change.

Recommendations

Informed Decisions and Recommendations

The FCN and coordinator experiences in this project illumined factors that can maintain

and improve efforts at replication. Champions throughout the continuum were necessary,

including strong partners in the providers' clinic, on the nursing unit, and in discharge planning. A

hospital program coordinator role was crucial to optimizing communication, data management,

and FCN connection to the hospital; still, communication was also enhanced when the FCN was

enabled to communicate directly with the provider office. A small-scale, one-unit pilot was a

great way to try out this new service model using FCNs. Elective patient care is the easiest for

FCN coaching assignments due to matching schedules, dates, and times

The CTI model is a best practice model and is a good fit when using FCNs in patient

follow-up work. There is official training required with opportunity for advanced training, tools

are available online for Coaches and health systems, and there are monthly teleconferences for

continual Coach support. The CTI model does require an organizational readiness evaluation that should be performed prior to training and implementation. Saint Alphonsus had already done this.

It was critical to have FCNs track barriers and facilitators to effective patient visits in order to continually improve the care experience for both the FCN and the patient in the community. Flexibility is a cornerstone and an advantage in providing transitional care. An adequate stipend was valued; professional nursing should be compensated. Liability insurance was extended to the FCNs, which is standard in any FCN engaged by hospitals in congregational care. FCNs should be recognized by their health system leadership for the impact made in the community and in patient outcomes. FCNs should be invited into more care transitions and other hospital work in the community.

Future projects should consider well-defined readmission rates as an outcome. There is also opportunity to study further the relationship between the health system and congregation in caring for patients and parishioners. This project could inspire additional scholarly works including studies that 1) measure activation level progress of patients over 30 days; 2) engage and assess patients on a proposed 5th pillar of spiritual health; and 3) create and test Coach-patient encounters prior to surgery. This project also revealed future project opportunities in follow-up care for patients who need it most such as uninsured patients, developmentally disabled patients, at-risk patients under 65, and Medicaid patients who are not eligible for other services.

Strategic Plan Congruence

This project aligns with the Saint Alphonsus and Trinity Health Systems' strategy to transform healthcare to community-based population health care. It is an expression of the spiritual care and community benefit ministry work that is part of the strategic plan as well. Saint Alphonsus leadership, especially physician leadership, is advocating for new innovations for

delivering community-based interventions to achieve healthcare transformation. This created a supportive culture for this project and lent energy and enthusiasm for the evaluation.

Application to Other Settings

Discussions with the FCNs, university faculty, and hospital stakeholders revealed that this project could be the first of several iterations at Saint Alphonsus. Ideas included connecting with patients first in the community prior to hospital admission, such as in the faith community or in pre-op appointments. FCNs could follow-up with patients with other outcome risks, such as mothers with new babies, patients with diabetes, homeless persons, and patients requiring follow-up for certain mental health needs. FCNs could be employed, paid drivers of preventive and follow-up care at the congregational level. It may be desirable to use FCNs to do follow-up with patients discharged to rehabilitation facilities as well.

Maintaining and Sustaining Change

This pilot program builds a case to expand and investigate further impact of FCNs in transitional care. Expanding capacity will require start-up and sustainable funding. One option is to seek a large-scale grant to establish widespread follow-up care in the congregational setting. This work could offer to: 1) train all FCNs desiring participation in the program; 2) fund growth and paid coordinator positions within congregations; 3) engage FCNs in access to the patient record/EHR for seamless work along care continuum; and 4) evaluate health system-congregation relationships to improve the transition from hospital to home.

Coleman, Rosenbek and Roman (2013) assembled a paradigm, based on the CTI model successes, of implementing best care practices. They found four factors that promote wide-scale CTI dissemination: model fidelity, selection of Transition Coaches and their training, model execution via existing workflows and fostering relationships with stakeholders, and continuing to make a business case for the model. These four factors will be key to expanding CTI services at

Saint Alphonsus. This scholarly work will be shared as a workshop presentation at the national

FCN symposium in April 2016 and in Saint Alphonsus and Trinity Health forums.

Lessons Learned

The transformation of healthcare, institutionalized with the PPACA (2010), asks nurses

to do more to care for patients in the community. Healthcare leaders are only on the cusp of

understanding how far beyond hospital walls an organization can take this expansion of

healthcare delivery. Combining faith community nurses and the CTI model, as in this project,

is one example of innovating around using nurses in a best-practice model to meet a

challenging demand of modern healthcare – managing population health to keep patients

healthy in the community (CMS, 2014).

Faith community nursing is a fast growing specialty of nursing, largely made up of

seasoned nurses, although its population of younger nurses is growing (Dyess et al., 2010). Many

in the FCN workforce feel called, spiritually, toward this special nurse role within their churches.

There is an opportunity for health systems to discern meaningful ways to connect FCNs

programmatically with initiatives that support outreach into these communities. The Church

Health Center, which provides resources to FCNs at the national level, is also studying and

promoting a Faith Community Nurse Transitional Care Program (Ziebarth, 2015). Care transitions

work presents a perfect opportunity for organizing FCNs for outreach into the community.

This feasibility project lends strength to building best practice around FCN-integrated care

transitions for hospitals. Potentially most faith-based hospital systems could have an FCN-driven

care transitions program with paid or volunteer FCNs connected to hospital care teams through a

coordinated admission and discharge process. The path for evolution of this concept is open.

Future scholarly work needs to evaluate how this field uniquely can impact health outcomes and

patient experience of care.

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Appendices

Appendix A Transition Coach Process

Appendix B Synthesis of Evidence Table

Appendix C IRB Approval/Exemption and Support Letter

Appendix D Logic Model

Appendix E Project Evaluation Plan

Appendix F CTI Contact Checklist

Appendix G CTI Patient Activation Assessment and Guidelines

Appendix H FCN Satisfaction Survey

Appendix I FCN Case Assignments

Appendix J Findings-Facilitators and Barriers

Appendix K FCN Satisfaction Survey Results

Appendix L Expense Per Case Results

Appendix M Evaluation Plan Results Summary

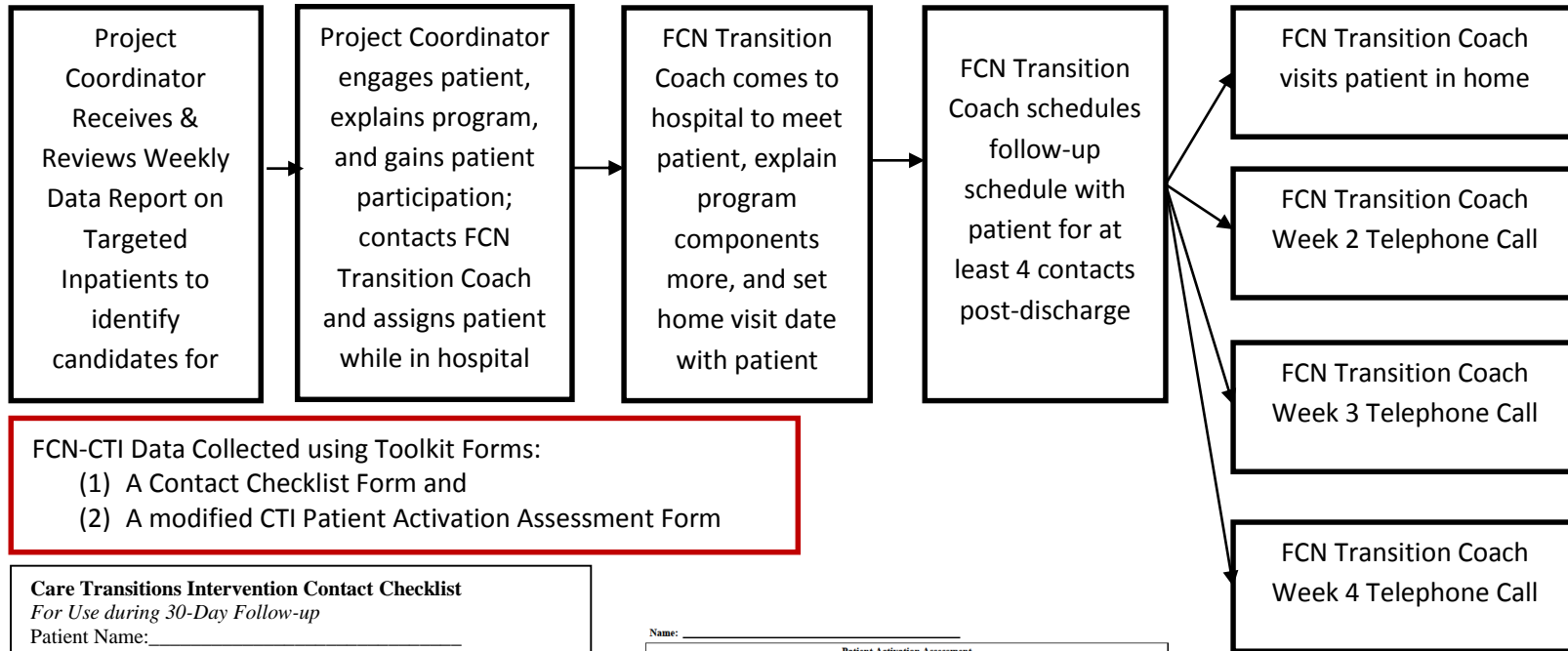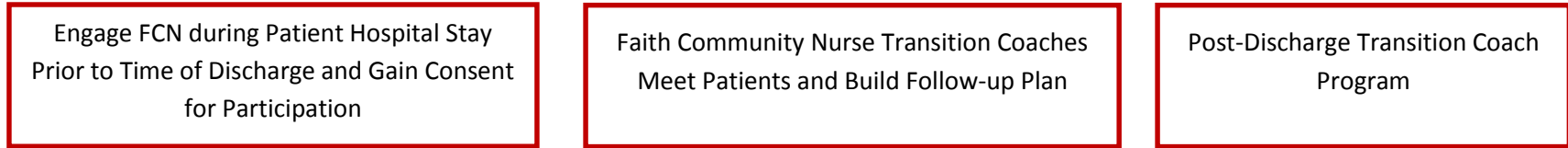Appendix N Operating Budget: Project Years 1 and 2

Appendix O Long Term Budget: Project Years 3 through 5

Appendix P Financial Analysis

Appendix Q Referral Documents

Appendix A

FCN Transition Coach Process

Engage FCN during Patient Hospital Stay Prior to Time of Discharge and Gain Consent for Participation	Faith Community Nurse Transition Coaches Meet Patients and Build Follow-up Plan	Post-Discharge Transition Coach Program

Project Coordinator Receives & Reviews Weekly Data Report on Targeted Inpatients to identify candidates for	Project Coordinator engages patient, explains program, and gains patient participation; contacts FCN Transition Coach and assigns patient while in hospital	FCN Transition Coach comes to hospital to meet patient, explain program components more, and set home visit date with patient	FCN Transition Coach schedules follow-up schedule with patient for at least 4 contacts post-discharge

FCN Transition Coach visits patient in home

FCN Transition Coach Week 2 Telephone Call

FCN Transition Coach Week 3 Telephone Call

FCN Transition Coach Week 4 Telephone Call

Non-FCN Employed SARMC Transition Coach will be on call for questions by FCNs

FCN-CTI Data Collected using Toolkit Forms:
(1) A Contact Checklist Form and
(2) A modified CTI Patient Activation Assessment Form

Care Transitions Intervention Contact Checklist
For Use during 30-Day Follow-up
Patient Name:_____
Best Contact Phone Number for Patient: _____
FCN Assigned: _____
Patient Discharge Date:_____
☐   Initial Patient Visit Date in Hospital (if applicable):
         o   OR
☐   Initial Introduction by Phone after Discharge:
☐   Patient Consent Gained for CTI follow-up (Date):
☐   Gave Patient FCN Transition Coach Contact Number:
☐   Week # 1 Home Visit by FCN Transition Coach (Date):
☐   Week #2 Telephone Call by FCN Transition Coach (Date):
☐   Week #3 Telephone Call by FCN Transition Coach (Date):
☐   Week #4 Telephone Call by FCN Transition Coach (Date):
         FCN, if you did not complete all checklist visits, please
         share reasons why: _____

Name: _____

	Patient Activation Assessment			
	Level of Performance (Please rate: 1 point each)			
Medication Management	**Red Flags**	**Medical Care Follow Up**	**Personal Health Record (PHR)**	**Comments**
__ Demonstrates effective use of Medication Management System (medication organizer, flow chart, etc.) __ For each medication, understands the purpose, when and how to take, and possible side effects __ Demonstrates ability to accurately update medication list __ Agrees to confirm medication list with PCP and/or Specialist	__ Demonstrates understanding of Red Flags, or warning signs that condition may be worsening __ Reacts appropriately to Red Flags per education given (or understands how to react appropriately)	__ Can schedule and follow through on appointment(s). __ Writes a list of questions for PCP and/or specialist and brings to appointment	__ Understands the purpose of PHR and the importance of updating PHR __ Agrees to bring PHR to every health encounter	
Sum: /4	Sum: /2	Sum: /2	Sum: /2	

Total Score: /10

Appendix B

Synthesis of Evidence Table

PICO Question: Is it feasible to use FCNs as hospital CTI Transition Coaches, and what are the facilitators and barriers to that work? *Longer version:* In a trained faith community nurse network providing post-hospital discharge care to patients (P), what is the effect of implementing a formal hospital care transitions pathway (I) vs. not having a formal pathway (C) on their ability to implement all aspects of the Coleman Care Transitions Interention(O)? In summary, is it feasible to use FCNs as hospital CTI Transition Coaches, and what are the facilitators and barriers to that work?						
Study	Author/Year	FCN/RN/Health Coach Post-Hospital CT/Intervention Protocol	FCN/RN/Health Coach Preparation/Training	Community-Hospital collaboration relationships	Target Patient Population	Influence on readmission/ compliance w/follow-up
1	Brock, J. *et al*, (2013)	Many protocols in review. Many communities used variety of care transitions models to reduce hospitalizations in Medicare beneficiaries	Variety of preparation across 14 intervention communities nationally	Yes: many healthcare partners: HH, hospice, nursing homes, social service agencies, Area Agencies on Aging, hospitals, state QIOs	Medicare beneficiaries; communities of cooperating healthcare providers focused on this group	Yes, reduced readmissions
2	Bay, M. (1997)	A single case example of FCN to provide partnership to hospital as home follow-up spiritual care and support as extension of inpatient oncology and when home health is not present. No particular method.	No training; 1:1 informal communication and learning between FCN and in patient nurse specialist	Yes, inpatient oncology nurse worked with FCN, who engaged and managed pastor and congregation engagement as appropriate	Ailing, elderly oncology post-discharge patient	Not discussed, but worked closely with inpatient team on symptom management until death

3	Baig, A. A., Mangione C. M., & Miranda, J. M. (2010)	Nurses followed their standard protocol for referring a person with HTN – no one referral method assigned.	No, nurses were not trained for this study; they used their individual method for referral for HTN follow-up, optional to include spiritual care.	Yes, safety net clinics with community outreach programs hired FCNs for already partnered churches to deliver services	Adults 18 yo+ (most 45+) with elevated blood pressure readings; most self-report poor health	FCNs associated with reduced SBP and improved medication management
4	Marston, D. (2012).	Yes, Eric Coleman's Care Transition Intervention (CTI) program	Yes, four FCN CTI coaches and a hospital health ministry nurse-liaison	Yes, engagement of Christian rehab care center, hospital health ministry outreach, local FCNs	Elders in eldercare rehab unit service	Yes, reduced readmissions
5	Rydholm, L. *et al* (2008)	Yes, protocol for *reporting* care data by DIARY format capturing patient barriers, facilitating self-care, functional concerns. No protocol for actual care provided in eldercare experiences	Yes, over half FCNs in study attended no obligation preparation session of DIARY charting workshop	Yes, FCN outreach from Area Agency on Aging, funded by a state DHHS and a local health insurance foundation	Older adults, mostly between 70 and 89	Not discussed, but showcased bridging urgent, functional and psychosocial support needs of patients outside of hospital
6	Parrish, M. M., O'Malley, K., Adams, R. I., Adams, S. R., Coleman, E. A. (2009)	Yes, Eric Coleman's Care Transition Intervention (CTI) program	Yes, Transition Coaches received training on CTI model, that could be a nurse, social worker, community worker	Yes, 10 hospital-community-based partnerships; hospital, county, community case management organizations, area	Varied across sites: homeless, 55-60-65yo and older, complex/ chronic	Not discussed; focused on identifying factors promoting system sustainability of intervention

				agencies on aging, SNF	conditions, Medicaid	
7	Parry, C., Kramer, H. M., & Coleman, E. A. (2006)	Yes, Eric Coleman's Care Transition Intervention (CTI) program	Yes, nurses received CTI model training to be Transition Coaches	Not discussed; qualitative follow-up to earlier randomized control trial of CTI	60 yo+ and chronic disease diagnosis	Yes, patients qualitatively described increased capacity for self-mgmt; emphasized caring coaching relationship enhanced intervention
8	Parry, C., Min, S., Chugh, A., Chalmers, S., & Coleman, E. A. (2009)	Yes, Eric Coleman's Care Transition Intervention (CTI) program	Yes, nurses received CTI model training to be Transition Coaches	Not significantly, senior care clinic, community-based hospitals; HH, SNFs as needed	Medicare/65 yo+ with at least one complex/chronic condition	Yes, patients who received CTI were less likely to be readmitted across 30-90-180 days post-discharge
9	Coleman, E. A. *et al,* (2004)	Yes, Eric Coleman's Care Transition Intervention (CTI) program	Yes, a geriatric nurse practitioner with master training cert in chronic disease self-mgmt served as Transition Coach	Not significantly, senior care clinic, community-based hospitals; HH, SNFs as needed	Medicare/65 yo+ with at least one complex/chronic condition	Yes, patients who received CTI were less likely to be readmitted across 30-60-90 days post-discharge
10	Coleman, E. A., Parry, C., Chalmers, S., & Min, S. (2006)	Yes, Eric Coleman's Care Transition Intervention (CTI) program	Yes, patients were followed by a CTI-trained Transition Coach	Not significantly, focused on patients from large non-profit hospital and delivery system	Medicare/65 yo+ with at least one complex/chronic condition	Yes, patients who received CTI were less likely to be readmitted across 30-90-180 days post-discharge

Appendix C – IRB Exemption Letter

Saint Alphonsus
RESEARCH INSTITUTE

April 2, 2015

Jennifer Palagi
SARMC
1055 N Curtis Road
Boise Idaho 83706

Re: **Faith community nurse care transitions intervention feasibility project**

Dear Jennifer:

This letter is to acknowledge that the Institutional Review Board (IRB) at Saint Alphonsus Regional Medical Center has reviewed the minimal risk protocol noted above and has determined that it meets the criteria for exemption. Criteria have been met and consent waived per 45 CFR 46 116(d). No further oversight by the IRB is necessary.

When the study is complete, a permanent closure form should be submitted. This form is available at http://www.saintalphonsus.org/forms-and-resources.

As a reminder, no changes may be made to the above protocol or consent without first submitting the changes to the IRB for approval, and any internal adverse events or unanticipated problems must also be promptly reported.

Should you have any questions, please feel free to contact SARMC Research Integrity at (208) 367-8897.

Respectfully,

John Mayberry, MD
Chairperson, SARMC Institutional Review Board

cc: IRB #15-10

**Saint Alphonsus
Regional Medical Center**

March 4, 2016

Jennifer Palagi, MPH, BSN, RN
Director, Mission Integration

Dear Jennifer,

The Saint Alphonsus IRB has no restrictions on the use of the name "Saint Alphonsus" in written submissions provided the work submitted reflects the project as it was approved (or determined to be exempt) by the IRB.

If necessary, please refer to marketing brand standards to ensure that the insignia, colors, and font are consistent with approved standards.

Should your work be approved for publication, please inform the IRB as the Board appreciates reading published works from Saint Alphonsus investigators.

Congratulations on your accomplishment!

Nichole Whitener, MSN, CNRN, NE-BC
Research Administrator
Saint Alphonsus Health System

Appendix D - Logic Model

Inputs	Activities	Outputs	Objectives	Outcomes		Impact
What we invest	**Action**	**What we do**	**Measurable**	**Short-term**	**Long-term**	
Hospital workgroup team meeting time	Recruit SARMC workgroup team members and set up meeting schedule	SARMC workgroup formed and meeting to determine model and plan	Create a SARMC workgroup, adopt CTI model and implementation plan by 7/14	Workgroup formed, CTI model adopted, implementation plan by 7/14	Complete pilot of FCN-driven CTI model by 12/15	SA stakeholders engaged; FCN integrated into hospital team CT work
Time for outreach visits, meetings, calls	Make recruitment visits with targeted FCNs.	Gain commitments of FCNs through dialogue	Recruit 3 FCNs from different churches by 6/14	100% of target FCNs commit	100% of committed FCNs complete pilot	Churches and FCNs support partnering work with hospital
SARMC Foundation grant $ for training	Train FCNs on CTI model and Coach protocols	Train the recruited FCNs on CTI model	Provide FCNs certified CTI training by 7/14	100% of FCNs ready for go-live 5/15	100% of target FCNs complete pilot project	Appropriate EBP coaching protocols used
Time of Employed Coach for mentoring FCNs	Provide FCNs 1:1 training to prepare for pilot	FCNs observe CTI protocol for follow-up with select discharged patients	FCNs shadow employed Coach 2/15-4/15	Prepare to use CTI 30-day protocol in pilot from 5/15-12/15	100% of FCNs complete shadowing experiences	FCNs competent and can shadow other new FCNs
Research and edit time for protocol tracking input elements	Create new CTI protocol Contact Checklist form for use by FCNs	FCNs use form as checklist for documenting completing visits	Pilot toolkit complete by 4/15; 2 tools are key pieces of FCN Transition Coach toolkit	FCNs perform 90% of appointments on Checklist	FCNs return 100% of Contact Checklist Forms	Reliable CTI tool packet created and improved over time for continued use in program
	Prepare CTI PAA Form with modifications	FCNs use PAA form for every patient contact		FCNs complete 90% of CTI PAAs for visits	FCNs report facilitators & barriers w/ form	
Research and edit time for FCN satisfaction survey	Create satisfaction survey for FCNs	Administer survey to FCNs at conclusion of pilot	FCNs complete post-pilot satis. survey	100% FCNs complete satisfaction survey	100% of FCNs report satisfaction with Coach role.	More FCNs want to be involved based on this pilot

Appendix E

Evaluation Plan for FCN CTI Feasibility Project

Category of Metrics	Objective	Data to be gathered	Specific measure (describe instrument)	Data collection procedure (how will you collect)	Data Analysis used (statistical test and rationale for using)	Outcome
Outcome	Create a pilot FCN-integrated Care Transitions Intervention program for SARMC	Documentation of pilot program produced.	Described model of procedures for implementing program	Document protocols and resources	Feasibility study: Data analysis is yes/no was it able to be implemented?	FCN-integrated Care Transitions Program feasible
Outcome *And* Process	Determine FCN effectiveness in CTI Transition Role (by evaluating Contact Checklist Forms and PAA Forms) *Was CTI protocol followed?* *If there was a break in protocol, why?*	Measure completion of each step of 30-day prescribed protocol via Contact Checklist form *Nominal data* Patient Activation evaluated regularly by FCN using PAA form *Ratio/Interval*	Protocol Contact Checklist form for tracking Touchpoints with patient CTI Patient Activation Assessment (PAA) tool that documents patient progress along 4 pillars	FCN complete and send Contact Checklist documentation to project lead PAA Form completed for each encounter and return to project lead	Descriptive data: % protocol completed on Contact Checklist Form Descriptive data: % of Encounters PAA tool completed	FCN completes CTI protocol fully on each patient recruited and documents on Contact Checklist and reports any issues with process FCN activates patients along 4 pillars of CTI protocol and documents on PAA tool

Process	Understand hospital facilitators and barriers to FCN delivery of CTI care. *Ex. Did you have the resources you needed for this patient encounter?*	Facilitators and barriers to FCN for supporting patient care in this role. *Ordinal data; also including free-text comments*	Survey question on patient assessment form for each encounter	On PAA Form for each patient encounter, FCN will respond to survey question	Descriptive data: Report degree hospital resources facilitated role; share free-text comments as relevant.	FCN reports hospital facilitators and barriers on PAA form during any given follow-up event with patient
Outcome	Evaluate FCN satisfaction in CTI Transitions Coach Role	FCN Satisfaction *Ordinal data*	FCN Satisfaction Survey after project	Have FCNs complete quantitative survey with few open-ended questions	Not statistically strong with 3 FCNs, but important for story-telling	FCN describes satisfaction and alignment of Coach Role in relation to Scope of Practice

Appendix F

Contact Checklist Tool

Care Transitions Intervention Contact Checklist & Documentation Sheet

For Use Throughout 30-Day Follow-up   Procedure: _____ Age: _____

Patient Name:_____ Med Record # _____ Rm:___

Surgeon: _____ PCP: _____ FCN Assigned: _____

Best Contact Number for Patient: _____Patient (desire) text option? Y/N

Alternate Contact Person and Number: _____

Patient Home Address:_____

Patient Admit Date: _____ Discharge Date:_____

30 Day Period: ___/___/___ (D/C Date) through ___/___/____

☐ Patient Consent Gained for CTI follow-up (Jen or Cari): _____

☐ Initial Patient Visit in Hospital (Date) (if applicable): _____
    o **OR**
☐ Initial Introduction by Phone after Discharge (Date): _____

☐ Gave Patient FCN Transition Coach Contact Number (Y/N): _____

☐ Home Visit by FCN Transition Coach (Date): _____

☐ Telephone Call #1 by FCN Transition Coach (Date): _____

☐ Telephone Call #2 by FCN Transition Coach (Date): _____

☐ Telephone Call #3 by FCN Transition Coach (Date): _____

FCN, if you did not complete all checklist visits, please share reasons why:

_____

_____

RETURN to Project Coordinator at Fax 208-367-3898, email jennpala@sarmc.org,

For Office Use Only: % of Care Transitions Protocol Contacts completed by FCN_____

Documentation of CTI Visits

Patient Personal Goal: _____
_____
_____

Hospital Visit   Date: ____/____/____
Miles Commute: _____
Notes:_____
_____
_____

Home Visit   Date: ____/____/____
Miles Commute: _____
Notes:_____
_____
_____
_____

Phone Call #1   Date: ____/____/____
Notes:_____
_____
_____
_____

Phone Call #2   Date: ____/____/____
Notes:_____
_____
_____

Phone Call #3   Date: ____/____/____
Notes:_____
_____
_____
_____

Any additional calls from/to patient (record dates)
Notes:_____
_____
_____

Any additional miles commuted: _____
To be completed and faxed for each patient visit May 2015-January 2016
Faith Community Nurse Care Transitions Intervention Feasibility Project, Saint Alphonsus RMC

Appendix G

CTI Patient Activation Assessment and Guidelines

Date of Patient Coaching: _____

Circle Coaching Session: Hospital, Home Visit, Phone Call 1, Phone Call 2, Phone Call 3

Name: _____

Patient Activation Assessment				
Level of Performance (Please rate: 1 point each)				
Medication Management	Red Flags	Medical Care Follow Up	Personal Health Record (PHR)	Comments
__ Demonstrates effective use of Medication Management System (medication organizer, flow chart, etc.) __ For each medication, understands the purpose, when and how to take, and possible side effects __ Demonstrates ability to accurately update medication list __ Agrees to confirm medication list with PCP and/or Specialist	__ Demonstrates understanding of Red Flags, or warning signs that condition may be worsening __ Reacts appropriately to Red Flags per education given (or understands how to react appropriately)	__ Can schedule and follow through on appointment(s). __ Writes a list of questions for PCP and/or specialist and brings to appointment	__ Understands the purpose of PHR and the importance of updating PHR __ Agrees to bring PHR to every health encounter	
Sum: /4	Sum: /2	Sum: /2	Sum: /2	
Total Score: /10				

Additional Questions for FCN:

Did you have the resources you needed for this patient encounter? Y/N
Explain:_____

How did the hospital and/or hospital team members help facilitate an effective and efficient Transition Coach visit this time?

_____

How did the hospital and/or hospital team members create barriers to an effective and efficient Transition Coach visit this time?

_____

Patient Activation Assessment Guidelines

<u>Purpose:</u>
The Patient Activation Assessment® or PAA®, provides Transitions Coaches ® with a method of tracking patients' progress in skill transfer and activation along the Four Pillars® during their participation in the Care Transitions Intervention®. This tool provides Transitions Coach's will real-time feedback on which of the Four Pillars may need to be emphasized or reinforced during the course of the home visit and the follow up phone calls. The PAA provides supervisors of Transitions Coaches with quantitative data on the value they bring to patient encounters.

<u>Process:</u>
The first administration of the PAA serves as a baseline measure of the patient's activation before having received any coaching. This could either be in the hospital, the skilled nursing facility, or at the beginning of the first home visit. Then at each the subsequent encounter (home visit, three phone calls) progress across the Four Pillars is ascertained. The final PAA forms the basis for an overall determination of activation. If the patient and family caregiver are functioning in tandem, consider the PAA as measuring their activation as a "unit."

<u>Timing:</u>
Separate evaluations are to be completed by the coach:
- After the home visit
- After each telephone contact
- At the end of the 30-day relationship
- The evaluations are tracked on the Patient Activation Assessment form

Medication Management	Baseline	Final
• Demonstrates effective and reliable method of medication management (this could be of their own design or one suggested by the Transitions Coach such as a weekly medication organizer)	If prior to coaching the patient and family caregiver already have a method in place that works for them, score a 1. If no method exists, or the approach in place is not working for them, score a 0.	If during or after completing coaching the patient and family caregiver have a system in place that works for them, score a 1. If no system exists, or the method in place is not working for them, score a 0.
• For each medication, the patient understands the purpose, when and how to take, and possible side effects	If prior to doing any coaching, the patient and family caregiver already demonstrate a working knowledge of every or nearly every medication, score a 1. If not, score a 0.	If during or after completing coaching, the patient and family caregiver demonstrate a working knowledge of every or nearly every medication, score a 1. If not, score a 0.
• Demonstrates ability to accurately update medication list	If prior to coaching the patient and family caregiver already update a medication list, score a 1. If not, score a 0.	If during or after completing coaching, the patient and family caregiver already update a medication list, score a 1. If not, score a 0.

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Appendix H

Faith Community Nurse Satisfaction Survey: Role of Transition Coach

Please answer the following questions from the perspective of a faith community nurse and based on your project experiences:

1. Describe how *you* perceived Transition Coach role.

2. Does the Transition Coach role fall within the Scope and Standards of Practice for faith community nursing? Explain.

3. Would you recommend this role for other faith community nurses? Explain.

4. Tell me a story that you will never forget from your experiences in this project.

5. Explain the impact of having a stipend/remuneration for your work in this project.

6. What is one change the hospital could implement to improve the experience of Transition Coaching as a faith community nurse?

Appendix I

FCN CTI Assignments

Transition Coach	Completed Cases	% Case Load	Incomplete Cases	Readmissions*
FCN 1	10	55.5%	2	2
FCN 2	1	5.5%	2	0
FCN 3	7	39%	2	0
Total	18	100%	6	2

*Readmissions

Readmissions were not a formal evaluation component of this project; still readmissions are a figure of interest in this field of work. There were only two readmissions out of 18 completed CTI cases.

Appendix J

Findings: Facilitators and Barriers

Hospital Facilitators for Transition Coaching

Having a coordinator in the hospital who identifies and recruits patients, readies FCN hospital visit materials, contacts available FCNs, connects the FCN with both the patient and unit staff, and communicates / faxes information regarding patient to physicians' offices
Initial contact with patient by hospital project coordinator is very beneficial
Binder for Transition Coaches with all materials and contacts needed
Mobile, lockable file box for keeping personal health information private
Smartphone App for ease of faxing project forms/patient information to hospital
One-page CTI Program information sheet for patients, physicians, and hospital staff, that includes photos of each of the Transition Coaches for ease of recognition and relationship building.
Nurse staff on hospital unit helped escort FCN to patient
Nurse staff on hospital unit helped pinpoint FCN hospital visit time around physical therapy schedule
Unit team was very supportive of care transitions with client(s).
Discharge folder was complete with instructions and a home medication log initiated
Discharge papers complete and clearly written
Unit Joint Program Coordinator and Case Manager alerted project coordinator for some patient candidates
Physician office initiated engaging project coordinator for some patient candidates
Physician's office and hospital unit staff were easy and open for telephone calls from Transition Coaches about patients
Project coordinator sent thank you notes and patient survey to patients after cases closed
Hospital visits were coordinated over lunch so patient would be in room and available
Checklist form was adapted a couple of times to include additional helpful items such as procedure, age, secondary contact info; Also prefilled by coordinator to include known address and phone number
Preferred communities/zip codes/radius for each FCN
Meeting with orthopedic physicians to discuss program was helpful
Added home visit d/t patient living along and blind

Hospital Barriers for Transition Coaching

Personal health record designed and provided by hospital is very Coach and patient unfriendly. It should be replaced with a better tool. Very difficult to get patients to adopt use.
Discharge exercises and protocols were confusing, unclear, or contradictory for total hip client
Discharge papers had conflicting instructions for treating opioid-related constipation.
Discharge pain control options were not clear to patient; confusion about paint control prescriptions
Staff need to explain to patient better the expected degree and trajectory of pain after block wears

off; patient felt he took more pain medication than needed because worried about surprise pain.
Patients may need more information on what all is considered an infection after surgery
Physical therapist was rushed and discouraged patient from asking questions
Needed gloves during community visit to assist patient
Patient wasn't sure when next appointment was with surgeon
Patient would have desired advice on meal plans after discharge
Missing burn salve and spacer for inhaler
Patient sometimes created barrier – sedated at home visit
No parking near hospital
Afternoon unit class for patients prevent visiting in afternoon; can cause wait time for FCN
No single ideal place for file location when coordinator leaves patient room after recruitment. Has been in a few locations (her office, patient window, patient shelf, patient couch)
Prohibitive for remote/rural locations (took no patients past Kuna/Nampa)
Unclear for offices and unit staff on who to call to inquire about program or specific patients
Patient had questions about walker use and abduction exercises because felt rushed by PT
Not informed patient would have home health nursing and did not find out until home visit; removed case due to project criteria.
Some cases had home health or rehab discharge dispositions added after FCN hospital visit; this had no automated communication with FCN team and created confusion and dropped cases

Appendix K

Faith Community Nurse Satisfaction Survey Results

1. Describe how *you* perceived Transition Coach role.

FCN 1:
   Upon discharge the Transition Coach provides the next level of care for those patients identified by hospital staff as being at risk for readmission. The Coach evaluates the following: post op status (i.e. surgical wound status and pain control), ease of ambulation in their home, environmental needs and safety (availability of needed medical assistance devices, environmental risks like throw rugs), and meal availability. Medications are reviewed and confirmation of a system for tracking medications is in place. Follow up appointments with both the surgeon and primary care provider are verified. The Transition Coach confirms the patient/caregiver understands the red flags and what to do if one occurs.

FCN 2:
   Provide guidance and coaching to person being discharged from in-patient to home care.
   Facilitate personal goal setting and provide opportunity for accountability.
   Empower the person to advocate for self.
   Promote emotional and health education support.
   Be a caring presence and support.
   Assist in person's problem solving issues and goals.
   Be a resource for care needs, supplies and services
   Function as a caring guide and companion on the person's healing journey

FCN 3:
   Initially, I expected to be able to implement the Transition Coach role almost exactly as we had learned it. In practice, though, I began to see that it would look very different in the way I was performing the role. Keeping in mind that the primary goal was greater self-reliance and confidence in the taking charge of their own health and recovery, I could also see a need to show compassion and care for them as individuals. Being a transition coach means getting involved. You learn their health goals, what they want to get back to, you get to know their family, and you become a part of their healthcare team, if only for a little while.

2. Does the Transition Coach role fall within the Scope and Standards of Practice for faith community nursing? Explain.

FCN 1:
Yes,
Standard 1: Assessment - The FCN collects comprehensive data pertinent to the patient's wholistic health or the situation.

Surgical wound status / signs of infection
S/S of thrombosis / pain control
Assessment pertaining to additional diagnoses of the patient

Standard 2: Diagnosis - The FCN analyzes the wholistic assessment data to determine the diagnoses or issues.

Standard 3:0utcome Identification- The FCN identifies expected outcomes for a plan individualized to the patient or the situation.

Standard 4: Planning- The FCN develops a plan that prescribes strategies and alternatives to attain expected outcomes for individuals, groups, or the faith community as a whole.

Standard 5: Implementation - The FCN implements the specified plan.
5a: Coordination of Care- The FCN coordinates care delivery. 5b: Health Teaching and Health Promotion - The FCN employs strategies to promote wholistic health, wellness, and a safe environment.
5c: Consultation- The FCN provides consultation to facilitate understanding and influence the specified plan of care, enhance the abilities of others and affect change.

Standard 6: Evaluation - The FCN evaluates progress toward attainment of outcomes.

FCN 2:

STD one Assessment: Collects comprehensive wholistic data in regards to diagnosis, personal goals, preferences and resources found in chart notes and client introduction and intake interview. Protects person's ethical, legal, and privacy guidelines. Documents confidential pertinent data, which is securely kept and transferred.

STD two Diagnosis: Reviews possible issues with the client and family and collaborates with other health care providers.

STD three Outcome Identification: Collaborates with person to develop personal goals with measureable goals to reach desired outcomes

STD four and five: Planning and Implementation: Develops a plan in collaboration with the person goals, health status and needed services, resources, family support and dynamics. Monitors health status, progression to goals and adjust plan as necessary.

STD six: Evaluation: On going evaluation of goals in collaboration with the patient. Provide on-going health teaching and reinforcement.

FCN 3:

Yes. According to pp.17-18 of the S&S of Practice for FCN's this is seen as a developing role in some areas. Special care must be taken to screen potential clients to determine their eligibility for this program. In a few cases, it seemed that the care needed or

expected exceeded the intended scope of the role. For example, I ended up doing a dressing change for a blind client, who didn't qualify for home health. Of course I didn't mind this, but I questioned how this patient didn't qualify for some home care given her limitations and lack caregiver.

Also, if felt limited in my spiritual health role by the way the clients were chosen. I believe in care for all and want to provide it for anyone that needs it. However, I want to be free to tell them that I am a faith community nurse, and answer any questions they may have about it or let them know I am there for spiritual needs as well, if desired.

3. Would you recommend this role for other faith community nurses? Explain.

FCN1: I would recommend this role for FCNs. FCNs working in a faith community already follow their parishioners on an as needed basis. This specific role is a definitive way to prevent readmission and to prevent potentially prolonged recovery time for those parishioners.

FCN 2: Faith Community nurses are care givers, health educators and spiritually focused by definition. Most want to support, encourage self-actualization, advocacy and independence as is realistic for the situation.

FCN 3: Yes, I would recommend to other FCN's who have an interest in this type of role. It is quite different than other FCN roles, and should be explained carefully, and even have potential transition coaches shadow CTC's first to see what they would be committing to before a lot of time and effort is put into training them.

4. Tell me a story that you will never forget from your experiences in this project.

All three nurses shared meaningful stories that were not included in this report.

5. Explain the impact of having a stipend/remuneration for your work in this project.
FCN 1: It is wonderful to have costs covered: mileage on the car and the gas to drive it. Receiving compensation offers a sense of value to the work.

FCN 2: At this point having a stipend/remuneration for this work is beneficial and does make it easier when considering time and travel, but not make or break. My limiting issue is one of scheduling and competing priorities. As my other priorities are accomplished I would like to increase my participation.

FCN 3: I found the stipend to be very important in the CTC role. As FCN's, we are being asked to take on a more specific role, centered on individual patients. Success from our care impacts the bottom line for the hospitals and physicians in that we are there to ensure discharge orders and read, understood, and implemented as much as possible. Successful

transition means fewer readmissions or post-surgical complications, and that impacts the bottom line.

6. What is one change the hospital could implement to improve the experience of Transition Coaching as a faith community nurse?

FCN1: I would like two smalls tools: a personal health record booklet that is easy to use and has an appealing appearance in order to encourage its use. (The one currently available is not user friendly, and is not appealing to look at. None of my patients wanted a copy). I need pill organizers to give those who have no organizational method in place for their medication.

FCN 2: I'm not sure how the hospital could give increased lead-time in identifying possible applicants for the Faith Community Nurse Transition Coach program. If it would be possible it would be appreciated.

FCN 3: The discharge teaching instructions are confusing at best, and contradictory, or even incorrect, at their worst. I personally have an interest in improving these, so that the instructions are clear, consistent, and optimal for recovery and prevention of complications.

Appendix L

FCN-CTI Expense Per Case

Transition Coach	Completed Cases	Incomplete Cases*	Miles Traveled
FCN 1	10	2 (9 visits)	364
FCN 2	1	2 (3 visits)	38
FCN 3	7	2 (2 visits)	280
Total	18	6 (14 visits)	682
Expense Paid	$1800.00	$280	$391.48
Total Expense	**$2471.48**		
Expense per Case	**< $120 per case, including prorated cases**		

Mileage Rate* = $0.575 in Year 2015, $0.54 in Year 2016

Transition Coach Reimbursement per case:

Complete Cases =$100/case reimbursement.

Incomplete cases prorated at $20 per visit for up to 5 visits max per protocol.

Appendix M

Evaluation Plan Results Summary

Category of Metrics	Objective	Data to be gathered	Specific measure (describe instrument)	Data collection procedure (how will you collect)	Data Analysis used (statistical test and rationale for using)	Results
Outcome	Create a pilot FCN-integrated Care Transitions Intervention program for SARMC	Documentation of pilot program produced.	Described model of procedures for implementing program	Document protocols and resources	Feasibility study: Data analysis is yes/no was it able to be implemented?	FCN-integrated Care Transitions Program feasible
Outcome *And* Process	Determine FCN effectiveness in CTI Transition Role (by evaluating Contact Checklist Forms and PAA Forms) *Was CTI protocol followed?* *If there was a break in protocol, why?*	Measure completion of each step of 30-day prescribed protocol via Contact Checklist form *Nominal data* Patient Activation evaluated regularly by FCN using PAA form *Ratio/Interval*	Protocol Contact Checklist form for tracking Touchpoints with patient CTI Patient Activation Assessment (PAA) tool that documents patient progress along 4 pillars	FCN complete and send Contact Checklist documentation to project lead PAA Form completed for each encounter and return to project lead	Descriptive data: % protocol completed on Contact Checklist Form Descriptive data: % of Encounters PAA tool completed	100% protocols completed 100% of Encounters in which PAA completed

Process	Determine FCN support from hospital with each patient encounter *Ex. Did you have the resources you needed for this patient encounter?*	Facilitators and barriers to FCN for supporting patient care in this role. *Ordinal data; also including free-text comments*	Survey question on patient assessment form for each encounter	On PAA Form for each patient encounter, FCN will respond to survey question	Descriptive data: Report degree hospital resources facilitated role; share free-text comments as relevant.	99% of time FCN had resources needed for each encounter Appendix J shares results of FCN reported hospital facilitators and barriers
Outcome	Evaluated FCN satisfaction in CTI Transitions Coach Role	FCN Satisfaction *Ordinal data*	FCN Satisfaction Survey after project	Have FCNs complete quantitative survey with few open-ended questions	Not statistically strong with 3 FCNs, but important for story-telling	FCNs describe satisfaction and alignment of Coach Role in relation to Scope of Practice; stories shared.

Appendix N

Operating Budget: Project Years 1 and 2

Calendar Years	2014-2015	
Prep and Training 2014, Productive Study in 2015	**Budget**	**Actual**
Statistics		
# Productive Months during Period of Study	8	6
# of Patients seen by FCN (30-50 estimate) in whole study	40	18
Revenue		
SARMC Foundation Endowment Grant*	$15,000	$15,000
Care Transitions Intervention(CTI) Training Scholarship for 1 FCN ($3,000)	In-Kind	In-Kind
Staffing		
# of Volunteer FCNs in Study	3	3
# of Volunteer FCN hours spent per 30-day Coaching epidsode	15	10
# of Volunteer FCN hours spent total per month	75	30
Personnel Expenses		
Total Fixed Staff: Project lead (300 hrs)* *$12,900*	In-Kind	In-Kind

	In-Kind	In-Kind
Evaluation & Data Analysis Staff (100 hrs)** *$4,300*		
Stipend for FCNs per each 30-day Coaching episode (5 Encounters)	$100	$100
Total Stipend Costs per Study	$4,000	$2,080
Personnel Expense Savings (Volunteer - Saved Wages)	$15,500	$3,770
Total Personnel Expenses	$4,000	$2,080
Nonpersonnel Expenses		
Total Nonpersonnel Expenses	$9,638	$8,492
Total Personnel and Nonpersonnel Expenses	$13,638	$10,572
Indirect Costs (10% of total) including Malpractice	$1,364	$1,057
Total Expenses	$15,001	$11,629
Operating Income *(Net Grant Funds Remaining to be used for dissemination)*	--	$3,371

*Endowment grant was actually $30K, but earmarked for three FCN projects, including this
one. Remaining funds were used toward dissemination activities.
**In-kind

Appendix O

Long Term Budget: Project Years 3-5

Calendar Years	2016	2017	2018
Statistics			
# Productive Months	6	12	12
# of Patients seen per month of Study per Nurse	1	2	2
Revenue			
SARMC Foundation Endowment Grant*	$50,000		
Staffing			
# of Volunteer FCNs in Study	15	35	35
Total # of Volunteer FCN hours spent total per month	150	700	700
Personnel Expenses			
Total Fixed Staff: Project lead (100 hrs/yr) *$4,300/yr*	In-Kind	In-Kind	In-Kind
Evaluation & Data Analysis Staff (100 hrs/yr) *$4,300/yr*	In-Kind	In-Kind	In-Kind
Stipend for FCNs per each 30-day Coaching episode (5 Encounters)	$100	$100	$100
Total Stipend Costs per Study per year	$9,000	$84,000	$84,000

Total Hourly Wages per yr if had been paid RN Hourly Wage & Benefits	$29,250	$273,000	$273,000
Personnel Expense Savings (Saved Wages=RN Wages-FCN Stipend)	$20,250	$189,000	$189,000
Total Personnel Expenses	$9,000	$84,000	$84,000
Nonpersonnel Expenses			
Total Nonpersonnel Expenses	$51,500	$3,500	$3,500
Total Personnel and Nonpersonnel Expenses	$60,500	$87,500	$87,500
Indirect Costs (10% of total)	$6.050	$8,750	$8,750
Total Expenses Annually	$66,550	$96,250	$96,250

* Grant for sustainability will require grant application
**In-kind

Appendix P

Financial Analysis for Sustainability

Cost-Benefit Analysis	Project 2014-15	Year 3 2016	Year 4 2017	Year 5 2018
Personnel Expense Savings (Volunteer - Saved Wages)	$3,770	$20,250	$189,000	$189,000
Total Personnel Expenses	$2,080	$9,000	$84,000	$84,000
Total Nonpersonnel Expenses	$8,492	$51,500	$3,500	$3,500
Indirect Costs (10% of total) including Malpractice	$1,057	$6,050	$8,750	$8,750
Total Expenses	$11,629	$66,550	$96,250	$96,250
Net Savings Over Expenses	($7,859)	($46,300)	$92,750	$92,750
Cost/Benefit Ratio	3.08	3.29	0.51	0.51
Grant Revenue in Project and Year 3 phases	$15,000	$50,000	--	--

Net Expenses After Grant	**($3,371)**	**$16,550**	**$96,250**	**$96,250**
Cost/Benefit Ratio Considering Grant Revenue	**(0.89)**	**0.82**	**0.51**	**0.51**

Appendix Q

Referral Documents

TRANSITION SUPPORT PROGRAM

Your family member or friend is participating in a special program to help people after they are discharged from the health care facility. Following hospital discharge, patients often require care from different medical professionals in many different settings. This program is designed to improve the continuity of care for persons across different health settings and ensure that each transfer between settings goes smoothly.

This is a FREE service to help your loved one:
- Recover and thrive after discharge from the hospital
- Understand and manage their medications better
- Help prevent them from being readmitted to the hospital
- Make a plan for their follow-up appointment with their primary care physician

Your family member/friend will receive the following services during the 4-week program.
- A personal health record designed for them/you to manage their health condition
- A home visit and three follow up calls from a Transition Support Coach will provide support during the transition from the health care facility to home.

Transition Support Coaches:

{Place headshot photos and names of FCNs here}

The Transition Support program is different from other services such as home health or physical therapy as the Coach does not provide skilled services. The Coach works with the patient and family to help them be better prepared to take care of their health conditions and help them get their needs met during care transitions. This program focuses on the patient and family unit. The Coach will visit and call at times that are convenient for the patient and family. Together they review the patient's medications, prepare for the next doctor's visit, and help them understand their health condition better.

If you have any questions, please call me at: {Insert coordinator contact information}

Saint Alphonsus

FAX

Date: _____

Number of pages including cover sheet: ____

To:
_____
_____

Phone: _____

Fax:_____

CC: _____

From:

FCN Name/Credentials, Transition Support Coach, SARMC

_____

_____

Phone: _____

Fax: _____

DO NOT PUT PHI ON THIS FAX COVER SHEET

REMARKS: ☐ Urgent   ☒ For Your Review ☐ Reply ASAP   ☐ Please Comment

TYPE OF MATERIAL FAXED   ☒ Medical Records ☐ Billing ☐ Utilization Review ☐ Other _____

Comments:
Dear Health Care Provider,
I am a Care Transitions Coach for Saint Alphonsus Boise, and I am following one of your patients via the Care Transitions Support Program at Saint Alphonsus. I will be in contact with this patient over the next 30 days to help ensure they thrive after discharge and connect with any follow-up appointments needed. Please feel free to contact me with any issues or coordination requests. Please see the attached documentation for patient specifics. You may also contact the program lead, Jennifer Palagi, MPH, RN, Director, Mission Integration SARMC (208) 367-7949.

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