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Perceived Effects of Faith Community Nursing on Quality of Life and Overall Health

Vicie Renee Rutherford

Perceived Effects of Faith Community Nursing on Quality of Life and Overall Health

by

Renee Rutherford

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Submitted by:	Approved by:
_____	_____
Renee Rutherford	Abby Garlock, DNP, RN, LCCE
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Date	Date

Abstract

Faith Community Nursing (FCN) is a nursing practice specialty that focuses on the intentional care of the spirit, the promotion of an integrative model of health, and the prevention and minimization of illness. The FCN nursing specialty is believed to be an effective specialty to reverse the trend for declining health by aiding in the improvement of quality of life (QoL) and overall health for increasing numbers of people with multiple health problems; however, minimal research data and literature was available to substantiate the claim. This MSN thesis explored the relationship between FCN ministries and QoL and health by conducting a retrospective, qualitative study. A purposive sample of FCNs was chosen initially and expanded by a networking sample of parishioners referred by FCNs. Participants were interviewed, and data was analyzed for common themes. The Theoretical Model of FCN was used as a guide which allowed for comparison of retrospective data and aided in identifying and organizing common themes in pursuit of wholistic care, which includes faith integration and incorporates health promotion, disease management, coordination, empowerment, and access to care. A perceived positive impact of FCN ministries on QoL and health was manifest throughout the interviews. This information may be beneficial to expand FCN as a nursing practice and may benefit all nurses by improving understanding concerning the impact of spiritual care on QoL and health.

Keywords and phrases: Faith Community Nursing, parish nurse, quality of life, faith and health, health improvement, health disparities, coordination of care, case management, 30-day readmissions, transitional care, disease prevention, spirituality in healthcare, holistic care, and wholistic care.

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CHAPTER I

Introduction

Faith Community Nursing (FCN) is a "nursing practice specialty that focuses on the intentional care of the spirit, the promotion of an integrative model of health, and the prevention and minimization of illness" usually within faith communities (American Nurses Association and Health Ministries Association [ANA & HMA], 2010, p. 8). As FCN continues to expand since first recognized by the ANA as a nursing specialty in 1997, faith community nurses are more committed to evidence-based practice and greater specialization. With support from the Westberg Institute (WI), FCN continues to grow and integrate into many different settings, such as community centers, hospitals, and long-term care facilities (Eastridge, 2018).

In an era of a financially overwhelmed health care system trying to provide care to increasing numbers of people with poor quality of life (QoL) due to multiple health problems, FCN may be the ammunition that is needed to reverse the trend for declining health by aiding in the improvement of QoL and overall health; however, data is needed to affirm this speculation. Faith community nurses often focus on the care of underserved populations or those who are unable to advocate for themselves. By doing so, FCN can help relieve some of the burden on a health care system that is struggling to provide adequate continuity of care due to insubstantial resources (Pappas-Rogich & King, 2013). Advantages of FCN are revealed through the FCN conceptual model which embraces concepts of faith integration, health promotion, disease management, coordination, empowerment, and access to health care (Ziebarth, 2014). The multitude of contributions to the health of faith communities through partnerships between FCN, individuals,

families, congregations, and communities across the life span is expected to result in better overall health and QoL for those served by faith community nurses (Church Health Center, 2014a).

Significance

Healthy People 2020 (n.d.--b) is a nationwide initiative to improve health by identifying and increasing awareness of determinants of health, disease, and disability and setting goals for health improvement. Though many improvements have been made since goals were set in December 2010, the Healthy People 2020 Midcourse review (n.d.--b) reported that mental health disorders and oral health has worsened, and there has been little or no detectable change in nutrition and weight status or binge drinking. In 2017, the American Heart Association reported more than one in three adults have cardiovascular diseases in the U.S. and "the number of people diagnosed with heart failure is increasing and is projected to rise by 46% by 2030, resulting in more than eight million people with heart failure" (American Heart Association News, 2017, para. 1).

The National Cancer Institute (n.d.) reported an estimated 15.5 million cancer survivors in the U.S. in 2016 and projected the number of cancer survivors to increase to 20.3 million by 2026. A new 2018 report by The National Cancer Institute projected 1,735,350 new cases of cancer will be diagnosed in the U.S. and 609,640 of those diagnosed will die. According to the Centers for Disease Control and Prevention (CDC) (n.d.-b, para. 1) each year more than 795,000 people in the U.S. have a stroke, which is the "leading cause of serious long-term disability" and "reduces mobility in more than half of stroke survivors age 65 and over". In addition, a 2018 report by the National Institutes of Health (NIH) stated 16 million people are diagnosed with chronic obstructive

pulmonary disease (COPD), a disease that debilitates and kills, and millions more do not know they have it.

According to the National Center for Health Statistics, the top five causes of death in the U.S. in 2016 were heart disease, cancer, accidents, chronic lower respiratory disease, and stroke, respectively (Heron, 2018). Cardiovascular diseases accounted for 807,775 deaths according to a 2017 report and the death rate for COPD has doubled since 1969 (American Heart Association News, 2017; NIH, 2018). Leading causes for these diseases include poor diet, tobacco, alcohol, and lack of exercise indicating many of the reported deaths and diseases are preventable (McNamara, 2014).

As a means of controlling the astonishing cost of health care, the Affordable Care Act was passed in 2010 and Medicare established a new payment plan that included a readmission reduction program to lower readmission rates for hospital discharge in which hospitals receive payment penalties for certain diagnoses such as COPD, congestive heart failure (CHF), and pneumonia under the Inpatient Prospective Payment System (Zuckerman, Sheingold, Orav, Ruhter, & Epstein, 2016). In 2015, Modern Healthcare reported that only 799 of more than 3,400 hospitals performed well enough in 2015 to avoid penalties in 2016 (Rice, 2015). Ziebarth and Campbell (2016) claims that FCN can help with readmission reduction goals by helping patients to avoid deterioration of clinical conditions and medical errors.

Decades of research has shown that spiritual care has substantial effects on patients' overall health outcomes, and most modern nursing theorist agree nursing care must be holistic, including the mind, body, soul, and spirit; however, only 54%- 63% of hospitals employ chaplains to assess and meet patient spiritual care needs, although The

Joint Commission (TJC) (2010) now requires spiritual assessment (HealthCare Chaplaincy Network, and The Spiritual Care Association, 2017). In addition, few physicians or nurses have any formal training in spiritual assessments or providing spiritual care, although the Institute of Medicine (IOM) promotes frequent assessment of patient spiritual well-being and states that "attention to patient spiritual and religious needs should be among core components…of care" (Healthcare Chaplaincy Network, 2016, p. 12). The Joint Commission also suggested that quality improvement opportunities exist in the emotional and spiritual experience of hospitalized patients and recommended improvements that include developing standards for meeting the emotional and spiritual needs of patients (Healthcare Chaplaincy Network, 2016). The IOM's core competencies include providing patient-centered care, which incorporates physical, psychological, social, and spiritual needs, as well as providing basic spiritual care (Institute of Medicine, 2003).

According to the Health Care Chaplaincy Network, 87% of patients in one study reported spirituality is important in their lives and 72% of patients reported receiving minimal to no spiritual support from their health care team (Healthcare Chaplaincy Network, 2016). Studies have also validated that a person's beliefs in his/her health status are strongly associated with his/her perception of quality of life (Schuler, 2015). In fact, Schuler (2015) found that a person's beliefs in his/her health status is a significant predictor of his/her quality of life, but age, income, and physical or mental health was not.

The FCN specialty focuses on the intentional care of the spirit and has been evolving, since the ANA first recognized it as a nursing specialty in 1997, to include

numerous services believed to produce positive outcomes, such as bridging gaps between faith and health communities (Dandridge, 2014). Other leading roles of faith community nurses include health promotion, preventative care, and advocacy (Church Health Center, 2014a). Over the past 20 years, an abundance of supportive literature has emerged recounting FCN as a means for providing wholistic care with intentional focus on the spirit, but little is known about the effectiveness of FCN missions because data concerning the efficacy of the specialty is limited (Mock, 2017). Although it is believed that FCN missions will result in better overall health and QoL with cost saving as a likely biproduct for those served by FCNs, research to substantiate the belief is scant and little is known about the effectiveness of this nursing specially (Dandridge, 2014). One of few studies showed that after implementing a FCN program for employees at a theme park in Georgia, the company experienced a "company-wide reduction in health insurance payouts for illness or injury. This resulted in no premium increases over several years compared to an industry standard of 6% premium increases per year" (Parker, 2018, p. 3). Though the study provides valuable support for FCN, additional studies are needed to demonstrate the value of FCN.

Purpose

Though FCN makes many contributions to the heath of faith communities that are expected to result in better overall health and QoL for those served by faith community nurses, the claim has not yet been proven (Church Health Center, 2014c). The purpose of this MSN thesis was to explore the relationship between FCN ministries and QoL and overall health. This qualitative study seeks to provide evidence concerning FCN observations and parishioner's impressions of FCN ministries.

Theoretical or Conceptual Framework

The Theoretical Model of FCN was used to guide the study. The Theoretical Model of FCN is a relatively new and evolving theory based on concepts of relationships between clients and nurses with the primary purpose of pursuing wholistic care, which includes faith integration and incorporates health promotion, disease management, coordination, empowerment, and access to care (Ziebarth, 2014). The new conceptual model for FCN can be viewed in the Appendix. As defined by the theoretical model, clients in this study may include the person, family, group, or community and are believed to be individualistic, complex, and wholistic beings (Ziebarth, 2014). Faith community nurses must hold a current license as a registered nurse and additional FCN education that enhances the nurse's ability to "integrate current nursing, behavioral, environmental, and spiritual knowledge with the spiritual beliefs and practices of the faith community into a program of wholistic nursing care" (ANA & HMA, 2010, p. 4). The Theoretical Model of FCN allowed for comparison of the retrospective data collected and aided in identifying and organizing common themes (Figure 1). Interviews were conducted via telephone conferencing during which open end questions led to discussion.

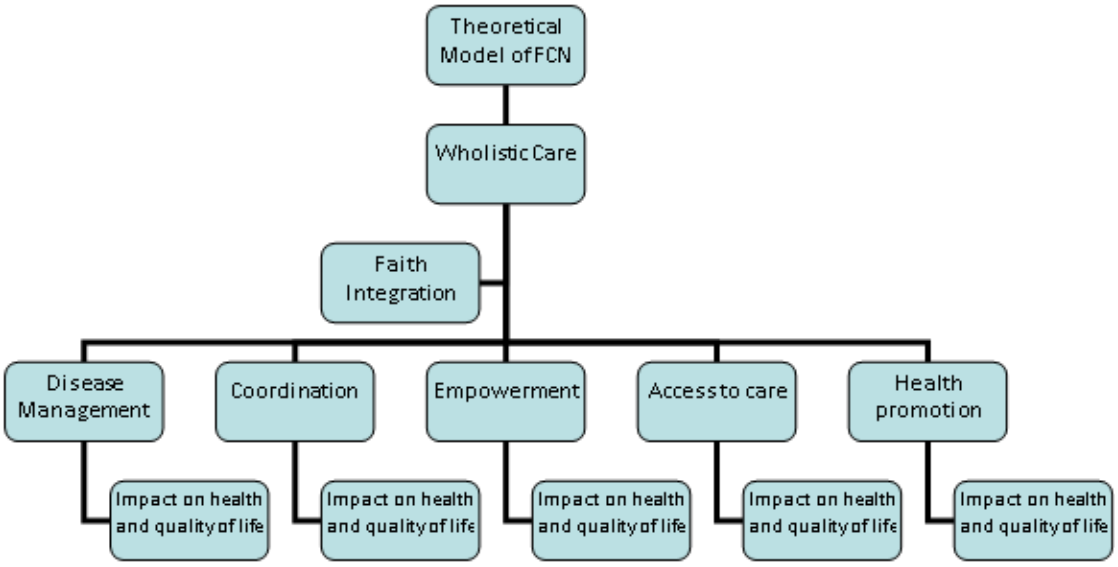

Figure 1: Conceptual-Theoretical-Empirical (CTE) Diagram

Thesis Question

The research question for this MSN Thesis was, "What is the effect of faith community nurse ministries on quality of life and overall health?" Participants included faith community nurses and parishioners who have been served by faith community nurses, therefore, participants were already familiar with FCN. Participants were asked to include any spiritual, physical, psychosocial, and/or educational impact after interactions with a FCN within their answers. The question aided in revealing faith community nurse's and parishioner's feelings about FCN missions.

Definition of Terms

- Congregations: faith communities consisting of an organized body of believers that include multiple faiths, religions, and/or denominations who usually meet for worship and religious instruction

- Faith Communities: congregations of faith consisting of an organized body of believers that include multiple faiths, religions, and/or denominations who usually meet for worship and religious instruction
- Faith Community Nursing (FCN): a "nursing practice specialty that focuses on the intentional care of the spirit, the promotion of an integrative model of health, and the prevention and minimization of illness" usually within faith communities and previously referred to as Parish nursing (ANA & HMA, 2010, p. 8).
- Health: "a statement of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" as described by the World Health Organization (WHO) in 1948 (Church Health Center, 2014c, p. 2).
- Health Communities: refers to organized groups of health professionals with the primary purpose of providing health care such as health organizations and facilities such as hospitals, skilled nursing facilities, rehab facilities, home care agencies, hospice agencies, health care provider offices, and health clinics
- Parishioner: a member of a parish, congregation, or faith community
- Quality of life: a personalized, or person specific, complex measure of a multidimensional concept that usually includes subjective evaluations of both positive and negative aspects of life and usually consisting of concepts such as health status, jobs, housing, schools, the neighborhood, with contributions from culture, values, and spirituality (Centers for Disease Control and Prevention [CDC], n.d.-a).
- Wholistic: care based on an understanding that a health care consumer is an interconnected unity and that physical, mental, social and spiritual factors need to

be included in any interventions. The whole system, whether referring to a human being or a faith community, is greater than the sum of its parts. This is the preferred term when referring to the type of care provided by a faith community nurse. (Church Health Center, 2014b, p. 3) The word wholistic is commonly referred to holistic. Both wholistic and holistic are used in this Thesis based on whether FCN is involved.

Summary

This MSN Thesis explored faith community nurses and parishioners perceptions of FCN missions on QoL and overall health. Effective measures for improving QoL and health are needed because the number of people with poor QoL due to multiple health problems continues to increase. Because FCN is a relatively new nursing specialty, research literature is limited. Although faith community nursing is believed to effectively improve the lives of those served with the potential for reducing overall cost of health care, research is needed to authenticate the subjective observations of faith community nurses and clients served by FCN missions. This MSN Thesis hopes to add value to the FCN specialty as an evidence-based practice effective for improving the QoL and overall health of those it serves.

CHAPTER II

Literature Review

The purpose of this study was to explore the perceived relationship between Faith Community Nurse (FCN) ministries and quality of life (QoL), and overall health among FCNs and those served by FCNs. Faith Community Nursing focuses on concepts of faith integration, health promotion, disease management, coordination, empowerment, and access to healthcare, and offers multiple contributions to health through partnerships between FCN, individuals, families, congregations, and communities across the life span (Church Health Center, 2014a). Many believe that the implementation of FCN ministries can lead to better overall health and QoL for those served by FCNs (Ziebarth, 2014). The need for improved health is well documented, as is FCN as a means for providing wholistic care with intentional focus on the spirit, yet little is known about the effectiveness of FCN missions on QoL and overall health due to the scarcity of research and literature in this area (Mock, 2017). This MSN thesis explored the perceived relationship between FCN ministries, QoL, and overall health by conducting interviews in which the Theoretical Model of FCN was used to compare retrospective data collected during the interviews to identify and organize common themes.

A literature review was conducted using database research retrieved using Bulldog Onesearch at the University, CINAHL, Pub Med, and Google Scholar, in addition to recommendations of scholars on the Westberg Institute, FCN Research Group platform on Yammer, a communication platform used by FCNs. Key words and phrases used included: Faith Community Nursing, parish nurse, quality of life, faith and health, health improvement, health disparities, coordination of care, case management, 30-day

readmissions, transitional care, disease prevention, spirituality in healthcare, holistic care, and wholistic care. Though thousands of articles were retrieved, only 21 articles matched the goals of this MSN thesis. Literature used was published between 2001 and 2018 with all but one article being published in the U.S. The other article was published in Britain.

Literature Related to Unclear Outcomes of Faith Community Nursing

Parish nurses provide many valuable interventions to diverse populations; however, they do not successfully document outcomes (Dandridge, 2014). A systematic, integrative review of 22 descriptive and qualitative studies published between 2008 and 2013 identified common interventions used by parish nurses in the U.S. but found minimal data to validate the value of parish nurse programs. The literature review uncovered a significant need for additional research to explore the efficacy and value of parish nursing (Dandridge, 2014).

Literature Related to the Need for Health Improvement

As a result of Medicare's hospital Inpatient Prospective Payment System (IPPS), the majority of hospitals were projected to face penalties in 2016 based on the readmissions reduction program, created under the Affordable Care Act (Rice, 2015). The IPPS and readmissions reduction programs were initiated as healthcare quality improvement and cost reduction strategies. According to data collected by Centers for Medicare and Medicaid Services (CMS)(n.d.) "only 799 out of more than 3,400 hospitals" performed well enough in 2015 to avoid penalties related to 30-day readmissions (Rice, 2015, p. 2). Under the readmissions program, CMS evaluated patients for 30-day readmissions who were treated for heart attack, heart failure, and pneumonia in 2014. In 2015, they included patients with chronic obstructive pulmonary

disease (COPD) and total hip and total knee replacements. Penalties for 30-day readmissions also rose from 2% in 2014 to 3% in 2015. This has made a significant impact on hospitals with the number of facilities facing financial penalties increasing by 55 facilities to 2,665 (Rice, 2015). The readmission reduction program is not without criticism. Health policy researchers and industry groups representing U.S. hospitals argue that hospitals are being unfairly penalized because many factors affecting 30-day readmissions, including poor communities, are outside the control of hospitals. Though the article may not be considered research literature, the report of data offers significant support for the need for health improvement as a means of cost reduction.

Intensive case management has been found to be an effective measure for reducing acute care utilization and healthcare costs as well as increase utilization of primary care (Glendenning-Napoli, Dowling, Pulvino, Baillargeon, & Raimer, 2012). A retrospective study of healthcare utilization and associated costs among patients enrolled in community case management was conducted. Participants included 83 uninsured patients with one or more chronic diseases who were enrolled in a case management program. A systemic review and paired t-tests were used to compare utilization and costs pre- and post- enrollment in a case management program between April 2007 and August 2008. The study revealed a decrease in acute outpatient encounters by 62% and a decrease in inpatient admissions by 53%. Primary care visits increased by 162%. A 41% decrease in cost was also noted (Glendenning-Napoli et al., 2012). The high utilization of acute care services and high costs of care prior to the intervention indicates a need for health improvements. Though the results may be skewed because the researcher failed to factor in the administrative costs when calculating cost savings and the study was limited

by a convenience sample of uninsured clients from a single hospital, the study supports community case management as a likely measure for improving health (De Vriendt, Peersman, Florus, Verbeke, & Velde, 2016).

Literature Related to Quality of Life

The Centers for Disease Control and Prevention incorporates data from multiple studies and defines health related quality of life (HRQoL) as "an individual's or group's perceived physical and mental health over time" (Centers for Disease Control and Prevention [CDC], n.d.-a, para. 3). It is important to note the CDC using Healthy Days measures, and a specific integrative set of broad questions about recent perceived health status to measure HRQoL. This permits health agencies and researchers to address common themes as related to public policy including social services, community planners, and business groups.

Several studies suggest that relational spirituality (RS) is associated with health benefits and QoL (Counted, Possamai, & Meade, 2018). A review of 20 empirical, cross-sectional, longitudinal, and quantitative studies performed between 2007 and 2017 revealed 12 of the studies reported positive associations between RS and QoL, while three studies showed a negative association between RS and QoL, and five did not show a significant association. Of the three studies that showed a negative association, sexual QoL was specifically stated as having a negative association, but the inferences were not found to be valid when factors such as gender, age, anxiety, neuroticism, extraversion, follow-up time, daily smoking, infrequent exercise, negative outlook, and positive outlook were controlled (Counted et al., 2018). Of the five studies that did not show an association between RS and QoL, two supported indirect associations between RS and

QoL. The integrative research review was limited by a lack of specific measures of QoL and varied meanings of terms within the studies. Although results may depend on the researcher's definition of terms, the review of literature supported the potential benefit of spiritual coping in the healing process and QoL (Counted et al., 2018).

Religiosity was found to be multidimensional and associated with overall better QoL and protection against diseases (Mishra, Togneri, Tripathi, & Trikamji, 2017). A positive relationship between religiosity, health, and QoL was supported in a comprehensive literature review of 126 evidence-based studies and reports between the dates of 1983 and 2014. Findings included a negative association between religiosity and onset of disease and progression of diseases. Although the study found the association between religiosity and QoL to be undeniable, the review also revealed many aspects of religiosity in need of further investigation to assure validity and reliability. Specifically, the literature was lacking in randomized, double-blind control studies, and longitudinal studies (Mishra et al., 2017).

Client-centered and activity-oriented interventions are thought to be effective measures of improving basic activities of daily living (ADLs) and health related quality of life (De Vriendt et al., 2016). A single blind, randomized controlled trial consisting of an intervention group and a control group was conducted. The intervention group included 86 community dwelling, frail, older, adults, and the control group included 82 community dwelling, frail, older, adults. Only the intervention group received client-centered and activity-oriented interventions. Following the intervention, the intervention group was found to have significantly more improvement in ADLs than those in the control group, but no significant difference in physical function or vitality was noted. The

study may have been limited by possible variations in implementation of interventions and the attitudes of professionals during the implementation and interview phases, as the study was conducted by several occupational therapists (De Vriendt et al., 2016). There was little discussion concerning the correlation between ADL and quality of life in this study, but if ADL is an indicator of QoL, this study supports client-centered care as a measure for improving QoL.

Subjective perceptions of health have been shown to be a better indicator of QoL than physical or mental health (Schuler, 2015). A case controlled, cross-sectional study of 150 adults in a free employment training program from 2011 to 2012, in a mid-Atlantic urban city was conducted using an adapted version of the Ferrans and Powers QoL index. The study concluded that perceptions of current health was a better predictor of QoL than the presence of a serious physical or mental health condition. Participants included people from a variety of minorities; however, measures of the study may have been skewed by the reliance on participate self-reports and limitations of adults from an urban city. Though subjective perception seems to be a good indicator of QoL, causal relationships between health and QoL could not be established in the study. Though the Ferrans and Powers QoL index has been established as a standardized, reliable measure of QoL, the altered version has not yet been validated.

Literature Related to Faith Community Nursing

The FCN model of community-based practice incorporates measures to address Healthy People standards (King & Pappas-Rogich, 2013). A descriptive, qualitative study of 120 parish nurses was conducted to determine if FCN interventions address strategies mandated by Healthy People 2010 Critical Health Indicators, the International Parish

Nurse Resource Center functions of the parish nurse, and the American Nurses Association (ANA) Scope and Standards for FCNs. A Parish Nurse Questionnaire was developed by two authors using the Healthy People 2010 Critical Health Indicators, the International Parish Nurse Resource Center functions of the parish nurse, and the ANA Scope and Standards for FCNs, and was submitted to a purposive sample of parish nurses across 30 states and 15 denominations. Parish nurses most frequently reported functions of health counseling, referrals, education, advocacy, and integration of faith and health (King & Pappas-Rogich, 2013). The study established that FCN successfully addresses health promotion and wellness interventions, but additional studies are needed to demonstrate the effectiveness of FCN.

Evolution of faith community nursing. Faith community nursing is an evolving specialty. From its founding in 1984 as a vision for how nurses and churches could work together, parish nursing is expanding its reach into other community healthcare settings and organizations. In an article, an expert in the field suggested that with over 30 years of evolving data, the nursing specialty has grown beyond the term parish; therefore, the term faith community nursing has been adopted and better describes the concepts of spiritual and physical health promoted by the nursing practice (Eastridge, 2018). As evidence of a continued morphing of FCN, the expert reported FCN continues to expand with "limitless horizons" and is becoming more committed to evidence-based practice and specialization (Eastridge, 2018, p. 7).

A new evolutionary concept analysis method has been chosen to define FCN. Although FCN is a relatively new concept, a recent study indicated evolutionary conceptual changes have already occurred, including changes in labels, roles, and

environments. A systematic review of 124 theoretical articles, studies, and concept analyses from 1990 to 2011 was conducted by an expert in FCN to report an evolutionary concept analysis of FCN. Literature was examined for antecedents, attributes, and consequences of the concept using Rodgers' evolutionary analysis to gain an understanding of the historical and social nature of the concept and how it changes over time (Ziebarth, 2014). The resulting, proposed theoretical definition of FCN is:

> 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, p. 1831)

An evolutionary concept analysis is necessary because FCN is ever changing, and the concept will continue to evolve. The evolutionary concept analysis may be beneficial as a foundation for additional FCN research studies (Ziebarth, 2014).

A FCN Transitional Care Model has been developed to specify care that occurs pre and post hospitalization to support patients in transition from one level of care to another (Ziebarth & Campbell, 2016). The Transitional Care Model is the result of a systematic literature review of predictive factors of 30-day readmissions and readmission

reduction strategies published between 2006 and 2015. The model begins with a referral, usually while a patient is in the hospital, and allows for the FCN to earn the patient's trust prior to discharge. The model follows the patient after discharge from the hospital as the FCN remains approachable and available with a goal of assisting clients to achieve self-care or caregiver independence within 60 days (Ziebarth & Campbell, 2016). Faith community nurses have been providing transitional care services for many years. Development of "the FCN Transitional Care Model offers a professional guidebook for FCNs and hospitals to offer consistent, high quality care" as a means of moving toward wholistic heath, and avoiding unnecessary readmissions (Ziebarth & Campbell, 2016, p. 117).

Health improvement and faith community nursing. The greatest asset of FCN for health improvement may be its ability to achieve consistency and build trust between parishioners and faith communities (Schroepfer, 2016). A literature review of 32 sources, including one case study, was conducted to explore how FCN is uniquely positioned to meet health challenges of older adults. Faith community nurses have been found to be instrumental in collaborating with congregations and members of the community to provide care to patients transitioning from the hospital and coordinating services for those disconnected from the healthcare system. Though research suggests that FCNs are uniquely poised to help meet healthcare challenges, the available research has focused on small projects leaving the benefits of FCN poorly supported. Additional research is needed to better explore the comprehensive ramifications of FCN practice (Schuler, 2015).

Parish nursing may enhance the work of community nurses by providing additional sources of holistic care and health promotion (Wordsworth, Moore, & Woodhouse, 2016). A review of ongoing quantitative and qualitative data, as reported by parish nurses in the UK between November 2014 and November 2015, was conducted to examine the effectiveness of parish nursing to improve health outcomes and support the work of district and community nurses. The data review found that most reports highlighted the positive aspects of the parish nursing model; however, it was noted that the service was limited to clients in locations where congregations and nurses had taken the initiative to implement the parish nurse model. Partnerships with parish nurse services is recommended to assist with efforts to meet community health needs and contain the cost of health care. Investments into these partnerships will require efforts to increase awareness of the model, so it may expand to other communities (Wordsworth et al., 2016).

It is a common belief among parishioners that the church should play a role in helping its members meet their health needs (Swinney, Anson-Wonkka, Maki, & Corneau, 2001). A large urban Massachusetts congregation recruited a school of nursing to conduct a case-controlled study via community survey to determine the health status of its members, identify their health needs, risk factors, and perceived barriers to develop a health program for the faith community. A health questionnaire was adapted from a questionnaire developed by the National Parish Nurse Association to reflect a holistic approach to health including physical, psychosocial, and spiritual aspects, and approved by the congregation's health council. Four hundred and twenty-one of 800 questionnaires made available were completed and returned for the study. In addition, six focus group

discussions were held with 17 church members chosen by willingness to participate. Though the study may have been limited by members who did not choose to participate and the reliance on members to self-report, the results of the surveys revealed most parishioners felt they were in good health, believe faith and spirituality are important in maintaining health, and thought the church should play a role in helping its members meet their health needs (Swinney et al., 2001). Reliability of the study was achieved by involving third party researchers and results of the study were validated by focus group discussions.

A parish nurse intervention program has been found to be effective in improving self-reported, health promoting, behaviors (Mendelson, McNeese-Smith, Koniak-Griffin, Nyamathi, & Lu, 2008). In a randomized controlled trial with a convenience sample of 100 Mexican American women, at an outpatient treatment clinic for gestational diabetes, 49 women received a supplementary diabetes education session and reinforcement by a parish nurse, while the remaining 51 women received care as usual. Results of the study showed a significant improvement in self-reported, health-promoting, behaviors among the intervention group; however, no significant differences in glycemic control, macrosomia, or days of maternal or neonatal hospitalization were noted. Because the study was limited to one education session, sample size, and demographics it cannot be generalized. However, it supports parish nursing as an effective tool for health promotion. With this in mind, continued investigation is needed to identify sources to meet the needs of vulnerable populations (Mendelson et al., 2008).

Parish nurses working in congregational settings feel they make the greatest impact through health promotion, prevention, advocacy, health education, and health

counseling through psychosocial support and spiritual care (Chase-Ziolek & Iris, 2002). Seventeen parish nurses in a hospital-sponsored, volunteer health ministry program participated in a qualitative study to gather parish nurses' perspectives on distinctive aspects of providing nursing care in a congregational setting. Data was gathered through a focus group and interviews. Though parish nurses reported challenges of providing care in a congregational setting that included autonomy, religious beliefs, and time constraints, the study suggests that parish nurses provide valuable care that may benefit the traditional care system (Chase-Ziolek & Iris, 2002).

One study showed FCNs were valued over other healthcare professionals because they were more accessible and were able to use nursing knowledge to support families in the community. A systematic review using a convenience sample of 10 participants, including three FCNs from two congregations, and seven of their clients was used to conduct a qualitative study to explore what FCNs offer their communities, and whether clients receive all the services and support offered by FCNs (Mock, 2017). The qualitative research platform, NVivo 10 was used to code the data and revealed frequently recurring topics including tasks and services offered, nursing expertise, spirituality, familiarity, and community support. Though the survey was not extended to the entire faith community which may have uncovered additional perspectives, the sample size was thought to be sufficient due to the presence of recurring themes. Limitations of the study included FCN role ambiguity. It was often difficult for participants to describe services provided by FCNs individually, but a clearer picture emerged when content of the interviews was viewed collectively. The study was also

limited to one community. To better support the value of FCN, further research is needed to explore the benefit of specific services (Mock, 2017).

Faith community nursing and cost reduction. Cost savings is often difficult to demonstrate but one case study revealed unexpected saving following the implementation of a FCN program (Parker, 2018). A large theme park implemented a FCN program to serve over 1,000 employees. The FCN attended to employee health concerns, provided support during times of grief and loss, promoted wellness, and made herself available by conducting venue-to-venue rounds for over eight years. The FCN program was found to be so successful, it was duplicated at other parks. Although quantifying outcomes was found to be difficult, the case study revealed a company-wide decrease in health insurance pay outs for illness or injury which resulted in no insurance premium increases as compared to an industry standard of 6% annual increase (Parker, 2018). Although the case study does not provide adequate data to correlate insurance premiums directly to FCN interventions, it suggests that FCN played a role and lays the groundwork for additional research.

Faith community nursing and quality of life. Faith-based programs that focus on disease and injury prevention can improve health and QoL (Pappas-Rogich & King, 2013). A literature review of eight sources from 2002 to 2012 were cited in an article of expert opinion to explore the philosophy, objectives, growth, and practice of FCN. The roles of FCNs were listed as integrator of faith and health, health educator, health counselor, referral advisor, health advocate, developer of support groups, and volunteer coordinator. Though the article only provided a glimpse into the philosophy and practice interventions of FCN, it was recognized that FCN promotes health and healing, and

empowers others to take an active role in their own health (Pappas-Rogich & King, 2013). The philosophy, objectives, and practice of FCN is thought to lead to better health outcomes and QoL, but research is needed to substantiate this thought.

Faith community nursing and spirituality. Patients of parish nurses who face health challenges experience renewed spiritual identity (Van Dover & Pfeiffer, 2012). A purposive sample of 20 patients referred by parish nurses participated in a grounded theory, qualitative study to explore their experiences of receiving spiritual care from parish nurses. Participants reported resolving their health challenge became their main concern which lead to changes in their spiritual identity; however, spiritual care provided by the parish nurse helped them gain an understanding of who they are in Christ (Van Dover & Pfeiffer, 2012). The study results may have been limited because it was conducted by a ministry of nurses in a congregational setting and may not be transferable to other types of care or care settings; however, credibility of the study was established by the use of two analysts and an independent researcher review of the emerging categories and supports parish nursing as a means for providing spiritual care.

Summary

The literature review supports a need for interventions to promote health improvement and recognizes case management as a likely effective measure. Quality of life was described as one's perceived physical and mental health. The literature also supports spirituality and religiosity as important factors of QoL and suggests that client centered care improves QoL. In addition, client subjective perceptions were found to be better indicators for QoL than physical or psychological health.

Current research suggests the FCN model of community-based practice incorporates measures to address Healthy People standards and is becoming more committed to evidence-based practice and specialization. It also found a new evolutionary concept analysis method has been chosen to define FCN. The new definition includes essential attributes of FCN as wholistic health, health promoting, disease managing, coordinating, empowering, accessing health care, and faith integration. To address health needs, FCN has also adopted a new transitional care model. Assets of FCN believed to help improve overall health includes the ability to achieve consistency and build trust between parishioners and faith communities, and the ability to enhance the work of community nurses by providing additional sources of holistic care and health promotion. Faith community nursing was also found to be effective in improving self-reported, health-promoting behaviors. Parish nurses working in congregational settings perceived they make the greatest impact through health promotion, prevention, advocacy, health education, and health counseling through psychosocial support and spiritual care. One study even suggested FCNs may be valued over other healthcare professionals. In addition, research shows that FCN has been associated with cost reduction and reduced insurance pay outs.

Of note, literature suggests the philosophy, objectives, and practice of FCN can lead to better health outcomes and QoL. Literature also suggests the church has long been involved in caring for communities and many continue to believe the church should play a role in helping its members meet their health needs. As evidence of the benefit of church involvement in helping meet health needs, it was found that even in times of health crisis, those served by FCNs have experience renewed spiritual identity. Although

there is a substantial amount of literature exploring care provided by FCNs, little research has reported outcomes of FCN missions. There remains a significant need for additional research to explore the efficacy and value of FCN to validate its value. To address the need for additional research to explore the efficacy and value of FCN, this MSN Thesis explored faith community nurse's and parishioner's perceptions of FCN missions on QoL and overall health.

CHAPTER III

Methodology

With more than one in three adults diagnosed with cardiovascular diseases, 1,735,350 projected new cases of cancer, more than 795,000 people having a stroke each year, and 16 million people diagnosed with chronic obstructive pulmonary disease (COPD), the U.S. health system is under enormous strain (American Heart Association News, 2017; National Cancer Institute, n.d.; Centers for Disease Control and Prevention [CDC], n.d.-b; National Institutes of Health [NIH], 2018). In effort to relieve some of the strain, the Centers for Medicare and Medicaid Services (CMS), the Institute of Medicine (IOM), and Healthy People initiates have called for innovative care with an integrative approach as a means of improving quality outcomes in healthcare (Centers for Medicare and Medicaid Services [CMS], n.d.; The National Academies of Sciences, Engineering, Medicine: Health and Medicine Division [HMD-NASEM], n.d.; Healthy People, n.d.-a). Faith community nursing missions have been found to be effective in addressing health promotion and wellness; however, little is known about the effectiveness of FCN missions on QoL and overall health (King & Pappas-Rogich, 2013; Mock, 2017). This qualitative study aimed to expand what is known about FCN missions and its perceived effectiveness.

Study Design

A retrospective, qualitative study design was chosen to explore perceptions of FCNs and parishioners to allow study participants to express their views of FCN missions openly through broad, open-ended questions. A purposive sample was chosen initially

and expanded by a networking sample. Participants were interviewed, and data was analyzed for common themes.

The purpose of this study was to gain a better understanding of the impact of FCN missions on QoL and overall health; therefore, the Theoretical Model of FCN was used as a guide. The Theoretical Model of FCN allowed for comparison of retrospective data and aided in identifying and organizing common themes in pursuit of wholistic care, which includes faith integration and incorporates health promotion, disease management, coordination, empowerment, and access to care (Ziebarth, 2014). Asking participants open-ended questions allowed for flexibility and freedom to explore complex perceptions of FCNs and parishioners through the retrospective, qualitative study design. The study question was further refined by asking participants to include additional data specific to spiritual, physical, psychosocial, and/or educational impact after interaction with a FCN. Interviews were conducted, and data was collected until saturation was achieved and information was reoccurring (Polit & Beck, 2004). Individual interviews were audio recorded for review and field notes of participant perceptions were taken throughout the study.

Setting

The purposive sample was chosen by reaching out to FCNs on the Westberg Institute, FCN platform on Yammer to invite FCNs to participate in the study. The FCN platform is an international platform used by FCNs to communicate. By using the platform to recruit participants, restricting the study sample to one geographic area was avoided. Though FCNs often work with faith congregations, the specialty is expanding and FCNs may now work in a variety of other settings such as hospitals or other

community organizations (Eastridge, 2018). Parishioners in this study may receive services from FCN ministries within their own congregation or any place the FCN provides services. Because participants were located in distant areas from the researcher, interviews were conducted by telephone conferencing.

Sample/Participants

Participants recruited from the Westberg Institute, FCN platform on Yammer were required to practice in the United States, hold a current license as a registered nurse, and have additional FCN education that enhances the nurses ability to "integrate current nursing, behavioral, environmental, and spiritual knowledge with the spiritual beliefs and practices of the faith community into a program of wholistic nursing care" as required by the American Nurses Association and Health Ministries Association (2010, p. 4). Once a purposive sample of FCNs was chosen, a networking sample of parishioners was chosen by requesting FCNs to make referrals to parishioners who were known to have received services from FCNs. A purposive sample was necessary to choose participants who meet the requirements for FCN practice. Further expanding the sample by networking aided in identifying participants who are familiar with FCN missions and have experienced services provided by FCNs. Other criteria for inclusion included being 18 years old or older, having the ability to understand and speak English, and willingness to participate in an audio recorded interview. Demographic information was limited to identifying the participant as a FCN or parishioner and was considered as a potential contributing factor to the understanding of the effectiveness of FCN on QoL and overall health by comparing perceptions of FCNs and parishioners. Participants were recruited until saturation was

achieved as evidence by recurring themes. The sample size included five FCNs and five parishioners for a total of 10 participants.

Measurement Methods

Interviews were conducted via telephone conferencing. The researcher took and recorded notes throughout the study process. With the Theoretical Model of FCN which is based on concepts of relationships between clients and nurses with the primary purpose of pursuing wholistic care and includes faith integration as a guide, interview data was coded for common themes within the model, including health promotion, disease management, coordination, empowerment, and access to care (Ziebarth, 2014). Attention was also given to themes that emerged outside the theory and coded accordingly as serendipitous themes. Demographic information, limited to identifying the participant as a FCN or parishioner, was gathered prior to conduction of interviews and was considered as a potential contributing factor to the understanding of the effectiveness of FCN on QoL and overall health by comparing perceptions of FCNs and parishioners. All data collected via telephone conferencing was voice recorded for review and transcription.

To avoid personal bias, the researcher continually reevaluated the impressions of the participants and challenged any personal preexisting assumptions. Credibility was achieved by respondent validation. After the study was completed, participants were invited to discuss the common themes and assess whether they felt the study results adequately described their perceptions of the effectiveness of FCN ministries on QoL and overall health. Participants were also invited to provide feedback on the interview formulary. Credibility was further validated by advisor review in which the advisor

reviewed all interview transcripts, field notes, and findings for validation of data and themes.

Data Collection Procedures

Interviews using an open-ended question was conducted for data collection. The following question was asked: How do faith community nurse ministries impact quality of life and overall health? Participants were asked to further refine their answers by including any spiritual, physical, psychosocial, and/or educational impacts of FCN because some previous studies have shown FCN to be beneficial in these areas (Ziebarth, 2014). Interviews were audio recorded. This allowed the data to be reviewed and analyzed for coding at a later time. The researcher took and recorded notes throughout the study process as a means of continuous reflection on participate assumptions and organizing common themes.

Protection of Human Subjects

Approval from the University Institutional Review Board (IRB) was obtained for the protection of human participants prior to data collection. Potential participants were notified of the purpose of the study and study questions during the recruiting process and prior to data collection. Participation in the study was voluntary. The only incentive for participating in the study was to add to what is known about the benefits of FCN. Minimal demographic data was collected, limited to only designation of parishioner or FCN. Signed informed consents were collected via e-mail prior to conducting the interviews. Written and typed names were accepted as signatures. All contact data such as e-mail addresses and phone numbers were kept confidential. Audio recordings were collected and stored on the researcher's password protected device. All e-mail data was

collected via the University password protected e-mail. Audio recordings and e-mails were deleted at the conclusion of the study.

Data Analysis

Study data, including interviews, and field notes were analyzed by using the concepts of the Theoretical Model of FCN for coding. Once data was coded and categorized by health promotion, disease management, coordination, empowerment, access to care, or other outlying concepts, a descriptive review of the data was written as a data report. The process of choosing a purposive and networking sample helped to assure the sample was adequate and the data gathered was sufficient to achieve saturation.

CHAPTER IV

Results

The purpose of this qualitative research study was to examine the perceived associations between Faith Community Nurse (FCN) ministries and quality of life (QoL), and overall health among FCNs and those served by FCNs. Although FCN as a means for providing wholistic care with intentional focus on the spirit is well documented, little is known about the effectiveness of FCN missions on QoL and health (Mock, 2017). The aim of this MSN thesis was to explore the perceived relationship between FCN ministries, QoL, and overall health by conducting interviews with FCNs and parishioners who have received care from FCN ministries. The Theoretical Model of FCN was used to compare data collected during the interviews to identify and organize common themes.

Sample Characteristics

A purposive sample of FCNs was chosen by posting a recruitment request to the Westberg Institute, FCN platform on Yammer, a social media platform for information sharing, used by over 1,100 nurses (Westberg Institute website, n.d.). A networking sample of parishioners or those who have received care from FCN ministers was chosen by asking FCNs to refer parishioners to participate. Initially, six FCNs reported being interested in participating in the study. A copy of the informed consent was e-mailed to all six FCNs. Five FCNs returned signed copies of the informed consent and participated in individual telephone interviews within the following weeks. All FCNs agreed to try to recruit parishioners to participate in the study. One FCN reported a parishioner was interested in participating and shared e-mail information with the parishioner to contact the researcher; however, the parishioner did not contact the researcher. The FCN later

reported the parishioner was unable to participate due to a family emergency but provided contact information for a second parishioner who was interested in participating. The researcher contacted the parishioner by telephone and the parishioner provided the researcher with an e-mail address. A copy of the informed consent was e-mailed to the parishioner. The parishioner returned the informed consent and a telephone interview was conducted. One of the previously interviewed FCNs e-mailed signed copies of the informed consent for four parishioners with contact phone numbers for each of the parishioners. Each of the four parishioners were contacted by telephone and individual telephone interviews were conducted with each parishioner. Following completion of five interviews with FCNs and five parishioners, an additional FCN reported interest in participating in the study but was not interviewed because saturation for the study had been met. One parishioner and one FCN who originally reported interested failed to reply after receiving a copy of the informed consent. One FCN did not reply until after saturation for the study had been met and, therefore, was not interviewed. A total of five FCNs, 100% of those who signed and returned the informed consent, and five parishioners, 100% of those who signed and returned the informed consent, were interviewed for the study. See Table 1.

Table 1

Sample Characteristics

Participants	Informed Consents Returned (*n*)	Interviews Conducted (*n*)
FCNs	5	5
Parishioners	5	5

Major Findings

Five FCNs and five parishioners were asked to describe how FCN ministries impact quality of life and health, using individual telephone interviews, and were asked to clarify answers by including any spiritual, physical, psychosocial, and educational impact. One hundred percent (n = 10) of individuals interviewed reported FCN ministries result in a positive impact on QoL and overall health. Analysis of interview data identified themes consistent with the Theoretical Model of FCN, thus supporting the Theoretical Model of FCN. Participants reported FCN ministries have a positive impact on QoL and health by promoting good health and maintaining one's current diseases through education on topics such as nutrition, exercise, disease processes, and medication management. Interviewees also reported FCN ministries have a positive impact on QoL and health by ensuring access to care and coordination of care and services. Benefits of client empowerment and the integration of faith on one's QoL and health provided by FCN ministries was also intertwined in every interview. Other serendipitous themes identified as positive impacts of FCN on QoL and health included trust and support.

Theme 1: Health Promotion

Limited or poor health literacy is linked to poor self-care behaviors such as poor nutrition and inadequate exercise (Shin & Lee, 2018). The same is true for parishioners as many lack understanding about the impact daily choices, such as poor diet and lack of exercise, has on health. One hundred percent (n = 10) of interviewees reported health promotion provided by FCN ministries has a positive impact on QoL and health. Eighty percent (n = 4) of parishioners reported a positive impact to their health based on FCNs teaching and encouraging healthy diet, and 60% (n = 3) reported a positive impact to their

health related to the FCN encouraging them to exercise. Eighty percent (n = 4) of FCNs reported they believe providing education on diet and/or exercise leads to improved QoL and health. One FCN reported promotion of "wholistic health and preventative health" has a positive impact on QoL and health and stated this occurs "through education and participation". Additionally, Parishioner #2 reported mental exercises promoted by the FCN helped to improve her QoL and overall health. Faith community nurses suggested that the positive impact of teaching healthy nutrition may lead to improved health for the entire congregation as FCN #3 reported their congregational "pot-luck meals even changed" to include a wide variety of healthy dishes and eliminated dishes that were high in fats, salts, and sugars. Other health promotion activities reported as having a positive impact on QoL and health included blood pressure screenings, educational seminars, newsletters or articles on healthy living, and education on hospice care.

Theme 2: Disease Management

Disease management is another theme of the Theoretical Model of FCN and was also identified as having a positive impact on QoL and health as related to FCN ministries by 100% (n = 10) of participants. Disease management programs have been linked with better adherence to healthy living activities and improved health (Matthew et al., 2018). Participants in this study reported disease management activities have a positive impact on health. Parishioner #3 stated "it keeps the sugar a little bit more under control" when referring to care provided by the FCN, while parishioner #2 stated the FCN "keeps me current on my medicine" while referring to diabetes management. Other parishioners reported services provided by FCNs encouraged them to continue with alcohol recovery, helped them to manage wound dressings, and helped them to

understand their medical conditions and treatment plans. Eighty percent (*n* = 4) of parishioners reported FCNs provided clarification on things their doctors or other nurses had told them, but they had not understood. Parishioner #2 even said, "they're more helpful than the doctor" and parishioner #3 stated, "they actually know more than the doctors do".

Faith Community Nurses indicated they feel the services they provide help parishioners maintain their health and has a positive impact on their QoL. Faith Community Nurse #1 reported assessment skills help FCNs identify health problems and allows for early intervention for parishioners. Faith Community Nurse #2 reported conducting monthly blood pressure checks helps to identify hypertension and dysrhythmias which results in parishioners receiving appropriate care. Faith Community Nurses also reported disease management tasks provided such as educating parishioners on disease processes, medication education, nail care, diabetic foot checks, appropriate diet, hydration, and weight management have a positive impact on QoL and health.

Theme 3: Coordination of Care

The term care coordination is often used synonymously with case management (Lukersmith, Millington, & Salvador-Carulla, 2016). Although various terms may be used, 100% (*n* = 10) of participants in this study suggested that FCN ministries have a positive impact on QoL and health at least in part due to coordination of care. Faith Community Nurse #4 stated, "case management is a critical part of what I do every day in my practice". Faith Community Nurse #1 stated "I think it is so important to form that bridge from hospital to home, from home to community and church", while other FCNs stressed the impact of making referrals to community services, primary care providers,

and specialists, and collaborating with health care teams to develop the best plan of care for parishioners. Faith Community Nurse # 1 stated “it’s putting the whole puzzle together from teaching them how to use Uber and connect to community and neighbors”. Faith Community Nurse #3 stated “I was an extra pair of eyes and ears for the doctor who normally only gets 15 minutes with a patient”. Faith Community Nurses also reported transitional care visits to parishioners in hospitals, long term care facilities, and at home have a positive impact on QoL and health. One FCN and one parishioner even suggested that the role the FCN plays as liaison between parishioner and family who cannot be there has a positive impact on QoL.

Parishioners reported coordination of care as provided by FCNs has a positive impact on QoL and health. Parishioner #2 reported being referred to community groups and volunteers. Others reported the FCN helped coordinate care with doctors and helped in explaining the treatment plan. Parishioner #1 reported being referred to a college for higher education, and parishioner #5 felt the FCN acted as an advocate between parishioner and church in addition to coordinating care with the health team leading to “a good circle to give you comfort”.

Theme 4: Empowerment

Patient empowerment has many definitions, but researchers agree that patient empowerment includes self-efficacy; knowledge, skills, attitudes and self-awareness necessary to influence their own health behavior; perceived personal control over health and healthcare; sense of meaning and coherence about their condition; health literacy; and feeling respected (Bravo et al., 2015). With this in mind, 100% (n = 10) of participants reported feeling empowerment by FCN ministries leads to a positive impact

on QoL and health. Parishioners reported FCN ministries empowered them to feel better and move more, stay active, and make one's own decisions concerning health care. Parishioner #3 said the FCN "did make it easier that way" when referring to managing health and "I'm in a lot better shape now than what I was" as a result. Parishioner #4 reported empowerment through comfort because the FCN "filled a void spot", and parishioner #1 reported being empowered to continue in alcohol recovery and to make health improvements through diet and exercise.

Faith Community Nurses reported empowerment through education and motivation to make better choices. Faith Community Nurse #1 stated, "once they get going and work through what we've seen, they blossom". Forty percent (n = 2) of FCNs reported empowering parishioners to be able to make end-of-life decisions. Faith Community Nurse # 3 reported empowering a parishioner to grieve when grief was needed. Faith Community Nurses also reported empowering parishioners to take an active role in their own health and wellness. Forty percent (n = 2) of FCNs reported congregations have been empowered to become a more caring community, one of which reported a parishioner was empowered to return to the church after a previous disagreement.

Theme 5: Access to Care

Many people face a variety of barriers to accessing adequate social and health care including health inequalities and an everchanging landscape of available services (Tod et al., 2015). Ninety percent (n = 9) of interviewees reported access to care as a factor addressed by FCN missions prompting a positive impact on QoL and health. All except one parishioner discussed improved access to care during the interviews.

Parishioner #4 reported the FCN helped “to get to the doctor, hospital, and cancer center” when needed. Parishioner #3 reported the FCN helped to access the right kinds of foods by making “suggestions about what I eat”. Other parishioners reported FCNs made sure they had needed supplies and simple equipment for exercise.

Faith Community Nurses reported assisting parishioners to obtain primary care, specialty services, and medications in addition to collaborating with and making referrals to community resources. Faith Community Nurse #1 reported helping to “provide the tools” parishioners need to achieve better health. Faith Community Nurse #4 stressed the importance of helping parishioners receive the right care at the right time. Faith Community Nurses also reported they partner with faith congregations that have food banks, medical supplies, or medical equipment loan programs to help meet the needs of those they serve.

Theme 6: Faith Integration

Analysis of the interview data disclosed faith integration as a unique component of care provided by FCN ministries with a positive impact on QoL and health as discussed by 100% (n = 10) of interviewees. Those served by FCN ministries said it was helpful to “know the church cares”, the spiritual impact was “more just natural”, and it “helped me a great deal spiritually”. Parishioner #5 said the FCN “comes from the church and is informational about spiritual help”. Parishioner # 2 said the FCN is “uplifting and positive”, while parishioner #1 said the FCN “prays with me and helps with God and stuff”.

Faith Community Nurses stressed the importance of providing wholistic care with intentional focus on spirituality to bring feelings of peace, love, and acceptance. Sixty

percent (*n* = 3) of FCNs reported they often pray with parishioners and one said she has had discussions about theology with one parishioner that led to improved spiritual health and the parishioner returned to the church. Faith Community Nurse #2 stated, "even when we talk on the phone convey how much Jesus loves them and that God is with them", while Faith Community Nurse #4 said, "they feel they do have a connection to God because God sent me their way".

Serendipitous Themes

Other themes that were repeated throughout the interviews included trust and support. Though these themes may be incorporated very well into other major themes such as empowerment and faith integration, they were repeated frequently enough that they are worth mentioning. Two FCNs and one parishioner (30%; *n* = 3) mentioned trust as being a component of FCN ministries that has a positive impact on QoL and health. Faith Community Nurse #1 said, "first you have to establish that trust" and "they don't feel reluctant" when communicating with the FCN. Faith Community Nurse #4 said, "they trust me, that I'm going to help them", while parishioner #5 reported being able to trust and talk to the FCN even when unable to talk to the minister.

Three parishioners and a FCN (40%; *n* = 4) talked about the impact of being supported by the FCN. Parishioner #4 said the FCN "is always there for me" and reported no longer feeling alone. Parishioner #3 said the FCN is "somebody to check up on you that you can talk to", and parishioner #1 said "it's good to have a good support system". In addition, FCN #3 stated "just the feeling of being supported really goes a long way" to provide a positive impact to their QoL and health. See Table 2.

Table 2

Impact of FCN Ministries on QoL and Health

Themes	Responses
Health Promotion	
	"We do nutritional classes"
	"We did a balance class"
	"I've done a couple articles on that" (mental health)
	"…got involved in the exercise programs"
	"I think you should just allow yourself to grieve"
	"We would put together…pastries that were low in fat, low in oil, low in this, low in that"
	"I do a lot of education on nutrition"
	"We try hard to promote wholistic health and preventative health…through education and participation"
	"I changed my eating habits, exercise more"
	"…been very helpful with my exercise, my diet"
	"…showed me exercises to do"
	"…talked to me about doing mental exercises"
	"has exercise classes"
	"wants me to stay busy"
	"…to learn how to eat all over again, and exercise"
	"…does blood pressure screenings"
	"…does articles in our parish newspaper…on health and things, eating and proper diet"
	"these are the qualifications" (hospice)
Disease Management	
	"understand the dynamics of diabetes and the influences of the choices they make"
	"break down your medications and make sure you're where you need to be"
	"I do blood pressures once a month…identify some people with hypertension…arrhythmias"
	"continue those instructions for his diabetes maintenance"
	"I got certified as an arthritis foundation instructor for what used to be called their PACE course"
	"provide nail care for them…regular foot checks for the diabetes"
	"talk to me about what that medication is and what it's going to do"
	"we want to help them maintain their health"

	"I started my recovery and not drinking anymore"
	"keeps me current on my medicine"
	"it keeps the sugar a little bit more under control"
	"…would break it down so I could understand it"
	"Can you show me how to wrap stuff on my neck?"
Coordination of Care	
	"bridge from hospital to home, form home to community and church"
	"put the whole puzzle together for them"
	"I do hospital visits"
	"go visit people that are homebound"
	"ask permission to share that to the pastor"
	"I was an extra pair of eyes and ears for the doctor"
	"collaboration with a lot of community partners"
	"Case management is a critical part of what I do every day in my practice"
	"collaborate with some community agencies"
	"…gave me a paper to go to a college"
	"told me about my community group and volunteers"
	"I tell her what both of them are saying, and she can tell me and explain to me"
	"go see their mom in the nursing home and report back to them"
	"it's just a good circle to give you comfort"
Empowerment	
	"empower the patient to be the best they can be"
	"empower the patient with knowledge and understanding to make better choices"
	"once they get going and work through what we've seen, they blossom"
	"brought our church in a more caring community"
	"I've seen them change their lifestyles"
	"taking really active participation in the health and welfare"
	"…ended up coming back" (to church)
	"They were so much more conscious of all of that"
	"help the overall feeling in the congregation"
	"allowing them to be able to put shoes on"
	"It makes their quality of life better"
	"gave me a lot more motivation…to be healthier"
	"I feel better"
	"motivate me to get up and start moving more"
	"it did make it easier"
	"...fill that void spot next to you was wonderful"

	"help me look forward to the next step in my life"
Access to Care	
	"to provide the tools in which they will move forward"
	"find opportunities to get engaged"
	"good to have the visiting nurse to come out…you're the one that suggested that"
	"helped them with placement of mom in the dementia unit"
	"We also have some durable medical equipment"
	"hook him up to patient assistance programs"
	"make sure that people have got the right things they need"
	"you're able to provide or meet a need"
	"…given me one of the elastic bands that you use for your arms and legs"
	"brings me a box every month or so" (of food)
	"…makes suggestions about what I eat"
	"help to get to the doctors…the hospital…down to the cancer center"
	"I didn't realize they could supply that" (dressing supplies)
Faith Integration	
	"spirituality and faith just brings a wholeness"
	"we'll read scripture"
	"We share God's love"
	"…pray with them"
	"conveying how much Jesus loves them and that God is with them"
	"I always prayed with them"
	"be non-judgmental and love them just exactly the way that they are"
	"they feel that they do have a connection to God because God sent me their way"
	"focuses pretty much on intentional care of the whole person"
	"prays with me"
	"…is very uplifting"
	"I think it's more just natural"
	"know the church really cares about you"
	"…comes from the church"
	"if you need spiritual help she's also very informational about that"
Trust	
	"first you have to establish that trust"
	"and that trust, they don't feel reluctant"
	"they trust me, that I'm going to help them"
	"if we don't feel comfortable calling our minister, then she would be our advocate"

Support	"just the feeling of being supported really goes a long way" "it's good to have a support system" "somebody to check up on you, that you can talk to" "…was always there for me"

Reliability and Validity

The thesis advisor reviewed all interview transcripts, field notes, and findings for validation of data and themes. After the study was completed, participants received the study results by email and were invited to join a group telephone conference to discuss the common themes and assess whether the study results adequately describe their perceptions of the effectiveness of FCN ministries on QoL and overall health, to ensure creditability. Participants were also invited to provide feedback on the interview process and questions. Four participants reported they had prior obligations and were unable to participate in the telephone conference. Four parishioners did not have access to e-mail and the referring FCN was unable to take a copy of the study results to them within the timeframe prior to the telephone conference. One participant did not reply to the e-mail. One participant, a FCN, participated in the telephone conference and reported the study results are “defiantly” consistent with the perception of how FCN has impacted individual’s QoL and health. Of the interview process, the participant felt it “went smoothly”. The participant also reported talking with one of the parishioners who participated in the study and was previously known by the FCN, and reported the parishioner said the interview went well also.

Summary

The goal of nursing research is to make changes to nursing care to improve the health of those it serves. This qualitative study disclosed that both FCNs and those served by FCN ministries value the care provided by FCN ministries as having a positive impact on QoL and overall health. Factors noted to play a role in FCN practice leading to better QoL and/or health included health promotion, disease management, coordination of care, empowerment, access to care, and faith integration. Trust and support also appear to play an important role in improving QoL and health as provided by FCN ministries. Faith Community Nurse #3 said it well when she said, “There are just so many ways a FCN can help steer good health and quality of life”.

CHAPTER V

Discussion

As the practice of faith community nursing (FCN) focuses on concepts of faith integration, health promotion, disease management, coordination, empowerment, and access to health care, it offers multiple contributions to health through partnerships between FCN, individuals, families, congregations, and communities (Church Health Center, 2014a). Now with a health care system that is financially overwhelmed, providing appropriate care to the increasing numbers of people with poor quality of life (QoL) due to multiple health problems is of utmost importance. Faith Community Nursing may be the ammunition that is needed to reverse the trend of declining health by aiding in the improvement of QoL and overall health, which is likely to relieve some of the burden on our current struggling health care system of insufficient resources (Pappas-Rogich & King, 2013). The Theoretical Model of FCN demonstrates many advantages of FCN by embracing concepts of faith integration, health promotion, disease management, coordination, empowerment, and access to healthcare (Ziebarth, 2014). This MSN thesis supports the likelihood that FCN ministries can help reverse the trend for declining health by improving QoL and overall health.

Implication of Findings

Analysis of data collected through individual telephone interviews revealed participants perceive that FCN ministries have a positive impact on QoL and health. Emerging themes were consistent with the theoretical model of FCN. All interviewees reported health promotion, disease management, coordination of care, empowerment, and faith integration as provided by FCN ministries has a positive impact on QoL and health.

The majority of participants discussed access to care as provided by FCN ministries as having a positive impact on QoL and health. It is also noteworthy that 30% of participants referenced trust as being a component of FCN ministries that has a positive impact on QoL and health and 40% conveyed that being supported by the FCN has a positive impact on QoL and health.

The literature review supported a need for interventions to promote health improvement and recognized case management as a likely effective measure (Glendenning-Napoli et al., 2012). Results of this MSN thesis suggests that FCN ministries provide essential case management and is an advantageous means to promote health improvement. Participants of this study also described how integration of faith had a positive impact on QoL and health consistent with the literatures support of spirituality and religiosity as important factors of QoL. These findings are significant because subjective perceptions have been found to be better indicators for QoL than physical or psychological health (Schuler, 2015). During the interviews, one parishioner said, "they're more helpful than the doctor" when referring to the FCN and another parishioner stated, "they actually know more than the doctors do". This is consistent with one study that suggested FCNs may be valued over other healthcare professionals because they were more accessible and were able to use nursing knowledge to support families in the community (Mock, 2017). Though FCNs did not claim to know more than the doctors and did not claim to be more helpful than doctors, FCNs participating in this study did feel that services they provide helps parishioners to maintain their health and has a positive impact on their QoL. This may be in part due to the trust built and support provided by FCNs. One parishioner said the FCN "was always there for me". Another

consistency with the literature surfaced when a FCN reported having theological discussions with one parishioner, who subsequently experienced improved spiritual health and returned to the church he had previously left due to a disagreement. During a prior literature review, it was found that even in times of health crisis, those served by FCNs have experienced renewed spiritual identity (Van Dover & Pfeiffer, 2012). Finally, a substantial amount of literature exploring care provided by FCNs was noted, but little research had reported outcomes of FCN ministries (Dandridge, 2014). This research explored the efficacy and value of FCN as perceived by FCNs and those served by FCNs and substantiates that FCN ministries have a positive impact on QoL and overall health.

Application to Theoretical/Conceptual Framework

The Theoretical Model of FCN was used to guide the study and is based on concepts of relationships between clients and nurses with the primary purpose of pursuing wholistic care, which includes faith integration and incorporates health promotion, disease management, coordination, empowerment, and access to care (Ziebarth, 2014). As defined by the theoretical model, clients in this study included the person, family, group, or community and are believed to be individualistic, complex, and wholistic beings (Ziebarth, 2014). The Theoretical Model of FCN allowed for comparison of the retrospective data collected and aided in identifying and organizing common themes. Analysis of the data revealed FCNs and parishioners perceived a positive impact on QoL and overall health with themes consist with the Theoretical Model of FNC.

Limitations

Limitations identified in this study included diversity and randomization of the sample. Because FCN is a relatively new nursing practice, the potential sampling pool was limited. A purposive sample was necessary to choose participants who met the requirements for FCN practice. Further expanding the sample by networking aided in identifying participants who were familiar with FCN missions and had experienced services provided by FCNs. However, the sample may be biased because of the purposive and networking sampling techniques. The networking sample may have resulted in a sample of individuals from the same social groups with similar views considering one FCN referred four of the parishioners who participated in the study. Limiting the sample to individuals able to speak and understand English may have eliminated views of many minority populations and resulted in less generalization. The methodological challenge of obtaining informed consent via e-mail and conducting interviews via telephone may have eliminated certain socioeconomic groups due to a lack of access to a computer and/or telephone. Since the researcher is also a FCN and was the sole interviewer, a bias related to the success of this study could have occurred although the researcher continually reevaluated the impressions of the participants and challenged any personal preexisting assumptions. The study was also limited by the loss of nearly five minutes of recorded interview data from the first interview, in addition to poor quality recordings that occasionally made it difficult to understand words or phrases.

Implications for Nursing

Although FCN makes many contributions to the health of faith communities with documented expectations that FCN results in better overall health and QoL for those

served by FCNs, the claim was poorly supported (Church Health Center, 2014c). This qualitative study provides evidence concerning FCN's observations and parishioner's impressions of FCN ministries and adds value to the FCN specialty as an evidence-based practice. Observations stressed the value of FCN ministries by acting as a bridge from hospital to home to community and church in addition to empowering those it serves to achieve the best health possible through disease management, healthy nutrition, exercise, and access to care. Faith Community Nurse ministries were also found to be an effective source of care management and coordination of health and social services. Faith Community Nurses are in a distinct position to provide accessible health care services to specific populations because they are located in communities, working in or with faith congregations. Finally, FCNs were specifically trained to integrate faith into practice, giving them unique skills to provide wholistic care to patients, families, and communities with intentional focus on the spirit. Because FCN is a relatively new nursing specialty, its footprint continues to be small compared to many other specialties. With the additional insight this study provides into the perceived effectiveness of FCN ministries, it is hoped that this research will be used to expand the influence of FCN. Not only will this study impact FCN ministries, but this study may also impact all healthcare providers in understanding why providing spiritual care, building trusting relationships, and providing supportive care is essential to improve a patient's QoL.

Recommendations

Further studies are still needed to explore the specific outcomes of FCN implementations. Although FCNs and those served by FCNs perceive that FCN ministries have a positive impact on health and QoL, it is necessary to determine whether

those who receive care from FCN ministries in fact achieve better health through randomized quantitative studies. For example, it may be beneficial to study whether patients with diabetes who receive care from a FCN achieve better control of glucose levels as compared to those who do not receive care from FCNs, or whether those served by FCNs have fewer hospital readmissions than those who do not receive care from FCNs. Because such studies may be difficult due to the lack of consistency in documentation by FCN ministries, it may also be beneficial for FCN ministries to adopt universal documentation criteria. Other health care providers may benefit from further studying the effects of spiritual care and/or trusting relationships between providers and patients.

Conclusion

The opportunity to interview five FCNs and five parishioner who have received care from FCNs provided valuable insight into the perceived effectiveness of FCN ministries on QoL and overall health. A perceived positive impact of FCN ministries on QoL and health was manifest throughout the interviews. This enlightening information may be beneficial to expand FCN as a nursing practice and may benefit all nurses by improving understanding concerning the impact of spiritual care and trusting relationships on QoL and health.

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Appendix

The New Conceptual Model for Faith Community Nursing (Ziebarth, 2014)