Advocacy, Care Coordination, and Transitional Care

Introduction

4 Hours

■ Description

Health advocacy, care coordination, and transitional care are key concepts in nursing. This module combines all three concepts. Through advocating, the nurse strives to protect the health, safety, and rights of patients (ANA, 2015). Health advocacy is an important component of care coordination. *Faith Community Nursing: Scope and Standards of Practice* (ANA/HMA, 2017) defines care coordination as the deliberate planned organization of activities to manage patient care, including advocacy, interprofessional collaboration, referral, and case management. Transitional care is time-sensitive nursing intervention that includes advocacy and care coordination to ensure continuity, avoid preventable complications, and promote a safe transfer from one physical setting to another or from one level of care to another (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). All three concepts require the faith community nurse (FCN) to have similar skills, including leadership, communication, collaboration, knowledge of resources, ability to work as an interprofessional team member, implementation, and delegation.

■ Research

The nurse advocates on behalf of the patient (ANA, 2015; ANA/HMA, 2017). Advocacy means to defend and protect the rights of people at a disadvantage, as well as to help them build self-efficacy skills (Farrer, Marinetti, Cavaco, and Costongs, 2015). The outcome of successful advocacy is self-efficacy, which is the extent one feels empowered to complete tasks and reach goals. Empowering is an essential attribute of faith community nursing (Ziebarth, 2015).

The FCN coordinates implementation of the plan of care. Lamb and Newhouse (2018) report that competencies for ambulatory care settings include: advocacy, education and engagement of patients and families, coaching and counseling of patients and families, patient-centered care planning, support for self-management, nursing process, teamwork and collaboration, cross-setting communication and care transitions, and population management. Using nurse-led care coordination among chronically ill Medicare patients revealed total costs were 15.7 percent lower (Atherly & Thorpe, 2011).

Nurses provide time-sensitive interventions post-discharge that include care coordination, education, caregiver support, medication reconciliation, advocacy, and promotion of self-management. Being present post-discharge ensures that discharge education is revisited, and needs are met, which reduces the rates of subsequent hospital readmissions (Scotten, Manos, Malicoat, & Paolo, 2015; Carthon, Lasater, Sloane, & Kutney-Lee, 2015). The FCN provides emotional and spiritual support in addition to transitional care interventions (Ziebarth, 2015). The FCN may ask questions such as: What sustains you during difficult times? Do your religious or spiritual beliefs influence the way you look at your disease and the way you think about your health? FCNs may complete a range of assessments and provide interventions that consider wholistic health needs.

Faith Tradition

A central theme in the Bible is our responsibility to care for God's people. Many faith communities are structured to encourage people to answer God's call to love our neighbors, stand with the marginalized, and work with God for a more just society.

Many faith communities recognize the needs of the people and communities they serve and have policy statements that support health ministries and FCN practice. The United Church of Christ speaks of advocacy and empowerment in its statements about health care justice (http://www.ucc.org/justice) that describe the church's mission as advocacy for full and just access to health and human services for all. An essential part of the church's commitment to health and human service ministry is advocacy on behalf of those who are oppressed or disadvantaged. Each denomination or faith tradition may have specific priorities for advocacy. It is important for FCNs to become familiar with the specific mission for advocacy of the faith communities they serve.

Key Terms

Advocacy: the act or process of pleading for, supporting, or recommending a cause or course of action. Advocacy may be for persons (whether as an individual, group, population, or society) or for an issue, such as potable water or global health (ANA, 2015).

Care coordination: deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care (AHRQ)

Collaboration: the process whereby two or more individuals or organizations work together to achieve a task or common goal

Cooperation: exchanging information, altering activities, and sharing resources for mutual benefit to achieve a common purpose

Coordination: exchanging information and altering activities for mutual benefit that achieves a common purpose

Self-efficacy: the extent or strength of one's belief in one's own ability to complete tasks and reach goals (Ormrod et al., 2017).

Transitional care: actions of faith community nurses or other healthcare providers designed to ensure the coordination and continuity of health care for healthcare consumers during movement between hospitals, subacute and post-acute nursing facilities, the healthcare consumer's home, primary and specialty care offices, and long-term care facilities as their condition and care needs change during the course of a chronic or acute illness (ANA/HMA, 2017).

Vulnerable persons: people at a greater than normal risk of experiencing abuse

Wholistic health: the human experience of optimal harmony, balance, and function of the interconnected and interdependent unity of the spiritual, physical, mental, and social dimensions (Ziebarth, 2016).

Reflection

"Then I said to the king, 'If it pleases the king, and if your servant has found favor with you, I ask that you send me to Judah, to the city of my ancestors' graves, so that I may rebuild it.'" ... "I told them that the hand of my God had been gracious upon me. ... Then they said, 'Let us start building!' So they committed themselves to the common good."
—Nehemiah 2:5, 18

"[Then] when you have decided on a course of action, put your trust in Allah: Allah loves those who put their trust in Him. If Allah helps you [believers], no one can overcome you."
—Qu'ran 3:159–160

Learning Outcomes

Upon completion of this module, the participant will be able to:

1. Advocate for the delivery of dignified and whole-person care by the interprofessional team.
2. Advocate for vulnerable populations experiencing contemporary health issues.
3. Apply advocacy skills in faith community nursing practice.
4. Coordinate implementation of a whole-person-centered plan of care with particular emphasis on the spiritual needs of diverse populations.
5. Apply competencies and skills that support successful care coordination.
6. Coordinate care by using volunteers and support groups to provide whole-person care.
7. Ensure continuity and coordination of health care for consumers during transitions between settings and levels of care.

Content Outline

Outcome 1

Advocate for the delivery of dignified and whole-person care by the interprofessional team.

Key Term: Advocacy is the act or process of pleading for, supporting, or recommending a cause or course of action. Advocacy may be for persons (whether as an individual, group, population, or society) or for an issue, such as potable water or global health (ANA, 2015). The goal of advocacy interventions is an increase in the patient's ***Key Term: Self-efficacy***, which is the extent or strength of one's belief in one's own ability to complete tasks and reach goals (Ormrod et al., 2017). For example: The FCN calls the clinic for an appointment on behalf of the patient. This FCN is a role model and demonstrates behavior for the patient. The patient learns and replicates the behavior. Advocacy interventions that increase self-efficacy include but are not limited to role-modeling, capacity building, supporting, encouraging, health counseling, health-promoting education, health resourcing, care planning, health support services, surveillance, lifestyle change support, caregiver support, and stress reduction and coping activities.

■ History of Wholistic Health

The FCN provides wholistic health care. ***Key Term: Wholistic health*** is the human experience of optimal harmony, balance, and function of the interconnected and interdependent unity of the spiritual, physical, mental, and social dimensions (Ziebarth, 2016).

Theological assumptions of wholistic health care are identified in the book, *Theological Roots of Wholistic Health Care: A Response to the Religious Questions which Have Been Raised* (Westberg et al., 1979), written with Granger Westberg's original Wholistic Health Centers in mind.

1. **Place matters.** The symbolism of a building and its physical arrangement. Health care delivered in a faith community has a symbolic message.
2. **The nature of person.** The nature and destiny of a person begins and ends with God. The value that each person has is derived from the value which God bestows upon persons, and is not dependent upon productivity or usefulness. Each person is a unity of body, mind, spirit, and soul.
3. **Sickness and health.** The brokenness and disintegration which penetrate every level of life are aspects of the same sickness. Illness relates to the whole person. A person can be sick mentally, emotionally, and spiritually, and in relationships and value choices. Health and salvation are twin expressions of wholeness, which has its source in God.
4. **Healing agents.** The job of healing calls for a multidisciplinary team. Professional providers bring special expertise. The focus of responsibility for health must be kept with the patient as the healing agent. Every person is commissioned to be a healing agent. Teamwork is essential in wholistic health care. The primary healing agent is God.

Westberg at age 70 stated that his goal was to place one nurse in every church. Thus, the term "parish nurse" was first used to describe the nurse in this specialized practice of faith community nursing.

Interprofessional Care

As **wholistic health care providers** working in the kind of interprofessional settings Granger Westberg envisioned, FCNs:

- Possess knowledge, skills, and licensure to perform interventions associated with the essential attributes of faith community nursing, which are faith integration, health promotion, disease management, coordination, empowerment [advocacy], and health care access.
- Are attentive, responsive, and intentional in providing integrative care that encompasses the interconnected unity of the patient's spiritual, physical, mental, and social dimensions.
- Have the ability to deconstruct personal attitudes and respond ethically.
- Are lifelong learners with specialized knowledge specific to (a) spiritual beliefs and interventions, (b) various faith traditions and practices, and (c) population-specific cultural beliefs, values, treatment, and outcomes.
- Possess congruent behaviors, attitudes, and policies to interact with a variety of patients in a way that is appropriate and understandable.
- Recognize the importance of the relationships to God, society, and others.
- Acknowledge that the relationship to the patient (person, family, or community) is of central importance.
- Are accessible, approachable, available, and accountable to patients.

Outcomes of advocating for the delivery of dignified and whole-person care by the interprofessional team are:

- access and effective use of the healthcare system
- humanized health care, focused on personal dimensions of care rather than "bottom line" outcomes
- care coordination that decreases fragmentation and optimizes outcomes
- empowerment and enhanced coping strategies
- engagement in the management of their patients' health and illness
- reduction in health care avoidance and improved care-seeking behaviors
- strengthened capacity to understand and care for self and others
- transformation of the faith community into a setting of healing and whole-person health

Outcome 2

Advocate for vulnerable populations experiencing contemporary health issues.

Advocating for Vulnerable Persons

Key Term: Vulnerable persons are people at a greater than normal risk of experiencing abuse. The FCN must **advocate** for, or speak on behalf of, those who are vulnerable because of disability, age, illness, or socioeconomic circumstances. These individuals may be unable to take care of or protect themselves against significant harm or exploitation. Vulnerable persons may also experience **health disparity**, an inequality or disproportionate difference in health care access or health outcomes. The FCN can help to close this gap.

Vulnerable groups may include:

- pregnant women
- infants
- persons who are chronically ill and disabled
- persons living with HIV/AIDS
- persons who are mentally ill and disabled
- persons with suicide- and homicide-prone behavior
- persons living in abusive families
- persons who are homeless
- immigrants and refugees
- older adults (especially those who are unwell, frail, or confused)

- persons who are incarcerated
- persons who abuse alcohol and other substances
- persons who lack family and social support
- persons who are questioning their sexual orientation

Critical Thinking

What person or group of vulnerable persons is present in your faith community?

What, if any, health care disparity do you identify with?

■ Awareness of Vulnerabilities

FCNs are exposed to vulnerable populations in the community. Awareness of the problem and appropriate resources are advantageous. A range of healthcare issues may contribute to, or arise from, vulnerability, including:

- **Access to health care.** The primary concern is that lack of access to health care will lead to unnecessary illness. Ideally, most individuals want the best possible health care regardless of age, sex, race, or ability to pay (Koch, 2017).
- **Cost of health care.** Be aware of the economics of health care in order to advocate for appropriate care of diverse populations.
- **Inadequate housing.** Inadequate housing can involve exposure to environmental hazards.
- **Homelessness.** Homeless individuals have complex physical, mental, social, and spiritual needs, and their access to health care is problematic. Nursing interventions for the homeless are unique and require education (Caldwell, Meraz, & Sweeney, 2018). Homeless children are at risk for poor school performance due to multiple factors, including lack of access to facilities for personal hygiene and lack of school supplies (National Center for Homeless Education, 2014).
- **Hunger or food insecurity.** Hunger and food insecurity are likely to occur in geographic areas where affordable and nutritious food is difficult to obtain, particularly for those without access to transportation. These areas, typically called *food deserts,* usually exist in rural areas and low-income communities. Food deserts are sometimes associated with supermarket shortages and food security. Diet-related health problems can be common in affected populations (Milan, Wolf, & Fagan, 2015).
- **Right to life issues across the life span.** For issues such as abortion, euthanasia, infanticide, or other deliberate destruction of human life, have denominational and health-related resources and referrals available.
- **Violence in the family and in the community.** Understand the basics about domestic violence. Work alongside secular advocates in the community.
- **Lack of health insurance.** Be aware of a variety of health care assistance programs available to help those who lack health insurance.
- **Cultural diversity.** Cultural groups view life processes, health, and illness differently. People may choose to seek health care from traditional healers instead of using healthcare institutions.

Critical Thinking

List the health care issues of vulnerable persons in your faith community in priority of greatest to least.

Which issue would you consider the most important to address first? How would you approach this issue?

These issues can be overwhelming for the FCN. The Serenity Prayer may serve as a reminder that God is ultimately in control. "God grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference."

Outcome 3

Apply advocacy skills in faith community nursing practice.

■ Understanding Advocacy Skills

Specific advocacy skills include:

- honesty
- assertiveness
- power

- directness
- risk-taking
- effective communication
- negotiation
- health coaching

The FCN uses power to advocate for improved health of individuals and families in the faith community. This power comes from several sources.

- expert power—in relation to person, evidence-based practice
- legitimate power—license to practice
- referent power—nurses often rank #1 in public opinion, such as in Gallup polls
- reward—improved health for faith community members

Effective advocacy is not only about power. It involves careful listening to the individuals being served.

- Allow individuals to identify their own situations.
- Assist individuals in clarifying personal values.
- Affirm individuals in selecting options.
- Support individuals in decision-making.

Advocacy Steps

Follow these basic steps for advocacy—either working alone or with others:

1. Assess the nature and source of the issue to be addressed.
2. Determine the appropriate target for the advocacy intervention.
3. Establish mutual goals with clients that are realistic and practical.
4. Negotiate an action plan with the client.
5. Consider the economic impact of the plan on clients and their families.
6. Determine availability of resources.
7. Assess receptivity to advocacy of all involved with the plan.
8. Serve as a navigator, while avoiding paternalism.
9. Establish boundaries—limits and lines of demarcation for your responsibilities and actions.
10. Recognize resilience in previous experiences.
11. Implement the plan.
12. Evaluate outcomes.

Successful advocacy depends on clear understanding of the concept of empowering. Empowering includes:

- positive nurse-client relationship
- respect for the person's autonomy and the right to make decisions about medical care
- education and knowledge
- respect for the person's self-determination
- affirmation of the person's abilities and resourcefulness

Remembering that FCNs are generalists, additional education on vulnerable population issues and resources may be necessary.

An example of advocacy: The FCN may work with shelter professionals or a clinic health care team to provide advocacy interventions for a woman who has experienced intimate partner violence. For example, FCNs may advocate in these ways:

- contact and support through phone calls, home visiting, or outings
- non-judgmental listening
- prayer and spiritual support
- prenatal or postnatal mentoring

- role-modeling a sense of hope
- parenting education and support
- health care coordination
- accompany client to medical visits
- referral to counseling services/resources (especially family violence services) for family and children (Rivas et al., 2015)

Outcome 4

Coordinate implementation of a whole-person-centered plan of care with particular emphasis on the spiritual needs of diverse populations.

■ Defining Care Coordination

Organizations involved in quality health care recognize the value of care coordination and define it in various ways.

The **Agency for Healthcare Research and Quality** (AHRQ) defines ***Key Term: Care coordination*** as deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. "This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient" (AHRQ). (https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html)

The **National Quality Forum's** definition of care coordination is a multifaceted concept referring to the need for meaningful communication and cooperation among providers as patients move through the healthcare system's many facilities and care settings—hospitals, doctor's offices, nursing homes, and people's own homes (National Quality Forum, 2012).

In a 2012 position paper entitled *Care Coordination and Registered Nurses' Essential Role*, the **American Nurses Association** (ANA) affirms the integral role of registered nurses in the care coordination process as a core professional competency. This involvement improves quality of care and outcomes across health care settings.

DeBrew, Blaha, Moore, and Herrick (2011), suggest the following skills are needed to support successful care coordination:

- communication and interpersonal skills
- clinical skills
- teaching skills
- counseling skills
- critical thinking, problem-solving, and knowledge of community resources
- group process skills
- collaborative networking skills
- leadership skills
- organizational skills
- research skills

■ Background and Opportunities

A review of current federal health care reform across states identifies that its focus is not only on expanding coverage for the uninsured or underinsured persons, but also on reorganizing the US healthcare system to include prevention and care coordination. Fragmentation of care within the US has been documented to have attributed to a lack of care coordination, which has produced increased costs and poor patient outcomes.

Changes in healthcare reform have resulted in the Centers for Medicare and Medicaid Services (CMS) and other third-party payers reconsidering the importance of case management, especially in individuals with multiple diagnoses or complex care situations. There are data that show good **care coordination** can prevent readmissions to the hospital, prevent complications, decrease the number of emergency department visits, and improve quality

of life (Cesta, 2013). Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health services (AHRQ). The FCN is an important community-based health team member in supporting (a) a patient's discharge from a hospital, (b) transitions in a patient's care level, and (c) complex care situations.

FCNs have a unique set of skills that can offer patients a wholistic approach to care coordination. Understanding the role of other professionals is a necessary part of care coordination. The FCN does not duplicate, but instead complements others on the health care team. There are 104 specialties in nursing. More than one-third of these specialties (34) are considered to be community-based, multifaceted, independent, and patient-facing. Of these, the following 19 nursing specialties seem to be very similar, requiring a generalized knowledge to practice although all specialties provide some level of care coordination.

- Ambulatory care nurse, camp nurse, community health nurse, domestic violence nurse, environmental health nurse, faith community nurse, holistic nurse, home health care nurse, hospice and palliative nurse, independent nurse contractor, international nurse, missionary nurse, health coach nurse, occupational health nurse, public health nurse, rural nurse, school nurse, supplemental nurse, case manager, and transcultural nurse.
- Case managers provide care coordination in hospitals. These persons may be nurses, social workers, or other individuals whose focus is on a select category of patients, primarily those in acute settings facing discharge to another level of care such as long-term care, rehabilitation, or at home with home care or hospice.

The medical home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. Building on the work of a large and growing community, the Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care (https://pcmh.ahrq.gov/page/defining-pcmh).

The medical home encompasses five functions and attributes:

- comprehensive care
- patient-centered
- coordinated care
- accessible services
- quality and safety

The American Academy of Family Physicians has identified Joint Principles of Patient-Centered Medical Home (PCMH) that include:

- a personal physician
- physician-directed services (team of healthcare providers directed by the MD)
- care coordinated across healthcare systems, and community-based services
- quality and safety incorporated into all layers of care (using evidence-based practices, quality improvement activities, information technology, etc.)
- improved access (open scheduling, expanded hours of service, better ways of communicating between providers)
- payment that is appropriate and is a valuable benefit to the patient

The care coordinator and case manager are essential to the success of this system.

- National demonstration projects have shown improved patient outcomes and reduced costs of care when these principles are in place.
- The *Geisinger ProvenHealth Navigator project* (Steele, Haynes, Davis, Tomcavage, Stewart, Graf, Weikel, K. and Shikles, 2010), involved studying patients with diabetes. The outcomes included an 18 percent reduction in hospital admissions, 36 percent reduction in hospital readmissions, a 4.3–7.1 percent savings in health care costs, depending on the medications prescribed for the patient, and a reduction in diabetes-related foot amputation.

- The Group Health Cooperative reported a 20–30 percent improved patient satisfaction score with services and a decreased provider emotional exhaustion score.
- A related outcome for this study was a 29 percent reduction in emergency department visits and a savings of $10.30 per patient per month.

While the results of care coordination are derived from a wide variety of settings and diverse patient populations, the conclusions reached are similar (ANA, 2012). Authors observed the following:

- reductions in emergency department visits
- noticeable decreases in medication costs
- reduced inpatient charges
- reduced overall charges
- average savings per patient
- significant increases in survival with fewer readmissions
- lower total annual Medicare costs for those beneficiaries participating in pilot projects compared to control groups
- increased patient confidence in self-managing care
- improved quality of care
- increased safety of older adults during transition from an acute care setting to the home
- improved clinical outcomes and reduced costs
- improved patient satisfaction overall

Critical Thinking

What is the role of the FCN in relation to others on the health care team that provide care coordination?

Outcome 5

Apply competencies and skills that support successful care coordination.

This section discusses selected competencies and skills related to successful care coordination, including collaboration and working with volunteers.

■ Care Coordination and Collaboration

Successful care coordination requires collaboration (Kaye & Crittenden, 2005). ***Key Term: Collaboration*** is the process whereby two or more individuals or organizations work together to achieve a task or common goal. Collaboration has many benefits.

- Collaborating with key professionals and various agencies in the community can legitimize an issue. For example, working with community leaders that represent multiple organizations can demonstrate the size and importance of an issue.
- Support from multiple organizations can collectively capture the interests of key policymakers.

Collaborating with Individuals

The FCN has the opportunity to collaborate with individuals and groups, many of which may be unique to the practice setting of the faith community. According to (DeBrew et al., 2011), these include:

- Collaborating **with the spiritual leader**. This is an essential member of the care coordination team. The respect and blessing of the spiritual leader are important. The spiritual leader can best guide in upholding faith community policies and doctrine.
- Collaborating **with God**. The FCN cares for the spiritual needs of patients.
- Collaborating **with the faith community**. Awareness of specific skills and competencies of members of the faith community is important. These individuals support care coordination efforts through volunteering, sharing resources, and supporting the FCN program.
- Collaborating **with the physician**. As a professional, it is essential that the nurse work with the physician and the entire interprofessional health care team to participate in the plan of care. This also includes home care agencies, hospice, durable medical equipment organizations, pharmacies, etc.

- Collaboration **with other ministries**. Working together prevents duplication of services and contributes to success. This includes working across faith communities and with other FCNs.
- Collaborating **with the patients and their families**. In providing care for individuals, the FCN must follow established guidelines related to confidentiality and documentation to maintain legal and ethical requirements for professional nursing practice (DeBrew et al., 2011).

Collaborating for Synergy

Collaboration often brings synergy that occurs through participating in a group (Kaye & Crittenden, 2005). When brainstorming an issue, ideas and energy create new avenues to address the issue. During the collaboration process, people become energized because each person at the table has a vested interest in finding a solution to the problem. This synergy may also bring about new ideas for additional resources that may be needed.

Collaborating for Grant Funding

Collaboration also might help obtain grant money. Collaborative efforts may provide wide support for grant funding. FCNs can contribute to the grant writing process about the needs of the faith community, and they have information on the multitude of community resources. It is important to note that some faith community-related projects have been awarded grants based on the number and strength of the collaborations formed. Certain funding guidelines sometimes encourage grantees to expand those collaborations to include all stakeholders involved (Nouwen, 2010).

■ Barriers to Collaboration

Some perceived barriers to collaboration are:

- "Stranger danger"—a reluctance to share information with others.
- "Needle in a haystack"—the belief that others may have already solved the problem. The question becomes, how do you find them?
- "Hoarding"—the basic premise that people do not want to share their knowledge because they see hoarding their information as a source of real power.
- "Not invented here"—the solution is not a product of the group but comes from outside the group (American Red Cross, 2011).

■ Differentiating Between Coordination, Cooperation, and Collaboration

Key Term: Coordination is exchanging information and altering activities for mutual benefit that achieves a common purpose.

- Coordination requires more than organizational involvement and networking. It can be an important strategy to implement change.
- Coordination is most effective when all parties affected by proposed changes share in the decisions about the possible consequences of the changes. An example of coordination is when community agencies work together to coordinate transportation services.
- Through coordination, families gain access to transportation services. In addition, unnecessary or duplicative services may be eliminated (DeBrew et al., 2011).

Key Term: Cooperation means exchanging information, altering activities, and sharing resources for mutual benefit to achieve a common purpose.

- Shared resources may include sharing staff, work space, training, information, and funding.
- An example of cooperation is when the public transportation system and the private local transportation system (such as a bus company) use the same coordinator to assist families in the event of a natural disaster evacuation (Kaye & Crittenden, 2005).

As mentioned earlier in this module, collaboration is the process of working together to achieve a common goal. **Collaboration** involves exchanging information, altering activities, sharing resources, and enhancing the capacity of another organization for mutual benefit and to achieve a common purpose.

- Members of a collaborative effort view each other as partners that are willing to share risks, resources, responsibilities, and rewards.
- A multi-sector collaboration is an alliance of public, private, and nonprofit organizations.
- An example of collaboration is illustrated by public and private agencies that are currently working together to create a disaster preparedness plan.
- All available resources, including community contacts and funding, are fully shared (Engel & Prentice, 2013).

■ Interprofessional Collaboration

The *Interprofessional Education Collaborative Expert Panel* (2011) suggests the following four core competencies for successful interprofessional collaborative practice:

1. Work with individuals of other professions to maintain a climate of mutual respect and shared values.
2. Use the knowledge of one's own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.
3. Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.
4. Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient- and population-centered care that is safe, timely, efficient, effective, and equitable.

Grey & Connolly (2008) explain the benefits of interdisciplinary collaboration. They composed the following list of benefits for clients, health care professionals, and organizations from interdisciplinary collaboration in health care.

Benefits to patients:

- improved patient outcomes
- lower mortality
- increased patient satisfaction (enhanced feelings of security, importance, and respect)
- increased feelings of empowerment

Benefits to health professionals:

- increased job satisfaction
- improved registered nurse (RN) retention
- increased RN involvement in decision-making
- decreased burnout
- improved career potential and career mobility
- increased professional growth
- cross-disciplinary peer review and critique of practice and research

Benefits to health care organizations:

- improved cost-effectiveness of care
- improved distribution of resources
- improved productivity of collaborators
- more knowledgeable practitioners
- increased funding for practice and research
- acceleration of innovation in health care due to cross-fertilization of creative ideas

Critical Thinking

How does collaboration in faith communities differ from other settings?

Why is interprofessional health care collaboration important?

Identify how you, as an FCN, can collaborate with other ministries or committees in your faith community?

Outcome 6

Coordinate care by using volunteers and support groups to provide whole-person care.

Like many nonprofit organizations, faith communities need volunteers (unpaid workers) to function. FCNs use volunteers in several ways. They may help with health-related programming, clerical work, or serve as speakers for events. Volunteers are used to help coordinate care and to provide important support services for those in need. The FCN should learn how to recruit, train, manage, and recognize volunteers. A great resource booklet for FCNs is *Volunteer Program Development: For Faith Communities* (2017). Chapter headings are: Biblical Foundation, Volunteer Recruitment, Types of Volunteer Programs, and Volunteer Training. It was written by an FCN who started with four volunteers and grew that number to more than 100. The volunteer program leadership served on the health ministry team and used monthly meetings to report on volunteer activities. Volunteers were used to provide friendly visits (in-person or phone calls), cards or notes of encouragement, transportation, and meals.

■ Working with Nurse Volunteers

In some settings, FCNs are unpaid and consider themselves to be volunteers (Ziebarth & Miller, 2010). Depending on the model and hours available, the FCN may need to recruit RNs to support the practice. Nurse volunteers are bound by state statutes in regard to individual practice. Providing nursing care as a volunteer does not relieve the nurse from liability or malpractice. Generally, when offering volunteer services as an RN, the following guidelines apply. The RN must:

- Possess a current, unencumbered license as an RN in the state in which the services will be offered.
- Perform only those duties for which the nurse possesses the necessary skills and competencies, including appropriate intervention and referral for persons at immediate risk for illness or injury.
- Perform duties according to nationally recognized standards and in accordance with the requirements of that state's Nurse Practice Act and *Faith Community Nursing: Scope and Standards.*
- Follow policies established by the faith community or governing body (Ohio Nurses Association, 2009).

Volunteer nurses should understand that the federal **Volunteer Protection Act of 1997** was passed to encourage volunteers and help protect them from lawsuits. The statute provides that volunteers of nonprofits or governmental agencies are not liable for harm due to acts of omission under these conditions:

1. The volunteer was acting within the scope of duties.
2. The volunteer was properly licensed, certified, or authorized, if required, for the activities performed.
3. Harm was not a result of willful or criminal misconduct.
4. Harm was not caused by the volunteer operating a vehicle for which the state requires operator licensure and/or insurance (Ohio Nurses Association, 2009).

Good Samaritan Acts vary from state to state. Volunteer nurses should understand the laws for their state. Generally, Good Samaritan laws do not cover activities that are not related to emergency situations, so they do not apply in faith community nursing.

■ The Recruitment Process

Understanding why certain people may want to volunteer in a faith community nursing program may help in recruitment. A few reasons that people commonly choose to volunteer are:

- They want to make a difference (contribute to a good cause).
- They hope to develop new skills.
- They want to meet people and make new friends.
- Some combination of these reasons.

The best place to recruit volunteers for the faith community nursing program is within the faith community. Members are considered stakeholders and have alliances within the faith community as well as the larger

community. Additionally, often a word from the faith community leadership regarding serving may encourage a volunteer to make a commitment. Remember that these are the faith community's volunteers, and not yours.

Finding Volunteers

At times the FCN may need more volunteers than the immediate faith community can provide. To find more volunteers, investigate:

- Corporate and governmental offices have community service opportunities for employees.
- Neighboring faith communities and other religious institutions may offer volunteer prospects because they are motivated by altruistic beliefs to serve the broader community.
- Internship programs at colleges and high schools often provide interns in exchange for a meaningful volunteer project.
- High schools and colleges may have programs that require students to give hours of service to community projects.
- Career counseling centers can help identify individuals who are changing careers and considering entering the nonprofit sector as volunteers.
- Civic clubs, fraternal organizations, sororities, and fraternities can be a great resource for volunteers.
- Newspapers, radio, television, and social media are excellent vehicles to promote volunteer needs, and many will allow nonprofit organizations to list volunteer opportunities for free.
- Other nonprofit community organizations can be a tremendous resource in identifying a source for volunteers.

Principles of Volunteerism

The American Red Cross (ARC) is an organization primarily governed and operated by volunteers. The ARC volunteer handbook includes the following principles on the importance of volunteers (American Red Cross, 2011):

- Volunteers are not free.
- Volunteer does not mean amateur.
- Volunteers and the organization they serve must meet each other's expectations.
- Volunteers must never be exploited.
- Volunteers make excellent middle and senior managers.
- When recruiting volunteers, it is more important to place the right person in the right job than to attract volunteers at random.
- Everyone benefits when nonprofit organizations collaborate.

■ Volunteer Management

Volunteer retention requires careful management. The management goal is to make volunteers feel successful and appreciated. Consider these methods for optimal volunteer management:

- Provide role descriptions to clarify responsibilities.
- Clarify who to report to.
- Match the right person with the right job.
- Provide training and education.
- Provide continuous feedback and do an annual evaluation.
- Keep documentation.
- Celebrate accomplishments.
- Pray for volunteers often.
- Send thank you cards/letters.
- Invite volunteer coordinators to report at health ministry meetings.

Show Appreciation

Showing appreciation may help prevent volunteer burnout. The following methods may be helpful in showing appreciation:

- Hold volunteer social events.
- Invite volunteers to special training sessions.
- Sponsor a volunteer appreciation luncheon.
- Give opportunities for volunteers to tell stories.
- Pray for volunteers often.
- Send thank you cards or letters.

Identify Roles, Expectations, Responsibilities, and Relationships

One challenge for any organization is preventing friction among staff, whether paid or volunteer. To avoid problems arising from unclear or overlapping responsibilities, clear job descriptions are important. A good job description will itemize duties of a volunteer position and who this person reports to. In addition, every volunteer position should have a time limit.

Documenting basic information about new volunteers includes:

- name, address, telephone number
- relevant experience
- interests and skills
- availability
- starting date
- emergency contact information

Insurance. It is important that the FCN recognizes that faith community liability insurance is needed when volunteer programs exist. The FCN should be aware of the existence and content of the faith community liability insurance policy as it pertains to volunteer coverage and bodily injury, personal injury, property damage, sexual abuse and molestation, and professional liability due to a volunteer rendering an unqualified professional service such as nursing or counseling.

Injuries. If volunteers are hurt while working in the faith community, they may be entitled to compensation beyond what their own insurance already covers. Speak to the faith community's insurance company to discuss possible solutions to this problem. One of these two solutions may be possible:

- Coverage under the faith community's worker's compensation policy. Usually, this means adding a "voluntary" endorsement to the faith community's existing worker's compensation policy. The faith community is then charged based on hours worked by volunteers.
- Coverage under a medical accident policy. These policies can cover anyone injured on the faith community's premises, including volunteers. The policy can also be extended to cover off-site activities, sporting events, or transportation to and from activities (National Mental Health Association, 2009).

Critical Thinking

Evaluate how volunteers are recruited and screened in your faith community. What additional steps do you think are necessary for volunteers involved in coordinated care?

■ Support Groups

In the role of care coordinator, the FCN may refer to existing support groups or facilitate the development of a new support group.

- Support groups, sometimes referred to as self-help groups, are people who gather to share common problems, experiences, illnesses, or life situations.
- The support group is generally made up of peers with a professional or volunteer facilitator, who may be the FCN.
- Generally, the most effective groups are small in number (10–15) and attendance is voluntary.

Support groups may empower people in these ways:

- Members solve their own problems.
- Members learn about conditions, diseases, or situations.
- Groups allow safe environments for people to share or vent their feelings with others who understand as a result of shared experiences.
- Attendance limits isolation.

Support groups generally help some individuals reduce anxiety, improve self-esteem, and improve quality of life.

- Research studies related to breast cancer support groups have found that participating individuals have a longer life expectancy and a more successful treatment trajectory.
- 6.25 million Americans use support groups at any given time, and over 15 million have participated at some time (Work Group for Community Health & Development, 2013).

Finding the Right Group

Even though some support groups have a long history (Alcoholics Anonymous has a very long history), some have a life span and disband after the group's needs are met. FCNs most often will be referring individuals to existing community support groups.

It is important for the individual to find a compatible group.

- Some people prefer groups facilitated by professionals while others prefer a peer environment.
- People with some health conditions often become experts as a result of their research about the therapeutic, social, and emotional aspects of having a particular disease.
- They may want to connect with others who can help plan solutions from an "I've been there, too" perspective (Shepherd & Shepherd, 2013).

A faith-based support group has the added advantage of being able to draw on shared beliefs and values related to hope and life's meaning.

- A faith-based support group honors the expression and understanding of the integration of faith into a life experience.
- These groups fulfill the modern role of a faith community to build relationships among participants.
- A faith-based support group also helps the faith community regain its place as the place for physical and emotional healing.

What are characteristics of a good support group? When a faith community member is searching for a support group, the most important thing is to remind the person: "If the group doesn't feel right to you or doesn't match your needs, try a different group. There are many options available." *Good* is a value judgment that differs from person to person; however, here are a few indicators of a well-functioning group:

- current, reliable information
- prompt response to inquiries
- regularly scheduled meetings or newsletters
- access to appropriate professional advisers (for example, medical specialists, licensed therapists, counselors, or employment attorneys for workplace discrimination)
- strong leadership
- clearly stated confidentiality policy
- specific qualities the individual is seeking (for example, a group around a specific condition, or a group for siblings) (Greenwood et al., 2013)

Support groups meet **where the group members are best served.**

- Hospitals offer support groups, but groups can also meet in an individual's home, churches or temples, libraries, or other community buildings.

- There are also online support groups, which may be especially helpful for people who are homebound, have limited free time to attend meetings, or don't have a group nearby that meets their needs (Varga and Paulus, 2014).

Size varies depending on the purpose of the group and the needs of the members.

- Some groups have fewer than ten members; others may have thousands.
- Groups with goals of raising money, influencing public health policy, or educating the public tend to be very large.
- Emotional support groups, addressing grief or loss, typically are small, so that participants can feel safe expressing feelings (Graves, 2012).

Starting a Support Group

Starting a new group is time-consuming and takes much work. Additionally, an established group probably has certain advantages, such as already-established informational materials, meeting times and places, and professional contacts. However, in some cases the type of group needed may not exist in the faith community or broader community. Ways to begin a new group include getting the help of a local hospital, health provider, or faith community (Graves, 2012).

It is important for the FCN to remember that a support group is not therapy. Individuals who present with symptoms of extreme emotional distress, long-term emotional complaints, depression, or suicidal tendencies should be referred as soon as possible to an appropriate counselor or therapist. Many pastors are certified counselors with specific training in assisting individuals or families.

Critical Thinking

What would you say is the first step in determining whether your work as an FCN should involve starting a support group?

Outcome 7

Ensure continuity and coordination of health care for consumers during transitions between settings and levels of care.

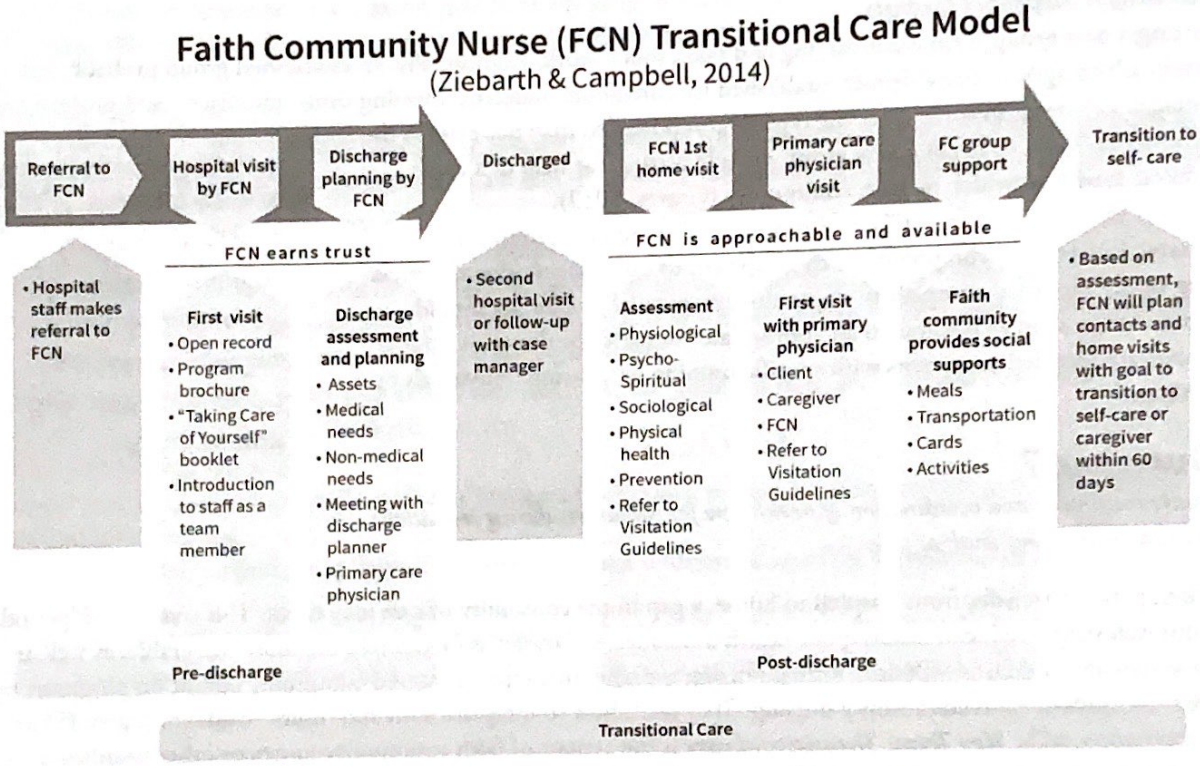
When patients transfer from hospital to home, a gap in the continuity of care may occur. This transitional period, if not well supported, can lead to poor health outcomes and readmissions among the most vulnerable, as well as cause demands on family. Besides formal nursing training, many nurses attend continuing education programs to learn the skills of faith community nursing. They learn how to integrate faith and health in advocating and care coordinating skills. ***Key Term: Transitional care*** is the actions of faith community nurses or other healthcare providers designed to ensure the coordination and continuity of health care for healthcare consumers during movement between hospitals, subacute and post-acute nursing facilities, the healthcare consumer's home, primary and specialty care offices, and long-term care facilities as their condition and care needs change during the course of a chronic or acute illness (ANA/HMA, 2017).

FCNs implement transitional care interventions differently. Because of this, patients experience a range of assessments and interventions that consider wholistic health needs. The FCN asks questions: "What sustains you during difficult times?" or "Do your religious or spiritual beliefs influence the way you look at your disease and the way you think about your health?" (Ziebarth, 2017). The FCN may use presence or prayer in providing transitional care.

The conceptual model of faith community nursing helps to define and clarify the practice and outcomes. The practice is described theoretically as a "method of healthcare delivery that is centered in a relationship between the nurse and client (client as person, family, group, or community). The relationship occurs in an iterative motion over time when the client seeks or is targeted for wholistic health care with the goal of optimal wholistic health functioning. Faith integrating is a continuous occurring attribute. Health promoting, disease managing, coordinating, empowering, and accessing health care are other essential attributes. All essential attributes occur with intentionality in a faith community, home, health institution, and other community settings with fluidity as part of a community, national, or global health initiative" (Ziebarth, 2014).

■ Faith Community Nurse Transitional Care Model

In the *Faith Community Nurse Transitional Care Model*, there are two phases when time-specific interventions occur. The two phases are pre-hospital discharge and post-hospital discharge (Ziebarth & Campbell, 2016). The model's aim is to transition to self-care within 30–60 days, based on the FCN's assessment. Campbell (2017) writes that transitional care can be terminated when a) access is established to PCP [medical home], b) transportation issues are resolved, c) there is competent and safe management of medications and other disease self-care activities, d) the caregiver is prepared and engaged, e) community resources are accessible and reliable, f) there is effective demonstration of knowing what to do, who to call, and what to report, and g) patient and caregiver have all instructions in writing.



Pre-discharge. Patient, caregiver, hospital staff or case manager, and doctor: In the pre-discharge phase, the **first visit** is made with the patient in the hospital. The FCN's goal in this phase is to earn the trust of the patient, caregiver, hospital staff or case manager, and doctor. This is done by introduction, information sharing, and developing the plan of care. The FCN delineates a patient's assets and strengths, along with medical and nonmedical needs. By means of introduction, the patient, caregiver, hospital staff, and doctor are oriented to the role of the FCN in transitioning from hospital to home. The FCN's role is to avert unnecessary re-hospitalization by increasing contact between the patient and doctor and by making frequent home visits to offer time-specific and wholistic nursing interventions. These interventions include:

- whole-person assessment, which includes spiritual
- appropriate referrals
- screening (vitals)
- disease education
- medication reconciliation
- self-care training
- safety assessments

The FCN should also contact the physician's office or clinic to introduce the FCN role and alert providers that an FCN may accompany the patient and caregiver to the first doctor's visit post-discharge.

A free booklet entitled *Taking Care of Myself: A Guide for When I Leave the Hospital* (https://www.ahrq.gov/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome/index.html) can be used by the FCN and patient to collect information such as discharge medications, important telephone numbers, doctor's appointment dates/times, and to develop a plan for emergencies, such as pain or anxiety. Another available tool is from the Pittsburgh Mercy Parish Nurse & Health Ministry (www.pmhs.org/parish-nurseprogram/educationand-resources.aspx).

An extra hospital visit with the patient or case manager may occur if:

- the patient, caregiver, or case manager was not available during the first visit
- a visit was requested by the patient, caregiver, or case manager
- the patient had complications necessitating a longer hospitalization

The FCN's goal for this visit is to develop a working relationship with the patient, caregiver, and hospital staff/case manager prior to discharge and to educate each regarding the FCN's role in transitional care.

Post-discharge. The FCN's goal for this phase is to be approachable and available. Soon after discharge (24–72 hours), **a second visit** is made in the patient's home setting. This visit includes:

- whole-person assessment, which includes spiritual
- appropriate referrals
- screening (vitals)
- disease education
- medication reconciliation
- self-care training
- safety assessments

The booklet *Visitation Guidelines for Faith Community Nurses* (available on Amazon) provides assessment guidelines for the first home visit and first doctor's visit. Based on assessment, the FCN plans contacts and home visits with the goal to transition the patient to self-care or caregiver within 30 to 60 days.

In addition to the role of the FCN, faith community volunteers are used to provide supportive services in the post-discharge phase. The FCN works with the faith community to create a team of volunteers based on the needs of the patient who is transitioning from hospital to home. The use of volunteers extends the care being provided by the FCN. The types of support that faith community volunteers can provide are:

- friendly visits (in person or by phone)
- cards or notes of encouragement
- light yard work or minor repairs
- transportation
- meals
- prayer

An excellent resource for FCNs in developing volunteer programs is the booklet, *Volunteer Program Development: For Faith Communities* (available on Amazon), written by an FCN who created a large and vibrant volunteer program in a church in the Midwest. The booklet contains tools such as different volunteer models, role descriptions for volunteers, role descriptions for volunteer coordinators, volunteer celebrations, volunteer evaluations, etc.

The third visit is made when the FCN accompanies the patient and caregiver to the first post-hospitalization visit to the doctor. FCNs attend the first post-hospitalization visit with the doctor to:

- ensure that the visit occurs
- introduce themselves and the FCN role to the doctor and clinic staff
- facilitate information exchange between patient, caregivers, and healthcare provider
- make sure that the patient and caregiver are fully engaged and participate in healthcare decisions

Additional home visits with the patient and caregiver may occur to continue the nursing plan of care, or are based on assessment and patient's need. In addition, telephone check-ins may occur. The FCN may need to provide care coordination and advocate on behalf of the patient to establish services, change medications, and access care. The duration of transitional services provided by the FCN is determined by the patient's needs, diagnoses, and program outcomes, but generally will not exceed 60 days.

■ Recent Research

Ziebarth (2016) found that the most frequently recorded nursing interventions classifications (NICs) by FCNs were: emotional support, spiritual support, active listening, medication management, health education, fall prevention, listening visits, telephone follow-up, coping enhancement, decision-making support, learning facilitation, teaching: individual, caregiver support, family support, telephone consultation, pain management, environmental management: comfort, socialization enhancement, anticipatory guidance, hope instillation, listening visits. In phase two of the study, the FCN focus group participants confirmed these interventions to be integral, important, and intentional to providing transitional care. Six of the nursing interventions represented 73% (n=155) of the 210 NICs documented by FCNs. The six interventions were emotional support, spiritual support, active listening, medication management, health education, and fall prevention.

Ziebarth (2016; 2017) documents findings that show FCNs perform many of the same transitional care interventions as those recorded by advanced practice RNs in previous studies (Naylor et al., 1999; 2004; 2011; 2012). In addition, emotional and spiritual support interventions were also recorded by FCNs. This finding is important because the Joint Commission (2010) states that patients have specific characteristics and nonclinical needs that can affect the way they view, receive, and participate in health care. In addition, supporting patients' spiritual needs may help patients to cope with illness better (Paloutzian & Park, 2014).

Standards of Professional Performance for Faith Community Nursing

■ Standard 11. Leadership

The faith community nurse leads within the professional practice setting and the profession.

Competencies

The faith community nurse:

- Serves as a nursing role model in the establishment of an environment that supports and maintains respect, trust, and dignity.
- Encourages innovation in practice and role performance to attain personal and professional plans, goals, and vision.
- Communicates to manage change and address conflict.
- Mentors colleagues for the advancement of nursing practice, the profession, and the specialty of faith community nursing to enhance safe, quality health care.
- Retains accountability for delegated nursing care.
- Contributes to the evolution of the profession through participation in professional organizations, professional development, certification, and continuing education.
- Demonstrates a commitment to lifelong learning, education, and spiritual growth for self and others.
- Influences policies that promote health and improve healthcare consumer outcomes.
- Collaborates to create a compelling and inspiring vision of excellence in nursing practice within the organization and the community.

- Serves in key leadership roles in the faith community by participating on committees, councils, and health ministry administrative teams.
- Endorses nursing autonomy and accountability and establishes an environment that motivates constructive change.

Standard 9. Communication

The faith community nurse communicates effectively in all areas of practice.

Competencies

The faith community nurse:

- Assesses one's own communication skills and effectiveness.
- Demonstrates cultural empathy when communicating.
- Assesses communication ability, health literacy, resources, and preferences of healthcare consumers to inform the interprofessional team and others.
- Uses language translation resources to ensure effective communication.
- Incorporates appropriate alternative strategies to communicate effectively with healthcare consumers who have visual, speech, language, or communication difficulties.
- Uses communication styles and methods that demonstrate caring, respect, deep listening, authenticity, and trust.
- Conveys accurate information.
- Maintains communication with interprofessional team and others to facilitate safe transitions and continuity in care delivery.
- Contributes nursing and spiritual perspectives in interactions with others and discussions with the interprofessional team.
- Exposes care processes and decisions when they do not appear to be in the best interest of the healthcare consumer.
- Discloses concerns related to potential or actual hazards and errors in care or the practice environment to the appropriate level.
- Demonstrates continuous improvement of communication skills.

Standard 10. Collaboration

The faith community nurse collaborates with the healthcare consumer and other key stakeholders in the conduct of nursing practice.

Competencies

The faith community nurse:

- Identifies the areas of expertise and contribution of other professionals and key stakeholders.
- Clearly articulates the nurse's role and responsibilities within the team.
- Uses the unique and complementary abilities of all members of the team to optimize attainment of desired outcomes.
- Partners with the healthcare consumer and key stakeholders to advocate for and effect change, leading to positive outcomes and quality care.
- Communicates with the healthcare consumer, family, groups, spiritual leaders, hospital and hospice chaplains, and other healthcare providers regarding healthcare consumer care and the faith community nurse's role in the provision of that care.
- Uses appropriate tools and techniques, including information systems and technologies, to facilitate discussion and team functions, in a manner that protects dignity, respect, privacy, and confidentiality.
- Promotes engagement through consensus building and conflict management.
- Uses effective group dynamics and strategies to enhance team performance.
- Exhibits dignity and respect when interacting with others and giving and receiving feedback.
- Partners with all stakeholders to create, implement, evaluate, and document a comprehensive plan.

■ Standard 5. Implementation

The faith community nurse implements the identified plan.

Competencies

The faith community nurse:

- Partners with the healthcare consumer, family, and significant others to implement the plan in a safe, effective, efficient, timely, patient-centered, and equitable manner (IOM, 2010).
- Integrates interprofessional team partners including spiritual leaders, caregivers, and volunteers from diverse backgrounds in implementation of the plan through collaboration and communication across the continuum of care.
- Demonstrates caring behaviors toward healthcare consumers, significant others, and groups of people receiving care to develop therapeutic relationships necessary for health and healing.
- Provides culturally congruent, whole-person care that focuses on the healthcare consumer and addresses and advocates for the needs of diverse and vulnerable populations across the lifespan with particular emphasis on spiritual needs.
- Uses evidence-based interventions and strategies to achieve the mutually identified goals and outcomes specific to the problem or needs.
- Integrates critical thinking and technology solutions to implement the nursing process to collect, measure, record, retrieve, trend, and analyze data and information to enhance nursing practice and healthcare consumer, family, or population group outcomes.
- Delegates according to the health, safety, and welfare of the healthcare consumer and considering the circumstance, person, task, direction or communication, supervision, evaluation, as well as the state nurse practice act regulations, institution, and regulatory entities while maintaining accountability for the care.
- Uses community and faith community resources and systems to implement the plan.
- Documents implementation and any modifications, including changes or omissions, of the identified plan.

■ Standard 5A. Coordination of Care

The faith community nurse coordinates care delivery.

Competencies

The faith community nurse:

- Organizes the components of the plan.
- Collaborates with the consumer to help manage health care based on mutually agreed-upon outcomes.
- Coordinates implementation of a whole-person-centered plan of care with particular emphasis on the spiritual needs of diverse populations.
- Manages a healthcare consumer's care in order to maximize independence and quality of life in accordance with mutually agreed upon outcomes.
- Engages healthcare consumers in self-care to achieve preferred goals for quality of life with attention to mind, body, and spirit.
- Assists the healthcare consumer to identify options for care.
- Communicates with the healthcare consumer, family, interprofessional team, and community-based resources to effect safe transitions in continuity of care.
- Advocates for the delivery of dignified and whole-person humane care by the interprofessional team.
- Documents the coordination of care.