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Faith Community Nursing Demonstrates Good Stewardship of Community Benefit Dollars Through Cost Savings and Cost Avoidance

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Health systems seeking responsible stewardship of community benefit dollars supporting Faith Community Nursing Networks require demonstration of positive measurable health outcomes. Faith Community Nurses (FCNs) answer the call for measurable outcomes by documenting cost savings and cost avoidances to families, communities, and health systems associated with their interventions. Using a spreadsheet tool based on Medicare reimbursements and diagnostic-related groupings, 3 networks of FCNs have together shown more than 600 000 (for calendar year 2008) healthcare dollars saved by avoidance of unnecessary acute care visits and extended care placements. The cost–benefit ratio of support dollars to cost savings and cost avoidance demonstrates that support of FCNs is good stewardship of community benefit dollars. **Key words:** *community benefit*, *cost savings and avoidance*, *DRG*, *Faith Community Nurses*, *measurable outcomes*

ALL across the United States, there are networks of Faith Community Nurses (formerly known as Parish Nurses but changed to FCN "in order to adopt an all encompassing title for this specialty")[1(p9)] faithfully carrying out their ministries of care and support. Twenty percent of their contacts are not members of their congregations.[2] Some nurses are paid by their congregations, while others are paid by other institutions. However, the majority are not paid but donate time, energy, gas, money, and other resources to promote health and improve the health status of their congregants and communities.[1] For over 25 years, healthcare institutions of various types have provided support to these nurses and their health team members in the form of guidance, education, resources, and many other administrative benefits.[3] Network staff are often paid by these institutions from operational funds reported to the federal government as community benefit dollars.[4]

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BACKGROUND

In the early 1990s, networks of FCNs proliferated across the United States.[5,6] In the late 1990s and early 2000s, other countries including Canada, England, Korea, Australia,

and Israel developed these ministries[5–7] Despite many case stories and documented quantitative and qualitative studies, the continuation of FCNs and supportive networks has remained precarious. Network finances have diminished, and out-of-pocket expenses have become deterrents to some congregationally based FCN health ministries. Even so, community benefit dollars of many nonprofit healthcare institutions have continued to be dispensed to projects oriented to processes aimed at achieving positive health outcomes through means such as brochure development, educational opportunities, luncheons, and other networking activities. Unfortunately, improvements in health status and quality of life because of these activities have not been well established.[8,9]

In 2007, new regulations were issued that set higher expectations for reporting the healthcare dollars used for community benefit.[9,10] At risk are the integrity of the community benefit efforts and nonprofit status of the institution.[9] The Cost Savings and Avoidance (CS/A) Tool, now used by 3 midwestern networks, not only demonstrates good stewardship of community benefit dollars, but also provides a tangible indicator of the value of faith community nursing to families, communities, and institutions.

PROCESS FOR DETERMINING COST SAVINGS AND COST AVOIDANCE

FCNs care for individuals and families. As they document their interactions, participating FCNs mark their electronic record with a check mark when they think that the outcome of their intervention(s) is a cost savings or cost avoidance. They also write in the note the medical diagnosis, nursing diagnosis, or both for which the CS/A was effected and also describe briefly why there was a CS/A. On a monthly or quarterly basis, FCN coordinators filter electronic records for individual interactions that are marked as CS/A. Using client numbers, the FCN coordinator reviews related documentation and identifies the "diagnosis related groups" (DRGs) product line and accepts, modifies, or rejects FCNs' assertions of CS/A. When the CS/A is decided upon, the FCN coordinator enters the data into the CS/A Tool under the appropriate DRG product line (Table 1).

The Henry Ford Macomb Hospitals' (HFMH—a member organization of Henry Ford Health System [HFHS]) Faith Community Network worked with an HFMH clinical analyst to develop the CS/A Tool. The purpose of this tool is to report CS/As resulting from interventions of FCNs and their health ministry teams in correlation with diagnostic-related groupings. The goal is that by sharing CS/As brought about by faith-based health ministries, financial and other support of these community partnerships would be maintained and enhanced.

To develop the tool, medical diagnoses most frequently documented by HFMH FCNs were given to the analyst. He or she then identified the DRG product lines into which they fell.[11] Using 2004 healthcare data and formulae, the analyst determined the Medicare reimbursement dollars for DRGs for the HFMH system located in southeastern Michigan (see Table 1).

The clinical analyst designed the tool using Excel (a Microsoft database software application) to assist in the collation and quantification of the data. The CS/A categories for which data may be entered were determined by focus groups of HFMH FCN network members. They are avoided cases (hospitalization), avoided days, emergency department (ED) visits, nursing home per month, assisted living per month, companion per week (considered a cost), physician office visit, and outpatient rehabilitation case. Once the CS/A is entered on the worksheet tab, the number and costs automatically tabulate on the summary sheet (Table 2). The summary sheet keeps a running total of the number of CS/As in a category, the number of dollars saved per category and DRG, and the total dollars saved per category and DRG (Table 2). Self-study modules are available to all FCNs and FCN coordinators to assist them in the

Table 1. Cost savings and avoidance dollars by product line

Tab[a]	Cost to patient	Day cost	Product line	Average LOS
Avoided case				
ALC	$2 677	$732	Alcohol and drug abuse	3.66
CAR	$4 272	$1 064	Cardiovascular diseases	4.01
CVS	$12 969	$2 357	Cardio\vasc\thoracic surgery	5.50
ENT	$3 303	$1 216	ENT	2.72
MED	$4 317	$938	General medicine	4.60
SUR	$10 973	$1 549	General surgery	7.08
GYN	$3 657	$1 511	Gynecology	2.42
NEO	$1 061	$337	Neonatology	3.14
URO	$4 622	$1 233	Nephrology\urology	3.75
NEU	$5 073	$1 025	Neuro sciences	4.95
NEW	$243	$131	Normal newborn	1.86
OBD	$2 738	$1 394	OB delivery	1.96
OBN	$2 170	$1 065	OB nondelivery	2.04
ONC	$6 263	$1 045	Oncology	5.99
OPT	$3 180	$1 458	Ophthalmology	2.18
ORT	$7 394	$1 846	Orthopedics	4.01
PSY	$7 926	$410	Psychiatry	19.32
PUL	$5 500	$963	Pulmonary medicine	5.71
REH	$17 674	$1 086	Rehabilitation	16.28

Abbreviations: ENT, ear, nose and throat; LOS, length of stay; OB, obstetrician.
[a]HFMH Cost Savings/Avoidance Tool. Copyright 2007 rev, Henry Ford Macomb Hospitals.

process of determining and evaluating CS/A choices.

DEMONSTRATION CASES

Examples of how this process is applied can be seen in the following cases taken from actual FCN individual interaction notes.

Case 1

The FCN writes,

Patient unable to afford prescriptions and therefore only takes cardiac and antihypertensives in half doses. Heart failure (HF) poorly controlled and patient is unable to leave the house because of fatigue and SOB. Referred to patient assistance program. Meds obtained. After six months of taking full doses of medications and FCN coaching in management of HF, the patient is now able to go shopping unattended. Quality of life improved.[12]

For this case, the nurse might document on the individual interaction form: CS/A diagnosis: "heart failure." She might also write in the note, "ED visit and hospitalization prevented." The FCN coordinator would then review the individual interactions associated with this client for the past 1 to 3 months and then decide whether the interventions provided this client by the FCN and her health ministry team prevented an ED visit, hospitalization, or both. For this case, the FCN coordinator found that other notes for this client indicated a steady deterioration that most likely would have resulted in a hospitalization. To record this CS/A, the FCN coordinator first clicks on the worksheet tab for the related DRG, in this case cardiovascular (CAR). Next, the coordinator places a "1" in the cell on the row for this patient's number under the "avoided cases" column representing an avoided hospitalization (see Table 1). The CS/A is $4 272.00 for

Table 2. Cost savings/avoidance summary sheet—Abbreviated diagram[a]

	Cases 1–5					Total dollars							
Tab	Cost to patient	Day cost	DRG product line	Average LOS	Avoided cases cost	Avoided days costs	ED visit	Nursing home/ month	Assisted living/ month	Compan/ week	Phys. off visit	Rehabilitation outpatient case	Total savings
CAR	4 272	1 064	Cardiovascular diseases	4.01	8 544 (2)	0	0	0	0	0	70 (1)	0	8 614
CVS	12 969	2 357	Cardiovascular/ thoracic surgery	5.50	0	0	0	0	0	0	0	0	0
MED	4 317	938	General medicine	4.60	0	0	0	0	945 (0.5)	0	0	0	945
SUR	10 973	1 549	General surgery	7.08	10 973 (1)	0	0	0	0	0	0	0	10 973
					$19 517	...	...	...	$945	...	$70	...	$20 532

Abbreviations: Ave. LOS, average length of stay; Compan/, companion per; CS/A, cost saving and avoidance; DRG, diagnosis-related groups; ED, emergency department; Phys off, physician office.

[a]The abbreviations under "Tab" are explained under "Product line." The summary sheet is automatically populated from the worksheet tabs. Cost savings and avoidances from the cases described in this article are shown for the purposes of this article. Five sample cases demonstrate $20 532.00 CS/A.

an "avoided case" (avoided hospitalization) in CAR (see Table 2).

The improvement of the quality of life for this client is evident from the FCN note; however, without the CS/A calculations, the additional value to the client and community in healthcare dollars saved might be missed. The client, his/her insurance provider (if any), and a healthcare system (if providing uncompensated care) would find this outcome very desirable!

Case 2

The FCN writes,

Once a month home and yard cleaning done by women and men's ministry. Shopping arranged every other week with assistance in meal preparation. Elderly couple ages 82 and 83 now able to stay in their own home a while longer and maintain some independence. Assisted living placement prevented.

The FCN lists the CS/A diagnosis as general medical and impaired home maintenance. In this case, the FCN coordinator records on the CS/A Tool using the "MED" tab for the "general medicine" DRG product line. After entering the client's electronic record number, the FCN coordinator enters the number of months of support for this couple into the cell, "assisted living per month (avoided)" column. Fractions of months can also be entered such as 0.5 for 2 weeks (see Table 2). This case represents a $945.00 CS/A to the client, the insurance payer, or both.

Case 3

The FCN writes,

Patient fell, broke hip (reports this as 3rd fall in two months) and required surgical placement of a pinned hip. Afraid of falling in home. Home assessed for safety. Rails and shower seat placed in bathroom. Tips placed on walker. Daily phone calls from senior's ministry support instituted. Reports no longer afraid of falling. Re-evaluated in six months. No falls in six months. Potential injuries related to falls avoided.

After checking the CS/A box to indicate CS/A resulting from her interventions, this FCN lists the "CS/A diagnosis" as orthopedic and potential for injury.

The FCN coordinator chooses the ORT worksheet tab and places a "1" in the "ED visit avoided" column. This case demonstrates a set cost savings of $410.00. Although some might choose to indicate a hospitalization avoided, the coordinators are instructed that if they are choosing between 2 equally plausible potential outcomes, to choose the outcome with the least number of dollars attached unless they are more than 75% sure otherwise. This is done to avoid inflation of CS/A.

Case 4

The FCN writes,

Patient has been on new antihypertensive for three days. Reporting dizziness and lightheadedness. Bilateral tingling in hands. Refused to go to ED. Medications reviewed. BP taken lying, sitting, and standing. Orthostatic hypotension noted. Physician's phone services contacted. Physician returned call. Following orders given: bed rest for eight hours, hold next dose of medication. Bp checked q four hours Xs two. On the next day, Bp in normal ranges. New medication held for three days based on parameters given by physician. Medication discontinued. ED visit prevented. Because of the history that the FCN knows: Hospitalization (potential medication overdose) and/or potential fall related to hypotension prevented.

The FCN coordinator lists this case on the CS/A Tool on the CAR tab since the DRG for the treatment of hypertension falls under cardiovascular diseases. The symptoms exhibited most likely would have resulted in a hospitalization. A $4 272.00 savings is effected and $70.00 for an avoided "physician office visit," which the FCN failed to note, but the FCN coordinator recognized (see Table 2) for $4 342.00.[13]

Case 5

The FCN writes in her notes that

Mr. M refusing colonoscopy (has done so for TWO years). Afraid of the pain. Procedure explained again. Mr. M made aware that he would

not experience any pain during the procedure. Prepared for the discomforts of the prep. Management of insulin dosages confirmed with physician's office. Procedure completed. Precancerous polyps removed. Hospitalization, and anticipated surgery avoided.[14(p30)]

The FCN documented this as an oncology case. The FCN coordinator, however, would use the SUR tab for the type of surgery avoided, general surgery. Although colon cancer would have required other treatments, credit is only taken for the general surgery ($10 973.00, see Table 2). The FCN coordinator makes the ultimate decision of CS/A. Coordinators from the various networks using the tool consult with one another on difficult judgments via phone and e-mails.

RESULTS

Table 3 shows data from 3 of the 4 FCN networks currently using CS/A. Each network reports its findings to institutional community benefit boards and executive teams (see Table 3). These results are indicators of the broad spectrum of services provided by FCNs and their health ministry teams as well as actual and potential CS/As to individual clients, payers, and communities.

The 3 networks depicted in Table 3 represent community-based institutionally supported systems of FCN and health ministry care. They are funded primarily by the operational budget of their institutions. FCN coordinators are paid by the health system while the FCNs are unpaid. Each network requires a written collaborative agreement with the FCNs' congregations, and FCNs, health ministry team members, or both who document utilize the network's Web-based documentation tool. Participation in identifying CS/As is not required but strongly encouraged. Seventy-three percent of the 106 FCNs who document individual interactions also document CS/As. Although 6 216 individual interactions were submitted for 1 756 individual

Table 3. Cost savings and avoidance data for 3 networks for calendar year 2008[a]

	Alegent Health, Omaha, NE	Henry Ford Macomb Hospitals, Clinton Township, MI	St. Joseph's Mercy Oakland Hospital, Pontiac, MI	Total
Number of congregations	49	42	51	142
Number of FCNs documenting individual interactions	42	37	27	106
Number of FCNs documenting CS/A	32 (76%)	27 (73%)	18 (67%)	77 (73%)
Number of individual interactions documented	1 880	3 296	1 040	6 216
Number of clients	694	743	319	1756
Number of clients with CS/A marked	134 (19%)	143 (19%)	183 (57%)	460 (32%)
Number of CS/As marked by FCNs	245	437	409	1091
CS/As verified by FCN coordinators	103 (42%)	251.5 (58%)	315 (77%)	669.5 (61%)
Total CS/A reported	$225 896	$280 050	$1 77 584	$6 83 530

Abbreviations: CS/A, cost savings and avoidance; ED, emergency department; FCNs, Faith Community Nurses.
[a]Henry Ford Macomb Hospitals. http://www.fcndocumentation.com internet application. Data from Alegent Health and St. Joseph's Mercy Oakland Hospital used by permission.

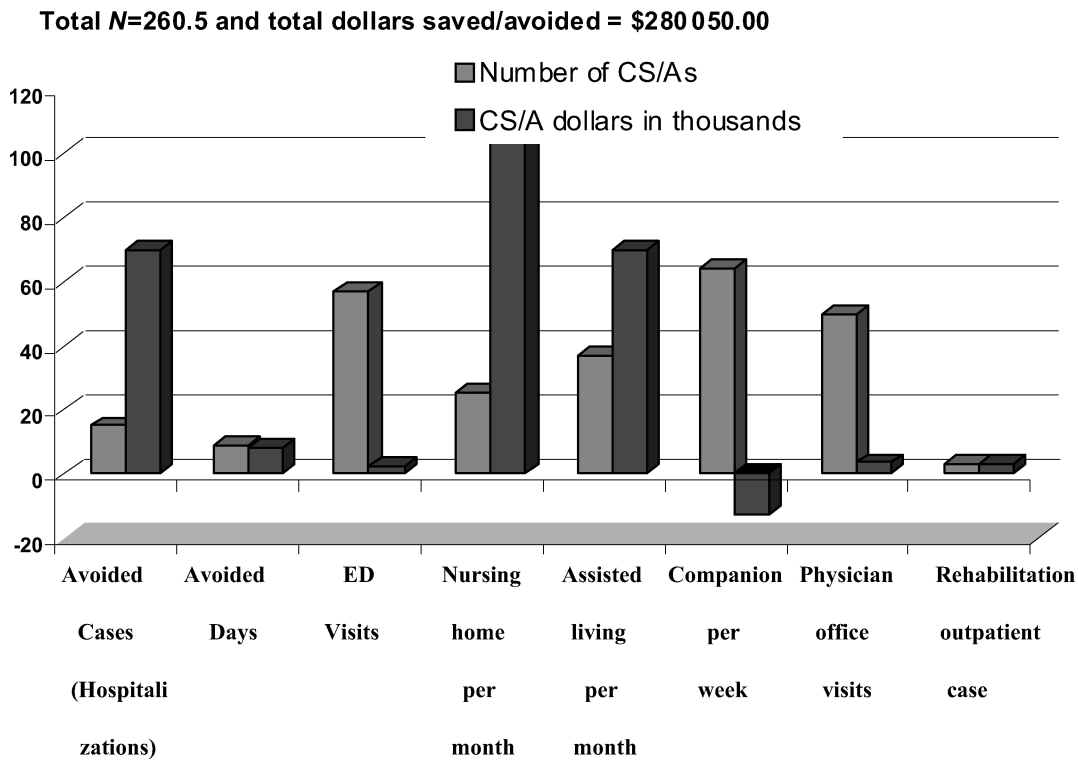

Figure 1. CS/As: Numbers and dollars for calendar year 2008; HFM FCN network. CS/A indicates cost savings and avoidances; ED, emergency department; FCN, Faith Community Nurse; HFMH, Henry Ford Macomb Hospitals.

clients, only 460 clients had CS/As identified as a part of their health ministry care. For these individual clients, FCNs marked 1 091 CS/As. FCN coordinators verified 669.5 CS/As (61%) as acceptable to be included on the measurement tool. These numbers indicate that there is critical review occurring in the process of gathering and reporting CS/As. A total of $683 530.00 is reported as CS/A for 3 FCN networks representing the work of 77 FCNs (for an average of $8 877.00 CS/A per nurse). Some FCNs report their individual results to their congregational supervisor.

Figure 1 is derived from the summary sheets of the HFMH FCN network and shows the number of interventions accepted by the HFMH coordinators as CS/A by CS/A categories and associated dollars saved for calendar year 2008. Figure 1 shows that 57 ED visits avoided represents 22% of the CS/As reported by 27 HFMH FCNs and $23 370.00 (8%) of the year's dollars saved.

Table 4 shows details for all categories. Fractions of time can also be recorded. For example, if the documentation for "nursing home per month" indicates only 2 weeks, then the FCN coordinator may enter 0.5 instead of "1" in the cell provided. When a companion is hired for a client, and the number of weeks of service are entered in the cell, the dollars will show up as negative and will be subtracted from the total.

The $280 050.00 saved and avoided by the HFMH FCN network represent a 1:1.4 cost benefit ratio for HFMH based on the operational budget for its FCN network. The HFMH network reports results of partnership with FCNs and health ministries to its corporate committee responsible for community

Table 4. Cost savings and avoidance reported by category by HFMH FCNs for calendar year 2008

	Avoided cases (hospitalizations)	Avoided days	ED visits	Nursing home per month	Assisted living per month	Compan/ week	Phys off visit	Rehabilitation outpatient case	Total number cases and dollars saved/ avoided
Number of CS/As	15 (6%)	9 (3%)	57 (22%)	25.5 (10%)	37 (14%)	64 (25%)	50 (19%)	3 (1%)	260.5
Dollars Saved or Avoided	$70 040 (25%)	$8 341 (3%)	$23 370(8%)	$114 750 (41%)	$69 930 (25%)	$−12 800 (−5%)	$3 290 (1%)	$2 919(1%)	$ 280 050.00

Abbreviations: Compan/, companion per; FCN, Faith Community Nurse; HFMH, Henry Ford Macomb Hospitals; Phys off, physician office.

benefit development and reporting and other interested healthcare and community partners. These measures are a part of HFHS and HFMH's community pillar strategic plans and reports.

CONCLUSIONS

Dollars saved and costs avoided demonstrate the power that FCNs contribute to the health and well-being of individuals, families, communities, and institutions. CS/As documentation helps FCNs and the networks with which they partner to tell the stories of their ministries in terms of quality of life improvements and dollars.[15] Interventions by FCNs and their health ministries allow families to avoid the costs of unnecessary emergency department and physician office visits.[13] They also help decrease unwarranted hospitalizations,[16] assisted living and nursing home placements by providing early interventions, ongoing chronic disease management assistance,[17] and in-home supports. Although it is clear that measures of CS/A are not precise and that study of interrater reliability is needed, CS/A remains a strong means of indicating the power of volunteerism, community partnerships, and faith community nursing to positively impact the cost of healthcare and quality of life of those in need across the United States. Because not all FCNs document CS/As and because a significant percentage of the CS/As marked are not accepted as valid, the authors believe that the data reported in Table 3 is the proverbial "tip of the iceberg." Studies are needed to validate the authors' belief that much more CS/A is being accomplished than is reported.

Administrators and institutional finance teams who are aware of the difficulty of demonstrating measurable outcomes in community settings will appreciate the use of the CS/A Tool to help quantify the value of dollars spent to improve the health and quality of life of the communities served. Use of CS/A data may assist FCN networks to gain acceptance from and integration into operational supports of sponsoring agencies needing

measurable outcomes to justify community benefit dollar expenditures and to fill gaps in services from acute care to self-management of health and disease by individuals. This acceptance and integration may serve to provide longevity and security of financial allocations to support FCNs, health ministries, and their FCN networks.[18]

REFERENCES

1. Health Ministries Association. *Faith Community Nursing: Scope and Standards of Practice.* Silver Spring, MD: American Nurses Association; 2005.
2. Brown A. Documentation: transforming image, ministry and health. Paper presented at: the Health Ministries Association Annual Meeting; June 2006; Durham, NC.
3. O'Brien ME. *Parish Nursing: Healthcare Ministry Within the Church*. Sudbury, MA: Jones and Bartlett; 2003.
4. Henry Ford Macomb Hospitals. *Community Benefit Report: Henry Ford Macomb Hospitals Selected Categories—Detail for Period From 1/1/2008 Through 12/31/2008.* Clinton Township, MI: Henry Ford Macomb Hospitals; 2009.
5. News from around the world of parish nursing. *Parish Nurse Perspectives.* 2008;7(1):8.
6. Zerull L, Solari-Twadell PA. Looking back: preparation for creating new horizons in parish nursing. Paper presented at: the International Parish Nurse Resource Center 20th Annual Westberg Symposium; October 2006; St Louis, MO.
7. Schafer S. First parish nursing program launched in Bethlehem. *LCMS World Relief and Human Care Newsletter*; 2007:1–2.
8. King MA, Tessaro I. Parish nursing: promoting healthy lifestyles in the church. *Journal of Christian Nursing.* 2009;26(1):22–24.
9. Levenson HA. Community benefit: how much is enough? *Healthcare Financial Management.* 2008;62(3):44–49.
10. Internal Revenue Service. *Form 990 Redesign for Tax Year 2008 Schedule H, Hospitals—Highlights*. Washington, DC: Internal Revenue Service; 2007.
11. Centers for Medicare & Medicaid Services. List of diagnosis-related groups (DRGs), FY 2004. http://www.cms.hhs.gov.hhs.gov/MedicareFeeforSvcPartsAB/Downloads/DRGdesc04.pdf. Accessed April 23, 2009.
12. Freeman JD, Kadiyala S, Bell JF, Martin DP. The causal effect of health insurance on utilization and outcomes in adults: a systematic review of US studies. *Medical Care.* 2008;46(10):1023–1032.
13. Zed PJ, Abu-Laban RB, Balen RM, et al. Incidence, severity and preventability of medication-related visits to the emergency department: a prospective study. *Canadian Medical Association Journal.* 2008;178(12):1563–1569.
14. Flood M, Buckwalter KC. Recommendations for mental healthcare of older adults, 1—an overview of depression and anxiety. *Journal of Gerontological Nursing.* 2009:35(2):26–34.
15. McCabe J, Somus S. Faith community nursing: meeting the needs of seniors. *Journal of Christian Nursing.* 2009;26(2):104–109.
16. Vasquez MS. Preventing re-hospitalization through effective home health nursing care. *Professional Care Management*. 2009;14(1):32–38.
17. Meyerson KL, Kline KS. Utilization analysis of a mutual goal-setting intervention in participants with heart failure. *Heart and Lung.* 2009;38(1):1–9.
18. Ezekowitz JA. What price to pay? The cost of everything and the value of nothing. *Circulation.* 2009;119(3):368–370.