# LAYING THE FOUNDATION – DETERMINING HEALTH CARE KNOWLEDGE AND INTERESTS OF PARISHIONERS OF THE PURPOSE AND FUNCTIONS OF A FAITH COMMUNITY MINISTRY

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# LAYING THE FOUNDATION – DETERMINING HEALTH CARE INTERESTS AND KNOWLEDGE OF PARISHIONERS OF THE PURPOSE AND FUNCTIONS OF A FAITH COMMUNITY MINISTRY

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## Abstract

The specialty practice of faith community nursing is centered on the spiritual aspect of health promotion. In initiating a faith-based program, the faith community nurse must educate, collaborate with, and investigate the needs and desires of the individuals within the faith community. The problem this researcher aimed to investigate was the parishioners' knowledge of what a faith community ministry is, and the role a faith community nurse plays within a parish community. In this study, participants also identified their needs and interests in future health topics, which will help to provide a direction when this ministry is initiated. The MAP-IT framework designed by The Healthy People 2020 initiative, was used to guide the study and measure outcomes. This quantitative method used a pretest, posttest survey design. An online descriptive survey was utilized to evaluate the participant's knowledge and interest in future health promotion topics.

The findings of this study revealed a statistically significant improvement in all ten of the queried subject areas. This reflected an enhanced overall knowledge in the parishioners' understanding related to Faith Community Nursing. The participants ranked potential health topics, and the results from this reflected the three most interested topics included: healthy eating and weight management, healthy lifestyle and activity, and spiritual well-being. These will guide the focus of the programs undertaken when the Faith Community program is initiated.

A faith community nurse's role is distinctive in focusing on the strength of spiritual beliefs while promoting health and wellness. They embody the principles of wholistic care,

honoring the body, mind, and spirit to achieve wellbeing. The critical challenge when initiating and building a faith community nurse ministry, is to lay a strong foundation by providing education to parishioners based on their interests and health needs.

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# Chapter 1

## Introduction

Faith Community Nursing (FCN) is a specialty practice in nursing that is recognized by the American Nurses Association (ANA) and Health Ministry Association (HMA). This specific nursing practice is unique, in that it acknowledges spiritual care as a crucial component in promoting whole-person health. The FCN embodies various dimensions of practice, including ministry, relationship, and advocacy. This makes this specialty practice beneficial and distinctive. The nurse's role is to help clients focus on wellness to achieve their perceived highest level of wellbeing. The FCN exemplifies the principal of wholistic care, honoring the body, mind, and spirit by connecting with others (Stewart, 2016).

As professional registered nurses, the FCN provides a faith community with a recognized and reliable resource, whose decision making and practice are guided by the nursing scope and standards of practice, state and commonwealth laws, statutes, regulations related to nursing, and federal regulations (ANA & HMA, 2017, p. xiii). This nursing practice brings a diverse rich mixture of skills, experience, unique knowledge, and faith traditions leading to nurse's credibility as community health providers (Campbell, 2014). The FCNs role has many initiatives that can be undertaken. Key aspects that are vital to the role is health promotion, preventative care, and education, all while keeping spiritual support as the center of the care provided. Programs should be flexible and adaptable to individuals' needs (Stewart, 2016). FCNs are in an ideal position to develop a faith community ministry within a congregation to address the needs of the parishioners. Additionally, initiating a faith community ministry in a church community, can offer support, knowledge, collaboration, and priorities for future healthcare needs (Campbell, 2014).

**Background of the Problem**

The word nursing is derived from the Latin verb nurture or to nourish, thus providing others with the material necessary for life and growth. The concept of parish nursing emerged in the 1980's when Reverend Grander Westberg initiated holistic centers in churches in the Midwest region of the United States (US) (Pappas-Rogich & King, 2014). The Parish Nurse Resource Center became the International Parish Nurse Resource Center in 2002 (FCN curriculum, 2019). This organization's mission is to cultivate relationships with individuals in congregations to encourage, educate, and equip people to build and sustain healing ministries. FCN is one of the best ways for a congregation to promote health and wholeness (Westberg Institute, 2014).

Throughout history, faith and health have had a connected relationship of wellness and healing (FCN curriculum, 2019). Early records support how community healthcare was often affiliated with religious institutions, where physical and spiritual needs were addressed simultaneously. Parish nursing is rooted in the Judeo-Christian tradition. (Westberg Institute, 2014). The early church ministered to the whole person. Christians ministered to the sick as an expression of God's love. In the mid 1800's Roman Catholic deaconesses came to the US and religious based hospitals emerged (FCN curriculum, 2019). Florence Nightingale emphasized in the 1860's the need for nursing to honor the dynamic process of the psychological and spiritual qualities in promoting health. In the 19$^{th}$ and 20$^{th}$ centuries scientific knowledge of the human body expanded, which led to a general separation of religious leaders from science, which contributed to treating the body and soul separately. Healthcare focused on curing illness, as the spirit became less important. Today, more than ever, there is an increased recognition of the

importance and need to integrate body, mind, and spirit in promoting health and healing. (Pappas-Rogich & King, 2014).

There are many potential opportunities for services and programs that can be offered within the faith community. The implementation of such a project will need to start with the evaluation of congregants understanding of what a faith-community health program includes, and what the faith-based nurse's role is in this program. Dr. Zerull from Shenandoah University notes, prior to implementing a faith community nursing program in a parish, it is essential to develop an education program for parishioners, pastors, and nurse volunteers to define the program and the role of the faith-based nurse in promoting body, mind, and spiritual wellness (Shenandoah University, 2018).

Several sources comment on the importance of assessing the congregation's education and health care needs, however no identified research components introducing this data has been produced. Sharon Hinton, a FCN states, "First and foremost when starting a ministry, listen to what the people want. As nurses, we know what health education people need, but we must go beyond the traditional assessment and see what the community want, start with what they say they need. This approach gained me overwhelming support. The key is to get involvement of the whole community" (Abell & Blankenship, 2019 p. 249). Interestingly, the Patient Protection and Affordable Care Act of 2010, requires nonprofit hospitals to conduct community health needs assessments every three years, and identify strategies to address the priority needs. The Institute for Healthcare Improvement triple aim has identified a new focus on population health and the integration of organizations for the community's benefit. A community health needs assessment can align processes with planning activities and develop strategic partnerships. (Pennel, McLeroy, Burdine, & Matarrita-Cascante, 2015). By educating the congregation, and preforming

a needs assessment, it has the potential to promote a faith-based ministry, thus enhancing health well-being in this community.

**Statement of the Problem**

The aim of this project involved the process of initiating a faith community health ministry in a Catholic parish in a rural area in Northwestern Pennsylvania. The micro-level population that will be the center of the project included parishioners in a Catholic congregation in a rural city in Northwestern Pennsylvania. There were originally five separate catholic parishes in the area and within the last three years they were combined into one parish community. The number of current active parishioners in this congregation include approximately 775 families. The vast majority of the congregants are Caucasian, speak English language and are over the age 50. This parish is part of the regional Dioceses of Erie (in Northwestern Pennsylvania).

The problem being investigated was the lack of understanding of what a faith community health ministry entails, and what the role of a faith community nurses plays in a rural health community program. The parishioner's interest in a health-based ministry and how it can help promote body, mind and spirit wellness was also evaluated. Individual members identified their needs and interests in potential future health related programs. This was done by establishing a ranking of their priorities in hopes of improving their overall wellness. This lack of knowledge has the potential to impact self-care measures, and inadequate health prevention measures which can lead to the many health risks that increase with age (Ayton, Manderson, Smith, & Carey, 2016).

## Research Questions

The focus of this DNP project was a descriptive approach in gathering data related to participants' understanding of what a faith community health ministry is and how it can be valuable in promoting body, mind, and spirit wellness. The objectives for this project were to lay a foundation in initiating a faith community health ministry within a rural Christian parish; establish basic knowledge detailing the role of a faith-based nurse, and what benefits a faith community ministry can provide. The researcher assessed a priority of topics related to health promotion and prevention measures based on the parishioners' interests. The questions purported were: What is the effect of an on-line educational program on parishioners' knowledge of a Faith Community Nursing ministry? What health topics are of interest to a parish community?

## Hypothesis

To initiate a faith community nurse ministry program, it is imperative to do an early, ground level investigation. The hypothesis for this project is, following an on-line educational presentation the participants will have an increased knowledge regarding what a faith community health ministry is, and what the role of a faith community nurse includes. Participants will show interest in participating in a faith community health ministry by identifying health topics the participants are interested in.

## Definition of Terms

Faith community nursing is recognized as a separate specialty in nursing practice and must work and comply with the standards of practice according to the state nurse practice act. The American Nurses Association recognizes parish nursing as a specialty practice and published: The Scope and Standards of Practice. Definitions are taken from the Faith Community Nursing: Scope and Standards of Practice, 3rd Edition (ANA & HMA, 2017).

**Faith Community Nursing -** A specialized practice of professional nursing that focuses on the intentional care of the spirit, as well as the promotion of whole person health and prevention or minimization of illness within a context of faith community and the wider community (ANA & HMA, 2017, p.1).

**Healthcare Consumer -** The person, client, family, group, community, or population who is the focus of attention and to whom the registered nurse is providing services as sanctioned by the state regulatory bodies (p. 87).

**Wholistic** – Based on an understanding that a healthcare consumer is an interconnected unity that physical, mental, social, environmental, and spiritual factors need to be included in any interventions. The whole system, whether referring to a human being or faith community, is greater than the sum of its parts. This term may be used in place of *holistic* when referring to the type of care provided by a faith community nurse (p. 91).

**Wholistic Care** – The integration of body-mind-emotion-spirit-sexual-cultural-social-energetic-enviromental principals and modalities to promote health, increase well-being, and actualize human potential (p. 88).

**Population health** – The health outcomes of a group of individuals, including the distribution of such outcomes within the group, and we argue that the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link these two (p. 89).

**Health promotion –** Activities and interventions that healthcare consumers undertake to achieve desired health outcomes. (p. 87).

**Need for the Study**

When initiating a faith community nurse program, education of the population, and assessing their healthcare needs are paramount for a variety of reasons. With the rising health care costs in the US, the emphasis on prevention and health education has spurred the justification of shifting health care delivery beyond the walls of traditional health care settings. Initiating a faith community ministry, led by nurses is a recognized and reliable resource for primary health care and health related services (Ziebarth, 2016b). Engaging and expanding research opportunities and initiatives related to identifying outcomes are needed to support the practice of FCN. The Faith Community Nursing Curriculum (2019) notes, currently there is a renewal of the incorporation of faith and health in communities. Dandridge (2014) revealed that FCNs are providing a wealth of interventions to diverse populations, but they do not effectively evaluate the outcomes (as cited in Stewart, 2016). FCNs are poised to address many of these gaps (FCN curriculum, 2019). The evaluation of research success is contingent on the knowledge of what is important to the recipients of faith community nursing (Ziebarth, 2014).

The majority of peer-reviewed journals that have examined the relationship between health and spirituality, noted that there are significant relationships between religion, spirituality and enhanced health. A significant volume of research revealed that people who are more religious or spiritual have better mental health and adapt more quickly to health problems, as compared to those who are less spiritual. Research has connected the impact of religion, spirituality, and health with the role it plays in preventing illness, speeding recovery, and motivating individuals to care for one another in the community. Given the research in this area the importance in addressing the escalating health-care costs in the US and countries around the world is critical (Koenig, 2012).

Faith communities are an ideal setting for health promotion and population health activities. Each faith community is unique, multi-faceted, and have varying needs. Health is related to all aspects of life, and spirituality is one component of wellness. Outreach includes a wide variety of potential interventions, and there is no single best approach. FCNs can have enormous impact on health promotion, within the population they serve. There are endless opportunities to support population health in a faith community. According to Harris (2017), it is important for members and friends to know that someone cares and show compassion. Blending physical, social, emotional, and spiritual care into one caregiving experience, is an alternative approach for providing care. The benefits of church-based health programs are grounded from their credibility and are well received by individuals and neighborhoods (Pappas-Rogich & King, 2014).

The Joint Commission for the Accreditation of Hospital Organizations (TJC) and Medicare have set standards that require providers to show respect for and incorporate patients' values, spiritual beliefs and preferences into client care (Koenig, 2012). One of the Healthy People 2020 objectives is related to nursing care is focused on holistic care, prevention, and wellness, with a goal of collaboration with community health services and hospitals (Healthy People 2020). An alliance with hospitals and community agencies can increase patient outcomes linked to understanding, adherence to treatment, monitor medication regimen, assist in health care literacy provide guidance with transitions from the hospital to home. FCN can often reach at risk populations that may lack both medical and spiritual support. Schroepfer (2016) noted that FCN are poised to meet health care challenges, and health care regulations to assist in reducing readmissions by providing a supportive network.

**Significance of the Problem**

Assessing the parishioner's knowledge regarding a faith community nurse program and studying their interests and priority of needs for health topics, are essential to build a strong foundation for a robust and sustainable faith-based program. Health is considered to be a state of wholeness, as opposed to brokenness. Health and wholeness are therefore linked to wholistic care, in treating the body, mind, and spirit. To address people's needs, nurses need to recognize the importance of spiritual practice of individuals (Stewart, 2016). Wholistic care has long been the cornerstone of nursing care. In providing holistic care, the emphasis needs to be not merely on physical care, but also on emotional, social, and spiritual care. However, the spiritual aspect of care tends to be neglected for a sundry of reasons. Westera (2016) identified that nurses are not educated about how to incorporate spiritual care into practice, they lack competence and comfort in incorporating spiritual aspects of care, they have uncertainty about what spirituality is, and there is a perceived lack of time to attend to such care. Nurses are to fulfill the compassion and ideal of wholistic care, they must incorporate the spiritual dimension into their practice. Clear rationale needs to be provided as motivation for nurses to be committed to include a patient's spiritual beliefs as ethical and wholistic care.

According to the Rural Health Information Hub, (2019), Americans in rural areas encounter health disparities and barriers related to lack of access to the care they need. Many residents in rural areas self-identify as having a close family like connection with their religious community. Developing a health program that integrates health with faith, is a prime opportunity for nurses to serve the rural community, where they are trusted and can support the parishioners. The National Rural Health Association (2019) noted rural areas have lower than median incomes, higher numbers of seniors, higher health acuity levels and a lower life expectancy.

Other factors that contribute to limited healthcare services in the rural community include: a shortage in health professionals, lack of financial means, inadequate or no insurance, lack of transportation, poor health literacy, low confidence and trust in providers (Rural Health Information [RHI], 2019).

A range of interventions that considers wholistic health needs may elicit an adaptive response of attaining or maintaining wholistic healing or wholistic health (Ziebarth, 2016b). Reports identified that two thirds of the population a FCN cares for is age 66 and older, and 80% of these clients live with at least one chronic disease (as cited in Hixson & Loeb, 2018). Dyes (2010) found that clients living with chronic illness desired not only symptom management but also wholistic approaches that addressed coping strategies for emotional and spiritual needs (as cited in Ziebarth, 2014). The faith community is poised as an ideal setting to provide education, support, and assistance in managing chronic conditions. Places of worship provide a comfortable, trusting, convenient and supportive environment for individuals (Hixson & Loeb, 2018).

**Assumptions**

The proposed study included both an investigational and a descriptive design. The investigational segment involved a pretest and a posttest survey. The descriptive portion assessed health topic preferences of this population. Assumptions that may have altered the study results may have been related to participants not having prior knowledge or experience with a faith community nursing ministry. Participants may or may not pay close attention to the educational presentation which may have altered the outcome of their attainment of knowledge. Another assumption may have been related to the participant's capability of completing the survey accurately related to a lack of understanding of the scoring or literacy limits. Lastly accuracy of

the outcome was associated to the participant's honesty in their completion of the survey and preferred educational health topics.

**Limitations**

The study limits deserve consideration. A sampling bias may exist for several reasons. One cause may be related to the current social distancing restrictions and health risks presented by the coronavirus. Parishioners may be reluctant to participate in an on-line survey. The number of participants may be limited and may not be an accurate sampling of the congregation's population. Secondly, there are decreasing economic resources and a diminishing number of active parishioners in this rural area. The churches in the area have recently consolidated from five parishes into one also, it is important to identify that church attendance has decreased. There has been unrest within the parish and church community as a whole. Lastly, the congregants who may benefit from a faith community program, especially those who are elderly, may have limited access and knowledge on navigating an on-line survey tool. Further data related to one parish community's health concerns, needs, and knowledge base may not be able to be generalized to the general population in other parishes in the US, as each community is unique and composed of different populations of people. The survey tool was a researcher developed instrument to assess the topics of interest for this individual parish.

**Summary of the Problem**

Faith based health promotion recognizes the value of intentionally integrating faith, with health education, and health counselling programs. The goal was to promote health, prevent disease, and lower the risks for disease at the individual, community, and societal levels (Patestos, 2019). It has been found that health promotion in traditional churches especially those with older members, are well suited for health promotion and disease screening activities. The

concept of “being church” emphasizes community, outreach, and engagement (Ayton, et.al. 2016). Within the practice of FCN, it is essential to build a therapeutic relationship with persons to promote trust and acknowledge caring as a sacred practice focused on faith and health. This dynamic process embodies the intertwined components of body, mind, and spirit in every person. (ANA & HMA, 2017, p. 3).

The initial goals of a FCN are to develop relationships, generate knowledge, and preform a needs assessment. The proposed study in this chapter involves the evaluation of participants knowledge related to what a faith community nursing ministry includes, and what is the role of the FCN. Assessing the parishioner’s preferences, will assist in ascertaining the priorities for providing future health related topics. These are exciting times, and FCNs are in the position to offer great services to their communities. In this way, there will be future growth in moving communities forward during these changing and challenging times for health care (Campbell, 2016).

# Chapter 2

## Review of Related Literature

### Background

"Faith community nursing practice is nursing care that focuses on intentional care of the spirit and is practiced within the context of a faith community." (ANA & HMA, 2017, p.4). The parish nurse often provides healthcare to individuals, centered on the spiritual aspect of health through prayer, group support, and the Sacraments to promote healing (FCN curriculum, 2019). To provide direction and develop a plan of care for the faith community, the FCN must collaborate with, and investigate the needs and desires of the various individuals within the faith community (ANA & HMA, 2017). As of 2015 there have been well over 17,000 FCNs who have been educated in the basic curriculum known as Foundations of Faith Community Nursing internationally (Daffron, 2015). The majority of FCNs commonly are volunteers, but some receive full or part time salaries, or received stipends from the congregation (ANA & HMA, 2017).

According to Standard 5b of the Faith Community Nursing: Scope & Standards of Practice, the FCN:

- Provides opportunities for the healthcare consumer to identify needed healthcare promotion, disease prevention and self-management topics.
- Uses health promotion and health teaching methods in collaboration with the healthcare consumer's values, beliefs, health practices, developmental level, learning needs, readiness, and ability to learn, language preference, spirituality, culture, and socioeconomic status.

- Uses feedback and evaluations from the healthcare consumer to determine effectiveness of the employed strategies.
- Provides healthcare consumers with information about intended effects and potential adverse effects of the plan of care and proposed therapies.
- Provides anticipatory guidance to the healthcare consumers to promote health and prevent or reduce the risk of negative outcomes. (ANA & HMA, 2017, p. 59).

In other words, FCNs use the nursing process by assessing their needs and readiness to learn, to provide a direction for providing education and evaluate their understanding.

A comprehensive literature search was conducted using CINAHL Complete, and Medline Complete, using the key search terms of faith community, faith nursing, parish nursing, faith nursing wholistic care, spirituality, knowledge, and needs assessment in FCN. The Boolean phrase option was utilized for this search. Yielding over 1,200 results, the search was then limited to articles, that were published up to 5 years ago, in the English language, and peer reviewed research which yielded 159 results. Abstracts were reviewed, and many subjects were related to the research of community-based interventions that focused on cancer prevention and detection, diabetes management, weight reduction, or management of blood pressure in parish communities. This left approximately 25 articles, however, many of these articles focused on FCN and were not specifically related to educating congregants or preforming a needs assessment when initiating a FCN ministry. Reference searches were also used for this literature review, this did capture some additional sources for appropriate journal articles. This limited evidence emphasizes gap in research related to this topic.

Several writers discussed the steps of how to initiate a FCN ministry, and provided recommendations such as: introducing the concept, involving the clergy, assessing the

congregation, and educating all regarding the role of the FCN. Tips for the beginner FCN included implementing strategies to evaluate the effectiveness of each educational program and to expand interventions by collaborating with other health care professionals (Zimmerman, 2013). Numerous research studies provided results related to disease specific interventions by FCNs in promoting healthy behaviors in parishioners. Many of these findings included comments mentioning the importance of assessing the parishioner's health needs. However, no research was found on the measurement of a community's knowledge when introducing the idea of a faith community ministry. Ziebarth (2014 a) stated, researchers are challenged to grow the scholarly body of knowledge of the practice of faith community nursing, focusing on accountability and innovation.

The research articles summarized here for review, focus on the general concepts from which this study aimed to examine. They are thematically presented to include the topics of the practice and value of FCNs, incorporating standards of care, assessing faith community's needs, insufficient research, and a theoretical and conceptual framework.

**Practice and Value of Faith Community Nursing**

Several writers provided insight on the topic of FCN. The researchers used various methods when investigating the definition of faith-based health promotion, the value of faith community nursing, and explored the experiences and challenges of FCNs in their practice. A brief summary of each of these papers will provide insight into the practice and role of a FCN.

A hybrid concept analysis was conducted by Patestos (2019), the aim for this project attempted to answer two questions: what the essential nature of faith-based health promotion is, and how is it defined and measured in the literature. Fourteen articles were reviewed based on theoretical, fieldwork and analytical phases. Patestos found that many of the studies focused on a

specific topic or ethnic population, and noted the review was limited and lacked consistent measurement of faith-based health promotion outcomes, creating challenges in utilizing this as an outcome strategy. From this review, a working definition of faith-based health promotion was constructed. The author suggested this new definition of health promotion be used to assist nurse researchers in developing measurement tools in addressing this concept in the future (Patestos, 2019).

A qualitative study was conducted by Mock, (2017), investigating the value of FCN from both the client and nurse's perspective. This study consisted of ten participants, three nurses, and seven of their clients within the same parish. The clients were recruited before and after church services. All three FCNs in the program participated in this study. Interviews were individually conducted using semi-standardized open-ended questions regarding their experiences with faith community nursing. Five similar themes emerged from each group: tasks and services provided, nursing expertise, spirituality, familiarity, and community support. The summary provided insight of the rich value of FCN especially in combining spirituality with care, noting the nurses were respected by the clients over other health care professionals. Clients felt supported, a sense of solidarity, togetherness and developed a close relationship with them. The nurses in this study uncovered that the extended community does not fully support or engage in the resources available, and those clients who do not fully understand the role of the FCN. Mock (2017) identified an outcome from this study was the need to explore various ways FCNs can increase awareness, visibility, and impact they can have on the faith community.

A qualitative study by Devido, Doswell, Braxter, Terry and Charron-Prochownik (2019), used focus groups, to look at parish nurse's practices, experiences, and challenges, in conjunction within their faith community. FCNs were recruited from a database and 48 nurses

voluntarily participated. Data was organized, analyzed, and coded into themes by two researchers. Each coded the data individually and then met to review and reach agreement on the four themes to assure reliability, validity, and rigor. The first theme addressed the importance of gaining trust, explaining the unique opportunity they have to build relationships with parishioners and how they developed a deep bond. Enhanced focus on spiritual caring was the second theme, which focused on connection between faith and health, and they developed increased comfort with discussing spirituality than they had before. The third theme addressed the nurses feeling that much was accomplished despite challenges they confronted. The participants uncovered several challenges FCNs may face, which included: practicing independently and in isolation in their parish, lack of support and networking with other nurses, a large number of client's health issues outside their expertise, limited financial resources, language and health literacy barriers, and health disparities related to lack of insurance. They discussed ways they addressed these issues, bridged gaps, and made the best of the circumstances. The last theme identified was making a difference in the community, and many of the participants described the programs offered and how they have improved their health outcomes in a wide variety of ways. The researchers stressed the value of continuing education, creating a supportive network, and the importance of developing programs and evaluating the establishment of connections with other health professionals (Devido, et al., 2019).

**Incorporating FCN Standards of Care**

In a descriptive study done by Pappas-Rogich & King, (2014), researchers identified how often FCNs practice incorporated the seven functions of the FCNs as identified by the ANA & HMA standards of care, and the Healthy People 2020 indicators. Their study explored how FCNs supported the implementation of community-based practices set forth by both Healthy People

2020, and FCN standards. This study utilized the MAP-IT framework identified as a guide to create and implement a plan in helping to reach Healthy People 2020 initiatives (Healthy People, 2020). The MAP-IT, acronym stands for mobilize, assess, plan, initiate and track. The 'mobilize' intervention looks for the partners who have a stake in creating healthy communities and who will contribute to the process. The researcher asks, what community or population should be represented? The 'assess' portion evaluates the needs within the community. Consideration of important issues such as, feasibility, effectiveness and measurability need to be included. The next step is to 'plan', which is done by identifying clear objectives and the concrete steps to be initiated to achieve the objectives within this population. Ask, what are the goals and how will success be measured? The 'initiate' segment is when information is provided to the community. Ask, was the plan followed? The last step is to 'track' the data that is collected. The data is then analyzed, while assuring standard collection and limitations. This leads to answering if the goal was reached and what the next steps in the process should be.

For the study by Pappas-Rogich & King, (2014), a flier, describing the research project, was listed on the International Parish Nursing Resource Center's (IPNRC) website to recruit participants, and the FCNs voluntarily completed an anonymous questionnaire. Two-hundred and forty-seven FCNs finished the survey and results were tabulated using statistical functions from Survey Monkey. The participants were primarily Caucasian and female (95%), all practiced in North America, experience as a FCN ranged from 1 to 21 years with a mean of 15 years, with varying religious denominations. Results highlighted the two highest functions implemented monthly based on FCN standards were health education (51%), and referral's to Healthcare or Social Services. Using the Health People 2020 indicators the percent of FCN monthly interventions were promoting good nutrition and healthier weight (33%) and emotional health

and well-being promotion (30). The study also highlighted the community agencies that FCNs partnered with and the top partnerships listed were Hospitals (32%), and programs co-sponsored by a health system and the faith ministry. The authors concluded their results showed how the FCN model of community-based practice of promoting health through education and activities, can be used to implement the Healthy People 2020 objectives. FCNs are in a key position to educate and council populations fostering healthy behaviors, in a trusted and spiritual environment (Pappas-Rogich & King, 2014).

**Assessment of Faith Communities Needs**

The work of the FCN has been categorized into five main areas: coordinating programs, assessing needs, educating on health issues, counseling, and making appropriate referrals (Westberg, 1990). In considering the topic of assessing the faith community's needs, it is recommended a survey analysis should be done to establish what programs to offer and used to plan for in meeting their preferences. One research study was found to be related to the topic of assessing a faith community's needs.

The ANA/ HMA's (2017) first standard of care for FCNs addresses the importance of assessment. It lists the value of eliciting the client's values, preferences, needs and knowledge. Highlighting the consumer as the authority of their own health and honoring their preferences of care (ANA/HMA, 2017). In considering the topic of assessing the faith community's needs, it is recommended a survey analysis should be done to establish what programs to offer and used to plan for in meeting their preferences. Two studies will be presented here: one research study is related to the topic of assessing a faith community's needs, and the other research was based on a congressional directive in the effectiveness of conducting a community needs assessment.

A descriptive study performed by Abell in 2016, focused on the importance of listening to the needs of the faith community. Abell noted, when implementing a health ministry program, it is vital to spend time planning, which included obtaining input from the members of the congregation. Abell's study included four research questions; the first two questions pertained to investigating the needs and elicited the best time to present a FCN program. The last two questions investigated what health topics would be of interest and ascertained if the topic correlated with a certain age or gender of the participant. In gathering the needs assessment, there were sixteen health topics for the subjects to indicate on a five-point Likert scale. Thirty-eight questionnaires were compiled and the top four topics of interest that ranked above 4.40 were, healthy heart, CPR training, nutrition, and diabetes. No gender or age correlations were identified as statistically significant with these four topics. The discussion noted parishioners showed an overwhelming interest in participating in a FCN led program and assisted the FCNs in identifying which health topics to initially focus on when building the program. These researchers proposed conducting ongoing needs assessment by completing periodic evaluations. An additional recommendation was to obtain evaluations from participants to enable improvement and sustainability as the ministry grows.

Another study was not conducted within a faith community, but rather a health needs assessment was done in a community population. An article by Pennel, McLeroy, Burdine, Matarrita-Cascante (2015), discussed the required community health assessment (CHA) as critical in the development and evaluation of health improvement policies and programs. The Affordable Care Act provides nonprofit hospitals guidelines for identifying, prioritizing, and developing implementation strategies to address health needs. Sixteen criteria were identified for the facilities to act and report on. The goal of this program was to create linkages between

medicine and public health to address disparities, improve population health, and quality of care. This research sought to evaluate how these facilities were fulfilling this requirement. An internet review of 95 nonprofit hospitals in Texas community health needs assessments and implementation strategies was completed. Scores were assigned to each of the criteria based on level of involvement with community sources. The average score was 38 out of a possible high score of 80. It was reported only 13% of the hospitals collaborated with the public health department. Additionally, hospitals generally performed poorly in identifying evidenced based strategies to address local health issues bases on the need's assessment and examining the contributing causes. The researchers concluded with this new emphasis of initiatives away from the silos of care and move toward public health integration. Noting it will likely create valuable opportunities for hospitals to form relationships with community partners, to achieve the ultimate goal of population health (Pennel et. al, 2015). Government led initiatives such as these are evidence that faith health ministries can and should collaborate with local hospitals and health care organizations to align services and opportunities for the population and support one another.

**Insufficient Faith Community Research**

As previously noted, there is a paucity of information related to the measurement of a congregant's knowledge of a faith community ministry. Dandridge (2014), conducted an integrative literature review of 22 peer reviewed articles from 2008 to 2013. This search revealed that parish nurses were providing many interventions to various populations, yet often the outcomes were not successfully measured. Dandridge categorized the articles into the recognized seven main functions of a parish nurse, and she provided a summary of the studies which corresponded to each of these seven functions. One example of this was related to the function as a health educator. The study's goal was to educate and improve physical activity and healthy

eating within the congregation. It was noted, despite a wealth of interventions provided by the FCN, the documentation for the study did not allow for clear measurement of outcomes. This literature review indicated that in general, many of the studies conducted by FCNs lacked unified language and documentation to permit critical appraisal of their work. Dandridge concluded, that despite a growing development and increasing popularity of faith community programs, studies measuring their effectiveness in promoting positive behaviors are lacking. In summary, it was stated parish nursing holds promise in helping to reduce health care disparities, but accurate documentation and clear goals, interventions and outcomes must be measured to facilitate valuable future research (Dandridge, 2014).

The consistent growth in the number of FCNs is gradually leading to an increase in research to advance the body of knowledge. At the Westberg annual symposium in 2015, it was identified that FCNs wanted more opportunities to share and interact. Work began on developing a knowledge ministry platform for FCNs. Focus groups were formed, and goals established, with a timeline for the launch of this platform. (Zalamea, 2015). A literature review article was presented by Ziebarth in 2016, with the aim of exploring literature to prepare for the development of a virtual knowledge platform project for FCNs. Various background concepts and technical details involved with the development and use of this platform was provided. This review discussed the impact this platform can have on the development of guidelines, processing needs, and the creation of an infrastructure that aligns with the mission and vision of the Health Ministry Association (HMA). Ziebarth, 2016a concluded the sharing of knowledge, skills, tools, and various policies, will potentially have an impact on patient outcomes.

## Theoretical and Conceptual Framework

Spiritual care has been identified as an integral aspect in several nursing theories. In Jean Watson's Theory of Human Caring, one of the predominant factors that form the foundation of this theory includes instilling faith and hope. Watson's theory proposes faith and hope are essential to both the caring and the curative processes. Faith and hope through a person's beliefs, assists in providing sense of well-being that is meaningful to the individual. (Petiprin, 2016).

A conceptual analysis was conducted by Ziebarth, (2014) on Faith Community Nursing. She noted FCN is a well-received and established alternative practice for the delivery of health care. Standardized training has been established and this practice has been established in several faith communities. However, with the evolving use of terms, roles and settings, there is a growing concern related to the clarity of the concept of FCN. A historical context is provided, and the emerging role of FCN is discussed in this analysis (Ziebarth, 2014).

A New Conceptual Model: Faith Community Nursing (Appendix A), was introduced by Ziebarth, (2014). This concept map was designed for faith community nursing, and it portrays the relationship between the nurse and the client (client as person, family group or community) as central. This relationship is a cyclical and ongoing process of analysis, where a client strives for optimal wholistic health functioning. Integrating faith into this process is a continual attribute in promoting health, managing disease, and coordinating, empowering, and accessing health care within a faith community (Ziebarth, 2014).

## Summary of the Review of Related Literature

This literature review shows there is consensus for the need to grow and expand research to advance the body of knowledge related to FCN. Additional research opportunities and initiatives related to identifying outcomes are needed to support the practice of FCN. The Faith

Community Nursing Curriculum (2019) noted, currently there is a renewal of the incorporation of faith and health in communities. Dandridge (2014) revealed that FCNs are providing a wealth of interventions to diverse populations, but they do not effectively evaluate the outcomes. FCNs need to address many of these gaps. The evaluation of research success is contingent on the knowledge of what is important to the recipients of faith community nursing (Ziebarth, 2014).

An important aspect of FCN practice is the concept of health promotion from a wholistic and spiritual perspective. While literature specifically describes the role of a FCN, the interventions they can provide, and their value, there is limited research specifically describing the significance of providing baseline knowledge to promote meaning, interest, and involvement from the parish community. There is also some evidence that has shown the importance and merit of conducting a needs assessment. The critical challenge when initiating and building a FCN ministry, is to lay a strong foundation by providing education to parishioners and evaluating their interests and health needs.

# Chapter 3

## Methodology

Faith community nurses are valued and trusted over other healthcare professionals, due to their accessibility, expertise, support, comfort, spirituality and understanding. They provide wholistic health services while highlighting the client's spirituality to promote health and improve the quality of care. Spirituality is a necessary component of FCN that defines this program in contrast to other healthcare services (Mock, 2017). The needs and desires of members of the faith community provide direction for the FCN interaction and have the opportunity to impact health care in a proactive manner (ANA & HMA, p.5). FCNs are challenged to engage in research to grow the scholarly body of knowledge of the practice with specific emphasis on innovation and accountability (Ziebarth, 2014a).

The purpose of the proposed study was to investigate the congregation's knowledge, of a faith-based health promotion program, and to determine what health care topics they perceive as being of interest. The local parishioners in a rural catholic community, have limited understanding of the unique role the church can play in both influencing their health promotion and addressing opportunities for improved self-determination in their health care. An educational program was presented to the participating parishioners, educating them on the unique opportunities a FCN ministry can provide. This researcher evaluated the knowledge gained by attendees, related to a church-based health promotion program and the role of the FCN has in its facilitation. This investigator appraised the faith community's interest in future health care topics by having participants' rank health care topics according to their interest.

### Research Design

The design for the proposed study was a quantitative method with a pretest, posttest interventional design. The intervention portion included a one group, pretest, posttest analysis. The measure used in the proposed study consisted of ten questions, designed to evaluate the parishioner's baseline knowledge, and their knowledge level after viewing an educational video. Each individual's difference between the two scores was calculated and the mean difference was determined. A descriptive survey was utilized to evaluate the participants' interest in future health promotion topics, this was done using a Likert scale ranking.

The hypothesis for the proposed project was, there will be an increase in the parishioners' knowledge following a survey with an educational video presentation, regarding what a faith community health ministry is, and what the role of a FCN includes. Participants also identified future health subjects of interest.

**Setting**

The setting for this study was in a Catholic community in a small rural town in Northwestern Pennsylvania. This church has been a prominent faith presence in the community since 1864. This parish is part of the regional Dioceses of Erie (in Northwestern Pennsylvania). The catholic community was recently merged together from five parish churches into one parish community. The yearly demographic data collected by the church reflects there has been a steady decline in the number of registered parish families. In 2014 there were approximately 1400 parishioner families, and currently there are approximately 775 active families. The vast majority of the congregants are Caucasian, speak the English language, and are over the age 50. The highest percentage of active parishioners is noted to be 51% are age 60 and older (Oil City Catholic Community, 2018). This community is identified as the community and partners

involved in this study who represent the mobilize section within the MAP-IT framework (Healthy People, 2020).

Due to the fact that this study was conducted during the COVID-19 pandemic, the survey and educational program used an on-line format through Campus Labs. The parishioners were provided a generic link to the survey in the weekly church bulletins and the link was able to be accessed through the church website. The link was available for participants to access at their convenience for a period of three weeks.

**Sample**

A convenience sample was used with the inclusion criteria being any parishioner age of 18 and older who voluntarily agreed to access the 30-minute program and complete the survey questions in entirety. The participant must be able to read, navigate the on survey with video, and not be cognitively impaired. The participant's identity was kept completely anonymous. A statement at the beginning of the survey declared, by completing the on-line survey they agree to the terms and conditions to participate in this research study. Therefore, the completion of the survey was considered an implied consent. Since the demographic information may be pertinent in data analysis, the second section of the survey included three demographic questions related to age, gender, and race.

In using a convenience sampling method, the recommended size with a confidence interval of 95% and a statistical power of 0.20, the suggested sample size was to be at least 31 participants. A representative sample of greater than 50 participants is preferred with the hope of obtaining a good depiction of the parishioner's understanding and interests in future potential health topics.

The lead researcher for this project had active participation throughout the study. There were no other data collectors or data entry persons involved. The researcher and the faculty chair were the only persons with access to the raw data. No participant's names were associated with the data or the study. The details provided within the setting and sample descriptions laid out and defined the plan segment of the MAP-IT model. It is important to distinguish clear goals and how the outcomes will be measured (Healthy People, 2020).

**Ethical Considerations**

Prior to starting the proposed study, approval from the Institutional Review Board of Clarion University was obtained. A signed approval letter from the parish pastor was obtained (Appendix B). The parishioners were recruited to participate in the study in a variety of ways. An invitation was placed in the church bulletin for three consecutive weeks, during the time the survey was open for parishioner's participation. This appeal provided a brief overview of the project, survey expectations, and directions on accessing link for the on-line survey. The presiding priest spoke in church at all three of the weekend masses during the time frame the survey was available. The priest's announcement provided a brief overview of the survey. Proper CDC safety considerations and precautions were maintained when this invitation at the masses was provided. A distance of six feet from other persons was maintained, a mask was worn, and no handshaking occurred (Center for Disease Control and Prevention [CDC], 2020), (Kaplan, Hoffman, & Parson, 2020). This personal invite was provided as a recruitment strategy hoping to encourage parishioner enlistment in the survey and to obtain a representative sample of the congregation (Appendix C).

Participation in this study was completely voluntary and no formal consent form was signed. The implied consent statement was documented at the beginning of the survey. This

statement notified the subject that participation in the survey was voluntary. Respondents were informed they may choose to not respond to any questions that they did not wish to answer, and they could withdraw or decide to not participate at any time throughout the survey.

This study was conducted anonymously, and the online survey and the data was not able to be linked to information that could be used to identify the subjects. The survey software used an internet protocol to prevent the user's addresses to be identified or tracked. The indirect and demographic identifiers collected were only used to evaluate if there were differences in the data results based on these identifiers. Per Campus Labs (2021), individual responses to the survey were not able to be identified in any report. A unique identifier number was used for participant tracking purposes. Due to the online nature of the survey, the researcher had no contact with the participants. Subjects were informed that all of the data would be kept confidential and anonymous. Overall, the data was collected and kept anonymous, thus it the lowest level of risk for harm was provided to the survey participants.

The data was collected through the Campus Labs reporting site. The primary researcher was the only person who had a secure, username and password-protected access to the reporting site. Campus Labs has security measures on several levels implemented to ensure that data is not compromised. These include such features as, dual firewalls, encryption, and 24/7 staff and camera surveillance, coding standards, guarding against hacking, password strength rules, and keeping appraised on security and release updates. They are housed within a data center that is compliant with Telecommunication Industry Association standards (Campus Labs, 2021). Data was analyzed using quantitative methodologies, and the results of the data and descriptive statistics was reported in an aggregate form (Campus Labs, 2021).

## Costs

The survey instrument was provided by the University, and no cost was involved with the use of this tool. The survey announcement that was included in the churches' weekly bulletin that is regularly distributed. The business cards distributed were at the researcher's expense. No compensation was provided to participants whatsoever, and participation in the survey did not cause any known financial, social, legal harms or risks to participants.

## Instrumentation

The primary researcher developed an on-line survey which was based on the MAP-IT framework. The researcher developed survey was designed to examine the participant's responses as accurately as possible once completed (Appendix D). To enhance the ease of use this survey, the questions were worded concisely and encouraged subjects to select the associated radio option for their answers. The survey correlates with the assess portion of the MAP-IT framework. Evaluating and measuring the needs of the community is key to success (Healthy People, 2020).

Each participant was guided to complete the sections of the investigator designed survey (Appendix D). The survey consisted of a total of seven sections. The first section consisted of the title of the survey and brief consent to participate. The consent to participate was an implied consent whereas by completing the survey, the respondent agreed to be included in this research project. The details of the consent were outlined at the beginning of the survey, there were nine bulleted statements explaining that their participation was voluntary, and the information will be kept confidential and anonymous. Participants were also informed they may withdraw from participating at any time.

In the second section of the survey the researcher asked the participant to provide three types of demographic information including age, gender, and race. Section three included the ten-question pretest questionnaire. The subject was given ten statements related to information about a faith-based ministry and the role and responsibility of a faith community nurse. Each statement was followed with the possible answer options of "Yes", "No" or "Unknown". The unknown option was provided in an effort to obtain an honest response from the participant. With "Yes" or "No" options, the participant may be guessing and possibly could choose the correct option. This guess would not be an accurate reflection of their knowledge on the topic. The pretest was designed to assess the participant's baseline knowledge of a faith community nursing ministry. A similar survey tool was found from a previous study by Abell (2016). Permission was granted for this researcher to use this tool with modifications (Appendix F).

The questionnaire used in the study by Abell (2016) was not validated however it provided evidence in consistency for the collection of data. Due to the fact that both of these surveys were researcher developed, neither of these surveys were used prior to this study. The reliability and validity for these tools had not been previously tested and therefore the consistency and accuracy of these tools cannot be measured or provided at this time. It is important to note that to evaluate the instrument used for this project, a small pilot study was completed as a trial to assist in determining if the survey questions were ready for implementation. A pilot test from five individuals revealed that the statements were clear to understand and straightforward. Based on this pilot study, no adjustments to the survey questions used in this study were needed. A pilot is important to help identify potential problems and help prevent them from impacting the accuracy of the data collected in this study. According to tools4dev (n.d.), it is valuable to conduct a test of the survey prior to collecting data. Obtaining a

range of five to ten people who are a good representation of the target audience is advised. Piloting the survey will normally identify practical problems with implementation (tool4dev, n.d.). For the proposed study, a pilot test was conducted to determine if any adjustments or adaptations to the survey is necessary (Health and Human Services [HHS], n.d.).

Subjects then viewed a 20-minute recorded educational video presentation on faith-based healthcare and faith community nursing ministry. The information included in this video is described in the program presentation section below. Following the participants observation of the video, the subject was guided to complete the fifth section of the survey which included the posttest questionnaire. The posttest section included the same ten questions as the pretest. Instructions were given, requesting participants to answer all questions to the best of their ability. The test questions assisted in measuring their knowledge gained and if the objectives were met during the presentation of a faith community nursing ministry. One additional follow-up question was included, asking the participant if they would be interested in attending the FCN programs in the future.

The sixth section included a list of twenty potential health care topics that may be offered to the parishioners in the future. This was done to identify and prioritize the subject's interests, for guiding the programming provided once the local Catholic faith ministry is initiated. A Likert scale was used for the subjects to score each potential health topic. According to Harpe (2015), a Likert scale is a common measurement method used to measure various contexts. The challenge is to measure phenomenon that is more cognitive in nature. The distribution of data was what mattered in selecting appropriate statistical testing (Harpe, 2015). Therefore, the statement at the top of this survey states "You are asked to choose your level of interest in learning more about each health topic listed below." The scale options ranged from 1 to 5. The options were, 1= Not

Interested at All, 2= Not Interested, 3= Neutral, 4= Interested, 5= Very Interested. A write in section was also be provided at the end of the section to enable the participant to list other additional health programs or topics that may interest them (Appendix D).

The final and seventh section of the survey informed participants that their survey was complete, and that their results were submitted. They were given a notice of thanks for their participation and were encouraged to watch for future programing options announced in the church bulletin and on the church website. Throughout the survey the participant was encouraged to complete each section. Data was excluded if either the pretest or posttest answers were not obtained. Any surveys excluded from the study were noted in the data results.

**Program Presentation**

Due to limitations from the pandemic, the educational program consisted of a video that included the primary researcher providing information while using a power point presentation as a guide. The video presentation was 20 minutes in length. Included in the presentation were the learning objectives, and content informing them what faith community nursing is. Specifically, educating them on the four main core values of a FCN. These include, spiritual formation, professionalism, whole person health and community were discussed (ANA& HMA, p. 4). An overview of the historical connection between faith and health, and how FCN has evolved over time was addressed. A brief historical perspective led up to the initiation of parish nursing in the 1980's and its growth into what it is today (p.6-8). The definitions of wholistic and wholistic health promotion, were provided (p. 91).

Included in the presentation was a review of the requirements, roles and activities of a FCN. An overview of how a FCNs practice is guided and reflected by both the professional and ethical standards of the nursing profession, as well as the legal scope and standards of

professional nursing practice were furnished (p. xv). The FCN conceptual model was briefly introduced to show how the health consumer, who can be the person, family, group, or community, is at the center of the FCNs focus of care (Ziebarth, 2014). Evidence based research was introduced, showing the connection of how the inclusion of body, mind and spirit has been proven to have health benefits and improved health outcomes. The vision and potential benefits of initiating a faith community nurse ministry within this specific Catholic Church community was shared by the researcher. It was explained to the participants how the health topics preferences identified during the proposed study will be used to plan what programs will be potentially offered in the future.

Lastly congregants were encouraged to participate in future health programs offered from this new ministry. A request for health professionals to consider volunteering and collaborating in this to help make this ministry successful and sustainable was also mentioned. At the end of the presentation, the researcher thanked them for their participation and led them in a closing prayer. The video presentation fulfilled the 'initiate' segment related to the MAP-IT framework. This is the implementation portion of the project and where information is provided to the community (Healthy People, 2020).

**Data Collection**

Once the survey time frame lapsed and was closed, the data was gathered and compiled into the reporting site within the Campus Labs project dashboard. This automated process ensured accuracy and minimized potential data errors. Any incomplete survey responses were reviewed for the need to eliminate their responses from the survey results. The reporting dashboard provided several reporting options and tools which were used to view the data. These options included filtering data, viewing question statistics in a graph form, or crosstab data of the

questions for comparison as needed. Data was exported into an Excel spreadsheet to allow the data to be sorted and organized as needed. The data was filtered based on demographic differences, to evaluate any demographic impact on the results. Any filtering process was conducted carefully using the Excel program features for accuracy. Open ended responses were exported and organized into themes by the primary researcher.

To safeguard and protect the data gathered, the primary researcher was the only person to have access to the raw data. By using the generic link without a validation screen, it was an anonymous survey and neither Campus Labs staff nor the researcher could track the identity of the survey respondent with this link. Additionally, the data entered into the Excel program was kept on a password protected thumb drive that only held the data from this project, and this thumb drive was kept in the locked cabinet accessible only to the researcher.

**Data Analysis**

The hypothesis of this study was achieved by showing that the participant's knowledge of what a faith community ministry includes and what the role of a FCN entails was increased following an educational session. The data that the researcher measured was the difference in scores from the pretests to the posttests. Descriptive statistics was used to provide a summary of the outcomes from the data collected. The posttest score was subtracted from the pretest score to determine the difference between the two scores. If the score decreased from the pretest to the posttest this was reflected in a negative score value. Each individual question variance in score as well as the overall test scores of all the participants were tabulated. The use of a univariate analysis was calculated to describe the distribution of this single variable. The central tendency measurements of mean, median, and mode were explored to examine the dispersion and range of the data. Additionally, the standard deviation of the measures was calculated to evaluate the

spread of the data. The results of the data for each question are displayed in a graph format to aid in the readers understanding of the data results. A Wilcoxon Signed Rank test was used to evaluate if the difference in pre and post test scores were statically significant.

A needs assessment was conducted, and potential future health topic items were totaled and listed in the order of the participants' interests. The Likert scores for each survey item were entered into a spreadsheet. The mean scores for each item were calculated, and tabulated and by using a frequency analysis, the topics were ranked by percentage of interest. The scores for each of the health topics ranking are specified in a graph and are arranged in the order of participants' preferences based on their interests. This ordering of responses determined the health topics that are of priority to the participants. These items will be considered as the priority for future healthcare programs to present to the parishioners. The additional topics of interest that were written in by the participants will also be taken into consideration for future health topic presentations.

The demographic characteristics will be tabulated by looking at the percentage of participants in each of the three demographic data areas. This data is displayed succinctly by using pie graphs.

The researcher also compiled the results of the participants' responses to the question related to the subject's interest and willingness to participate in a faith community ministry program, once they are initiated within the parish community. The results from this question were analyzed separately, and the average of scores were calculated and presented in a graph format to show a general overall interest in future faith health ministry programs.

The data analysis segment for this study is equivalent to the track portion and the final step in using the MAP-IT framework. This is where the data is analyzed, and leads to answering

if the goal was attained, leading to what the next steps in the process should be. (Healthy People, 2020). The data collected will help to provide the researcher, the pastor and the parish, community with baseline information for laying the basic foundation to initiate a faith community nurse led health ministry.

**Time Schedule**

Once IRB approval was obtained, the project was initiated in May 2021, and the survey was available for three weeks. The presiding priest announced the survey and encouraged participation at the weekend masses. The three weekend masses were held on Saturday at 4 PM, Sunday at 8AM, and 9:45 AM. Following survey close date, the data was automatically entered into an Excel spreadsheet, and the accuracy of data was examined as previously described. The time frame to calculate and analyze the data, validate the statistical components, and draw conclusions was within four months following the close of the survey.

**Summary of Methodology**

A faith community program, led by nurses is a recognized and reliable resource for health-related services (Ziebarth, 2016). The FCN can be a bridge by joining the disciplines of nursing and spiritual care within a faith community. One of the most important elements for the success of a parish nursing program is the endorsement and support from the faith community (McCabe & Somers, 2009). As ministries begin, it is vital to consider the factors for success, assessing the needs of the faith community is a prerequisite to meeting those identified needs. Identifying needs, establishing priorities for programing, and starting slow, is a good starting place to build a faith-based health program upon (FCN Curriculum, 2019).

This researcher attempted to measure the participants' increased knowledge of the benefits of a faith community program and identify health care topics based on the congregants'

interests. Applying the information acquired from this study and utilizing the steps of the MAP-IT framework established by The Healthy People 2020 initiative, has the potential to build a strong foundation in creating a faith community health program within one congregation. The results of this program may help in the development of future faith-based health programs and lays the groundwork in producing evidence that helps to inform this unique area of advanced nursing practice.

# Chapter 4

## Results and Discussion

The specialty practice of faith community nursing is centered on the spiritual aspect of health promotion. In initiating a faith-based program, the faith community nurse (FCN) must educate, collaborate with, and investigate the needs and desires of the individuals within the faith community. To initiate a FCN ministry, it is important to do an early, ground level investigation. The focus of this DNP project was to use an online descriptive survey to gather data related to participants' understanding of what a faith community health program is and how this program can be valuable in promoting body, mind, and spirit wellness. This quantitative method used an online pretest, posttest survey format. Participants then ranked a list of potential future health promotion topics of interests by using a Likert scale.

## Project Design and Model

### Project Design

This researcher evaluated the knowledge gained by attendees, related to the benefits of a church-based health promotion program, and the role of the FCN. This was accomplished with the use of an online survey. Applying the information acquired from this study and utilizing the steps of the MAP-IT framework established by The Healthy People 2020 initiative, has the potential to build a strong foundation in creating a faith community health ministry within this congregation.

This research used both an investigational and a descriptive design method, using a quantitative method of a one group, pretest, and posttest analysis. The questions were designed to evaluate the parishioner's baseline knowledge and their post intervention knowledge level,

following an educational video. The descriptive portion utilized a Likert scale to rank health topic preferences for this specific population.

## Project Setting and Population

The micro-level population at the center of this project, included parishioners from a Catholic parish in a rural area in Northwestern Pennsylvania. Human subjects were recruited to complete this survey in assessing the parishioner's knowledge and evaluating their interest in a faith-based health ministry program. Based on 2018 church data, there were 1500 registered parishioners, with approximately 775 active parishioners. Over the past few years, the number of active parishioners has significantly diminished related to the recent mergers of the five catholic parishes, and the COVID-19 restrictions. A convenience sample was used with the inclusion criteria of any parishioner 18 years of age and older, who voluntarily agreed to complete the entire survey, by answering the pre-and post-questions. The participant must be without cognitive impairments and be able to navigate the online survey. The survey period took place over three weeks in May of 2021.

## Objectives

The main objective for this project was to lay a foundation in initiating a faith community health program within a rural Christian parish. The researcher's aim was to assess whether an educational program would increase participant's basic knowledge related to the role of a faith-based nurse and the benefits a faith community ministry. The researcher also assessed topics related to health promotion and prevention measures based on the congregants' interests. The questions purported in this study are:

1. What is the effect of an online educational program on congregants' knowledge of a Faith Community Nursing Ministry? The hypothesis reflecting this objective is, following an online educational presentation the participants will have an increased knowledge regarding what a faith community health ministry is, and what the role of a faith community nurse includes. The null hypothesis would be the participant did not increase their knowledge pertaining neither the role of a FCN, or a faith-based ministry.
2. What health topics are of interest to a parish community? The participants will indicate interest in participating in future faith community health ministry programs and will rank their interest in various health related topics.

**Ethical Consideration/Human Subject Protection**

Due to the fact that this study was conducted during the COVID- 19 pandemic, the survey and educational program was conducted using an online format through Campus Labs. The parishioners were provided a generic link to the survey in the weekly church bulletins and the link was able to be accessed through the church website. The link was available for participants to access at their convenience for three weeks.

Protection at the network level included features such as dual firewalls, SSL encryption and. Campus Labs servers are protected with staff and camera surveillance. They are housed within a data center that is compliant with Telecommunication Industry Association standards (Campus Labs, 2021).

Data was able to be accessed by the lead researcher in real-time as it was being collected. There were no other persons involved in the data collection, a statistician assisted to confirm the accuracy of the statistical conclusions. No other persons had access to the raw data and no names

were associated with the data or the study. Campus Labs (2021) noted, individuals completing the survey were not identified in any way. Due to the online nature of the survey, the researcher did not have any contact with participants. Data was analyzed using quantitative methodologies, and the results of the data and descriptive statistics were reported in an aggregate form (Campus Labs, 2021).

**Data Collection-Procedures**

The survey on the Campus Labs site was available for the subjects to participate over 22 days. Campus Labs implemented security measures on several levels to ensure that data was not compromised. Survey data is not destroyed or deleted once the survey is complete. The data is only available to those with a designated passcode to the site. The primary researcher is the only person who has a secure, username and password-protected access to the reporting site. The survey software has an internet protocol to prevent the user's address to be identified or tracked reported (Campus Labs, 2021).

Each participant was given a unique identification number, this number ensured the participant information and scores remained private and anonymous. The indirect and demographic identifiers collected were only be used to evaluate if there were differences in the data results based on these variables. The data collected provided the lowest level of risk for harm to the survey participants. All data gathered from the survey was gathered by the primary researcher and inputted into an Excel spreadsheet. The data was stored on a password protected removable drive. This data will be permanently deleted within 3 years of the completion of the survey.

Data was analyzed using quantitative methodologies, and the results of the data and descriptive statistics are presented below. Data of a participant was excluded if either the pretest or posttest data is not obtained. Any surveys excluded from the study were noted in the data results.

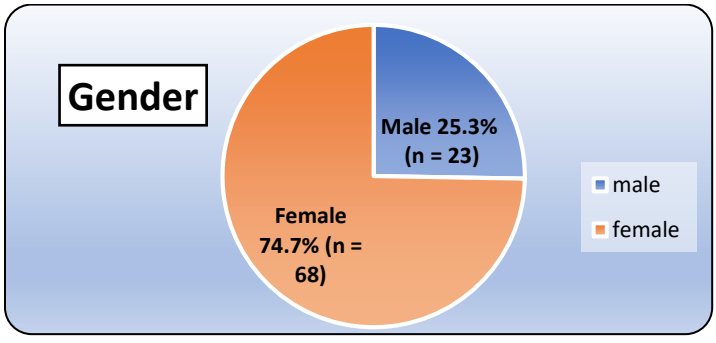
## Findings

### Demographics

Demographic characteristics serve as independent variables in the research design. The demographic data gathered for this study included gender, race, and age. This information was primality gathered to determine if the individuals who participated in this study are a representative sample of the population of the congregation for generalization purposes. The data was evaluated and divided into various groups based on demographic information.

There was a total of 91 parishioners (n = 91) who responded to and completed the survey. Of these subjects included in the analysis 74.7% (n = 68) were female, and 25.3% (n = 23) were male (Figure 1).

**Figure 1** – Gender



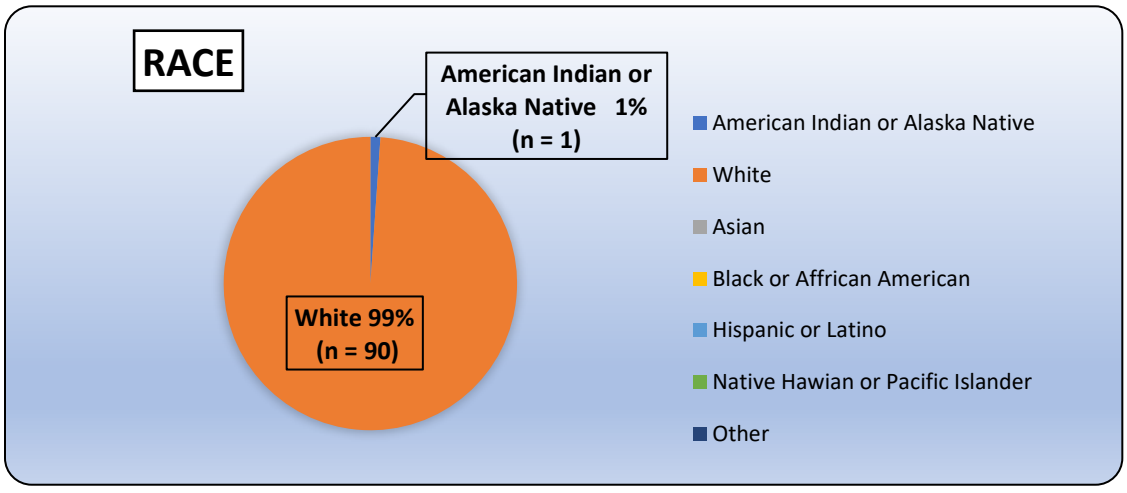

While three fourths of the survey participants were female and one fourth male, the variable of gender was not statistically evaluated to determine if it contributed to a difference in the outcome

score. The female average score difference was 2.4 points and male average score difference was 2.6 points. There were no obvious score differences noted based on gender.

It is unclear why more females participated in the survey. Smith (2008), concluded that women are more likely to participate in surveys than men. In his attempt to explain why higher survey response rates were from females, he noted womens' behaviors are more consistent with characteristics related to empathy and connectiveness. Thus, being a survey respondent is more highly valued by females than males. Additionally, the survey topic was shown to also influence response rates.

Subjects by race, were 99% (n = 90) identified as white, and 1 % (n=1) identified as American Indian or Alaskan Native (figure 2). The demographic results showed that the vast majority 99% of the participants were white. This result is reflective that the 98% congregation's population for this survey is mainly white. Due to the homogenous sample the potential impact race had upon the survey outcomes was unable to be determined for this study.

**Figure 2** - Race




The percentage of participants based on age were found to be, 2% (n= 2) age 18 to 30, 10% (n= 9) age 31 to 40, 7% (n= 6) age 41 to 50, 19% (n= 17) age 51 to 60, 45% (n= 41) age 61

to 70, 14% (n= 13) age 71 to 80, and 3% (n= 3) age 81 and over (Figure 3). This was found to be a similar distribution of age range of active parishioners based on data collected in 2018 (Figure 4).

In evaluating if there is a correlation between age and their score, an average score was determined for each age group. The average score difference from the pretest to the posttest for all of the participants was 2.5 points. The average score differences based on age were found to be, 3.5 for the age group of 18 to 30, 2.1 for the age group of 31 to 40, 2.7 for the age group of 41 to 50, 2.8 for the age group of 51 to 60, 2.07 for the age group of 61 to 70, 2.76 for the age group of 71 to 80, and 3.3 for the age group of 81 and over. None of the age groups average scores were greater than (+) or less than (-) one standard deviation (Table 1). It is concluded that there was no significant variation in testing score difference, based on age.

**Figure 3 –** Survey Participants Age

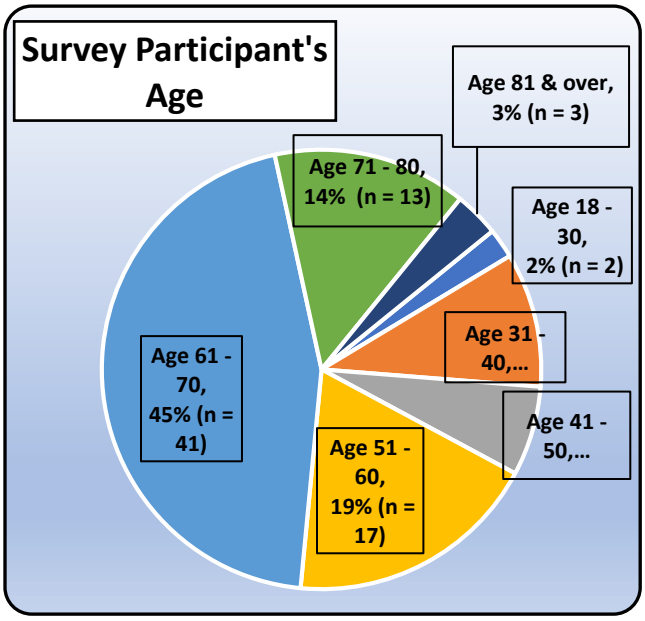
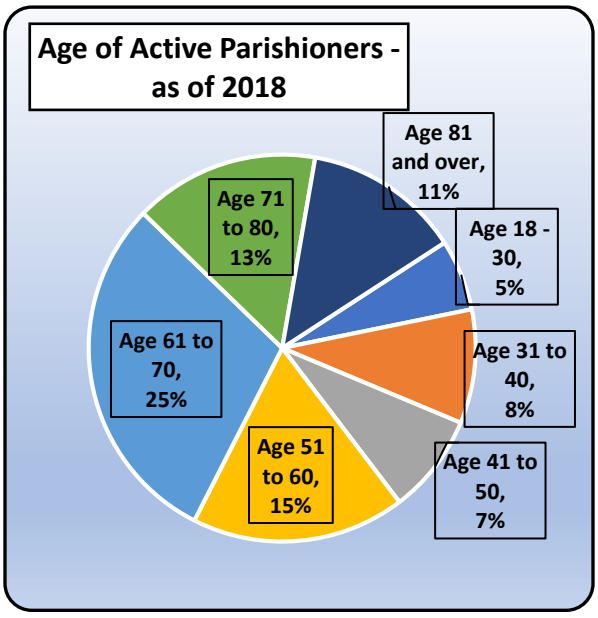


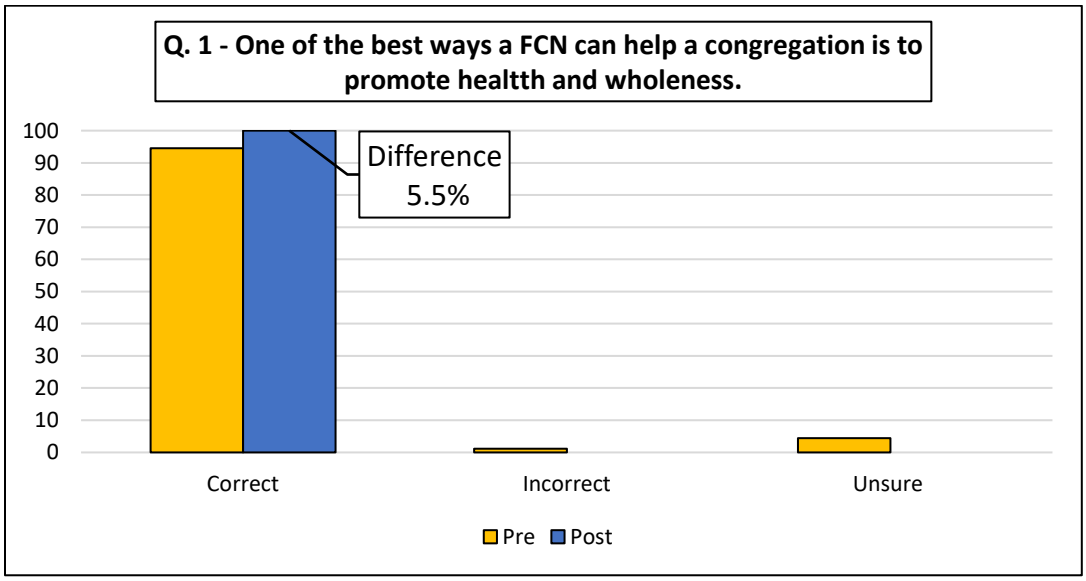

**Figure 4** – Age Active Parishioners (2018)



**Outcome Results**

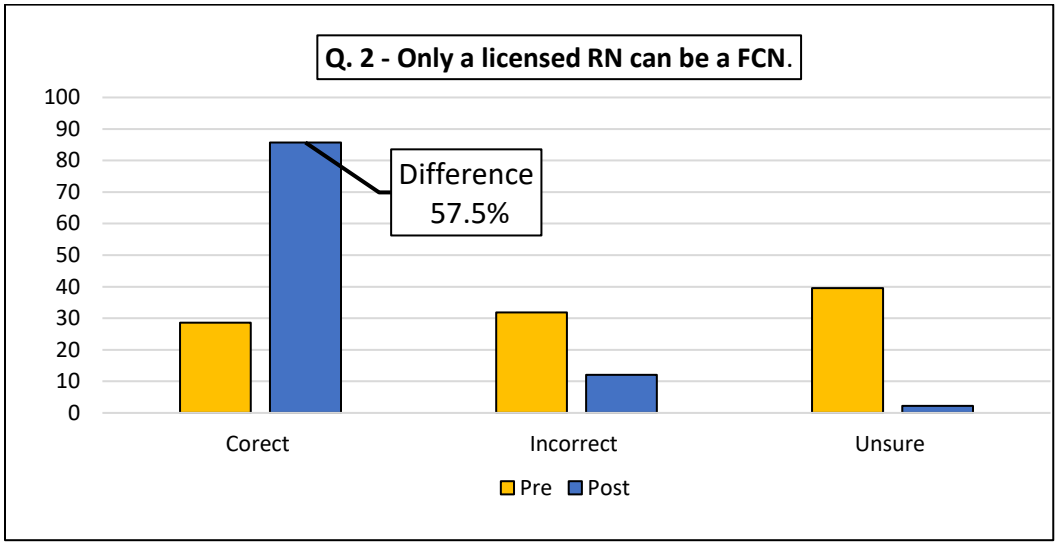
The first aim for this study was to measure if the subjects had an increased knowledge following an educational program. The participants were asked the same ten questions both pretest and posttest. Subjects were asked to honestly answer the questions by choosing one of the options of "yes", "no" or "unsure". These options were provided to encourage accuracy of the results, instead of merely guessing the answer as "true" or "false". The data will reflect the answers as "correct", "incorrect", or "unsure". Each of the pretest and posttest responses were evaluated to determine the effectiveness of the intervention as the independent variable.

**Figure 5 –** Question 1



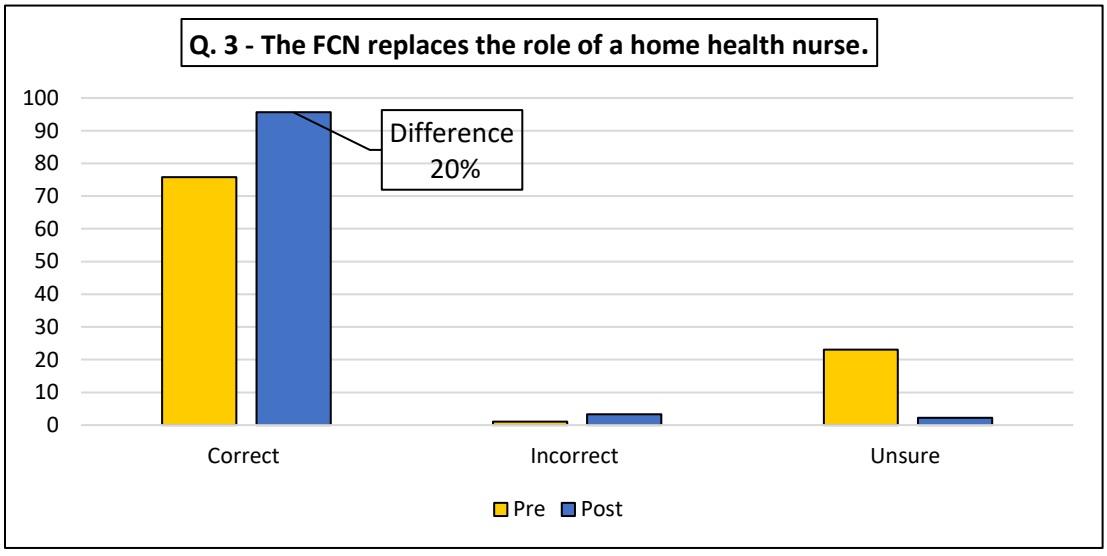

The first question assessed their knowledge asking if one of the best ways a FCN can help a congregation is by promoting health and wholeness. Pretest scores, 94.5% (n = 86) were correct, 1% selected this as incorrect, and 4.5% (n = 4) selected unsure. Upon completion of the educational video, 100% (n = 91) selected the correct response that the best way a FCN can help a congregation is by promoting health and wholeness. This exhibited a 5.5% increase in participant's knowledge on this topic (Figure 5).

**Figure 6 –** Question 2



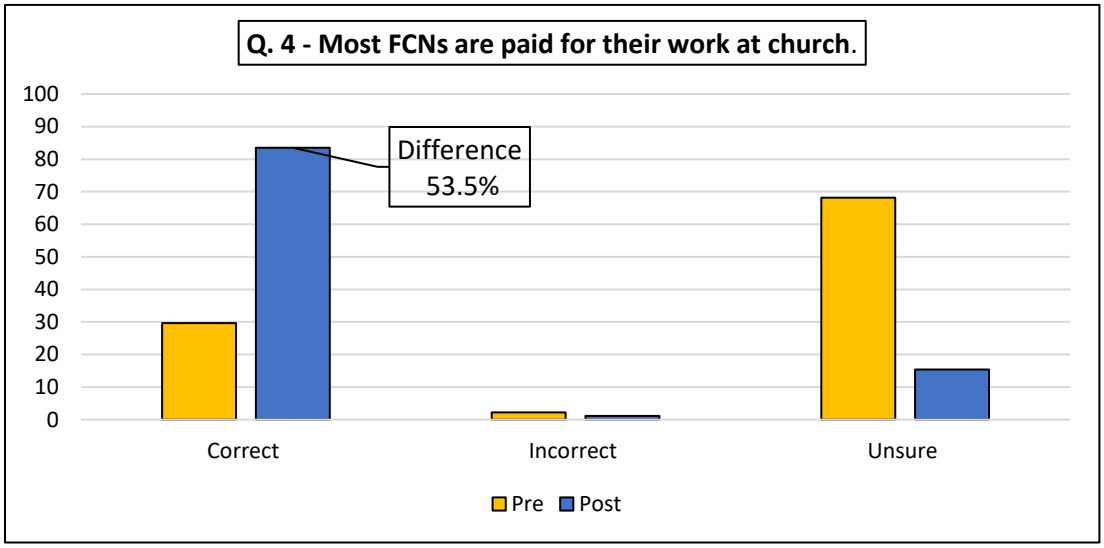

The second question reflected the highest increase of the participant's knowledge on the topic related to the statement that only a currently licensed registered nurse can be a FCN. In the pretest, 28.5% (n = 26) responded correctly, 32% (n = 29) responded incorrectly, and 39.5% (n = 36) responded unsure. Post educational video, 86% (n = 78) responded correctly, 12% (n = 11) responded incorrectly, and 2% (n = 2) responded unsure. This reflected a 57% increase in participant's understanding that a FCN must be currently licensed to practice (Figure 6).

**Figure 7 –** Question 3



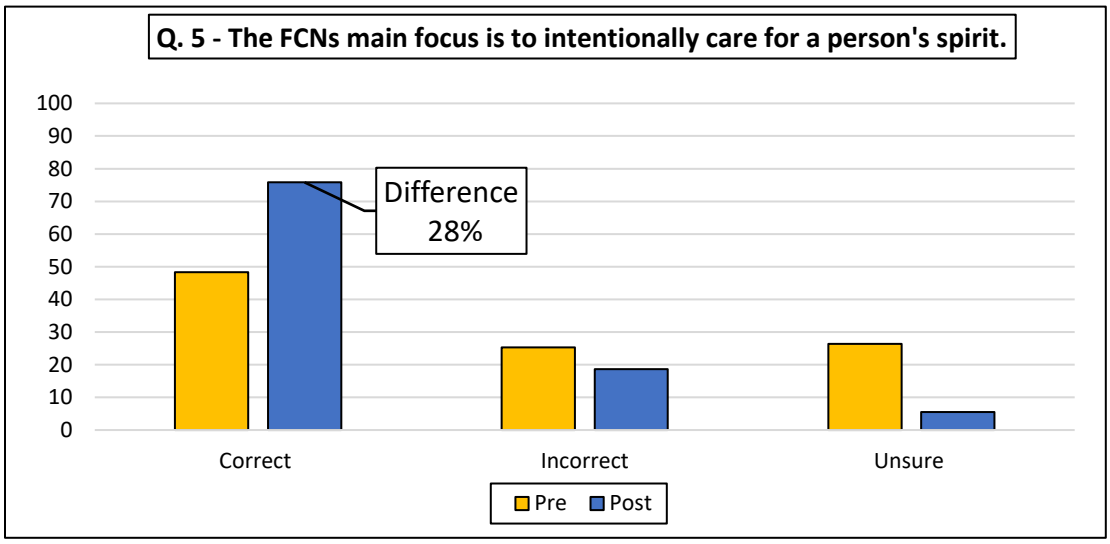
Participants were then asked if the role of the FCN replaced the role of a home health nurse. 75.5% (n = 69) initially replied correctly, 1% (n = 1) replied incorrectly, and 23% (n = 21) were unsure. Post video 95.6% (n = 87) replied correctly, 3% (n = 3) replied incorrectly, and 1% (n = 1) were unsure. This showed a 20% increase in the participant's comprehension that the FCN does not replace the role of the home health nurse (Figure 7).

**Figure 8 –** Question 4



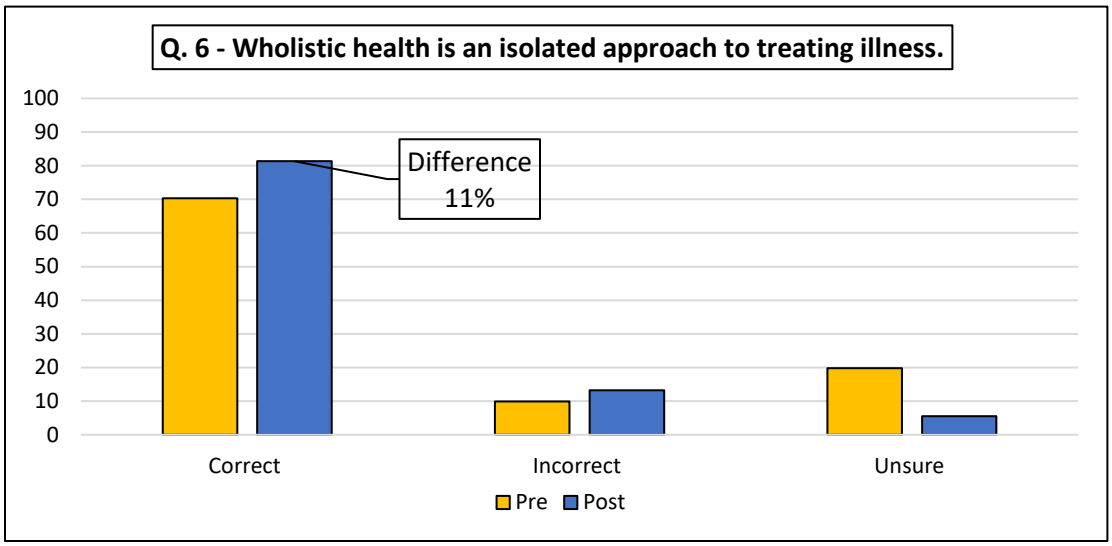

The question related to if most FCN are paid for their work at their church showed the second highest in improvement in the participant's knowledge. This provided the second highest increase in differences in scores from pre to posttest. Pre-intervention, 30% (n = 27) answered correctly, 2% (n = 2) answered incorrectly, and 68% (n = 62) respondents were unsure. Post intervention, 83.5% (n = 76) answered correctly, 1% (n = 1) answered incorrectly, and 15.5% (n = 14) respondents remained unsure. This reflected a 53.5% increase in learning that the most FCNs are not paid for their work at their church (Figure 8).

**Figure 9 –** Question 5



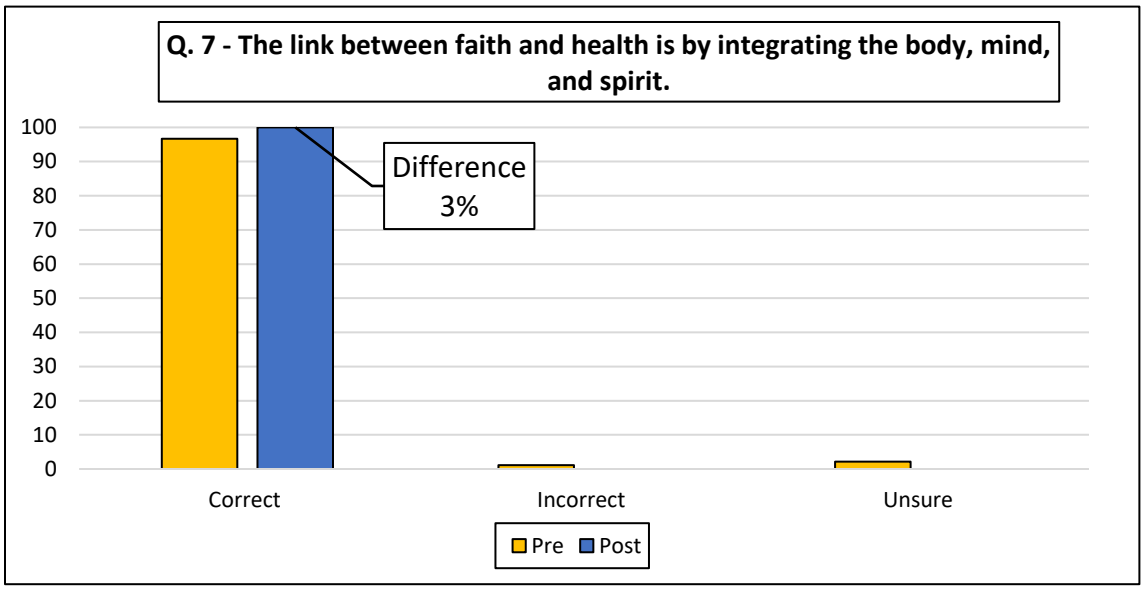

The congregant's knowledge associated with the point that the FCNs main focus is to intentionally care for a person's spirit was evaluated. Pre-intervention, 48% (n = 44) answered correctly, 25% (n = 23) answered incorrectly, and 26% (n = 24) respondents were unsure. Post intervention, 76% (n = 69) answered correctly, 18.5% (n = 17) answered incorrectly, and 5.5% (n = 5) respondents remained unsure. This indicated a 28% increase in the understanding that the FCNs main focus is to intentionally care for a person's spirit (Figure 9).

**Figure 10 –** Question 6



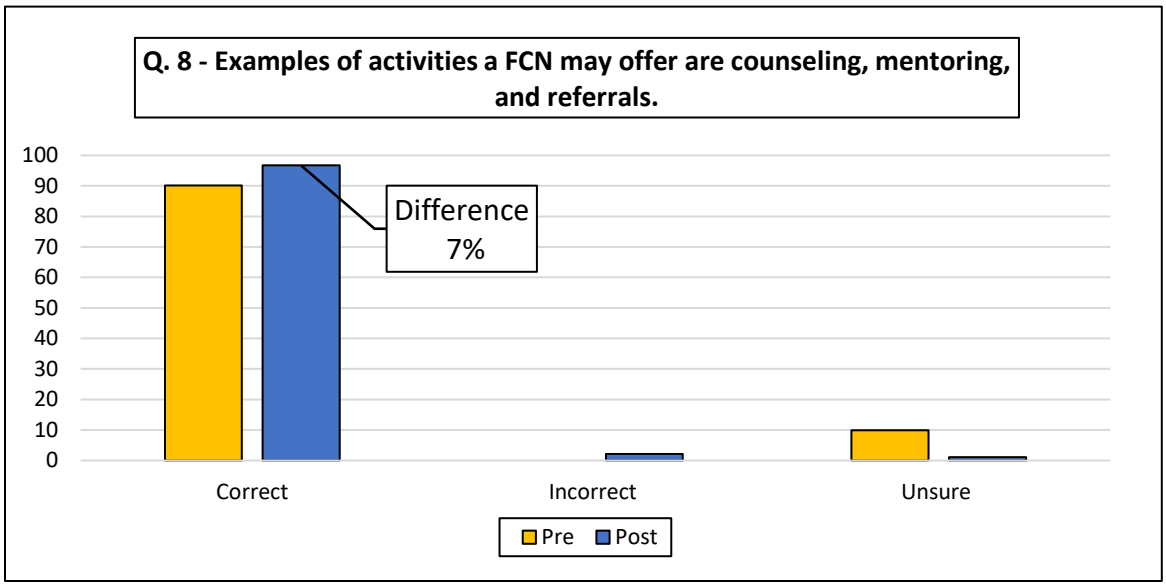

When asked if wholistic health is an isolated approach to treating illness, when in truth wholistic health is a multidimensional approach to treating and preventing illness. The results pretest revealed 70% (n = 64) answered correctly, 10% (n = 9) answered incorrectly, and 20% (n = 18) respondents were unsure. After the education video, 81% (n = 74) answered correctly, 13% (n = 12) answered incorrectly, and 5.5% (n = 5) respondents were unsure. This indicated a 11% increase in the realization that the FCNs main focus is to intentionally care for a person's spirit. It also revealed a 3% increase in the participants selecting the incorrect answer (Figure 10).

**Figure 11 –** Question 7



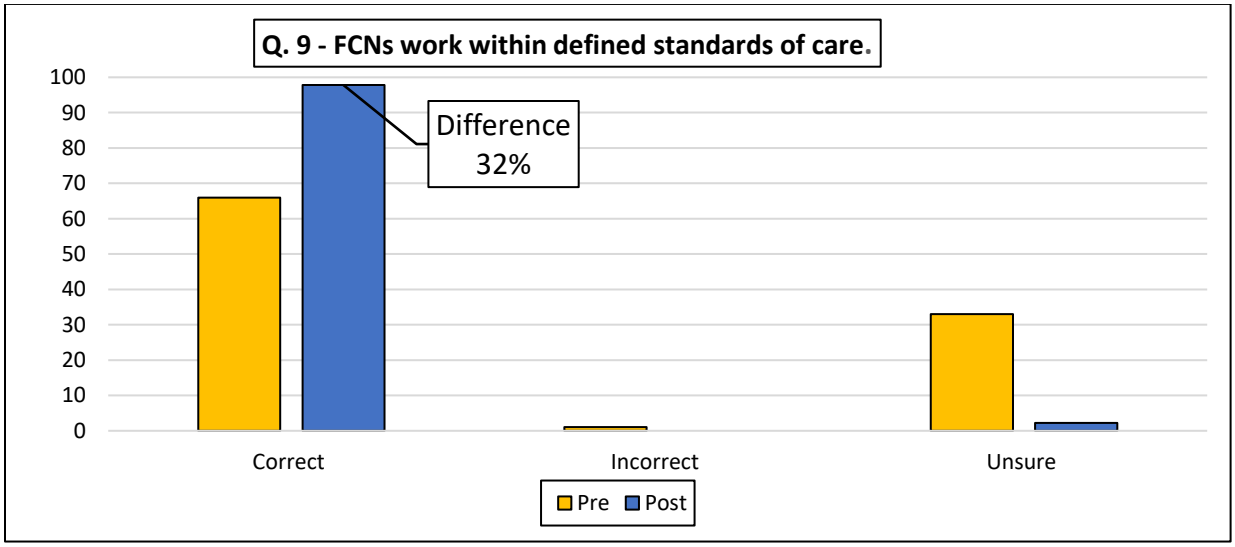

The lowest change between pretest and posttest knowledge was connected to query if the link between faith and health is by integrating the body, mind, and spirit. Pretest findings displayed 97% (n = 88) answered correctly, 1% (n = 1) answered incorrectly, and 2% (n = 2) respondents were unsure. After the education video, 100% (n = 91) answered correctly, reflection a 3% increase in knowledge (Figure 11).

**Figure 12 –** Question 8



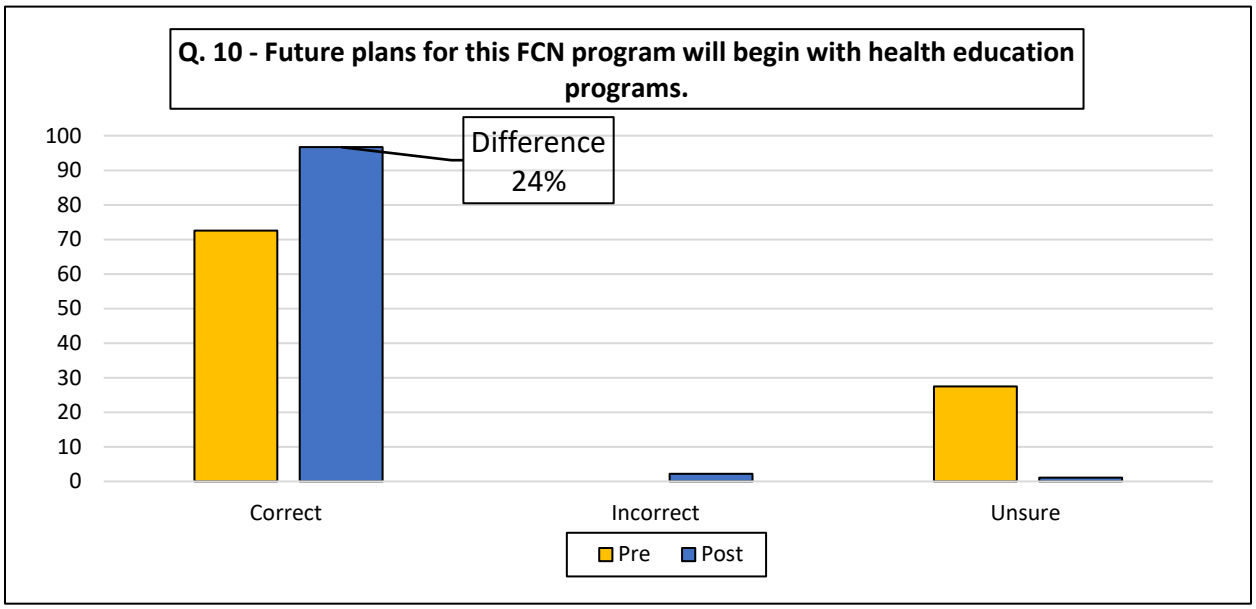

Another question that was put toward the subjects was to consider examples of activities a FCN nurse may offer include counseling, mentoring, and making referrals as needed. The results pretest displayed 90% (n = 82) answered correctly, 0% answered incorrectly, and 10% (n = 9) respondents were unsure. After the intervention, 97% (n = 88) answered correctly, 2% (n = 2) answered incorrectly, and 1% (n = 1) respondents remained unsure. This indicated a 7% increase in their comprehension that examples of activities a FCN nurse may offer include counseling, mentoring, and making referrals as needed (Figure 12).

**Figure 13 –** Question 9




The following question examined if the FCN must work within defined standards of care. Initial data exhibited 66% (n = 60) answered correctly, 1% (n = 1) answered incorrectly, and 33% (n = 30) respondents were unsure. Post intervention, 98% (n = 89) answered correctly, 0% answered incorrectly, and 1% (n = 1) respondents were unsure. This signified the third highest response increase, noting a 32% improvement in the participant's realization that the FCN must work within defined standards of care (Figure 13).

**Figure 14 –** Question 10

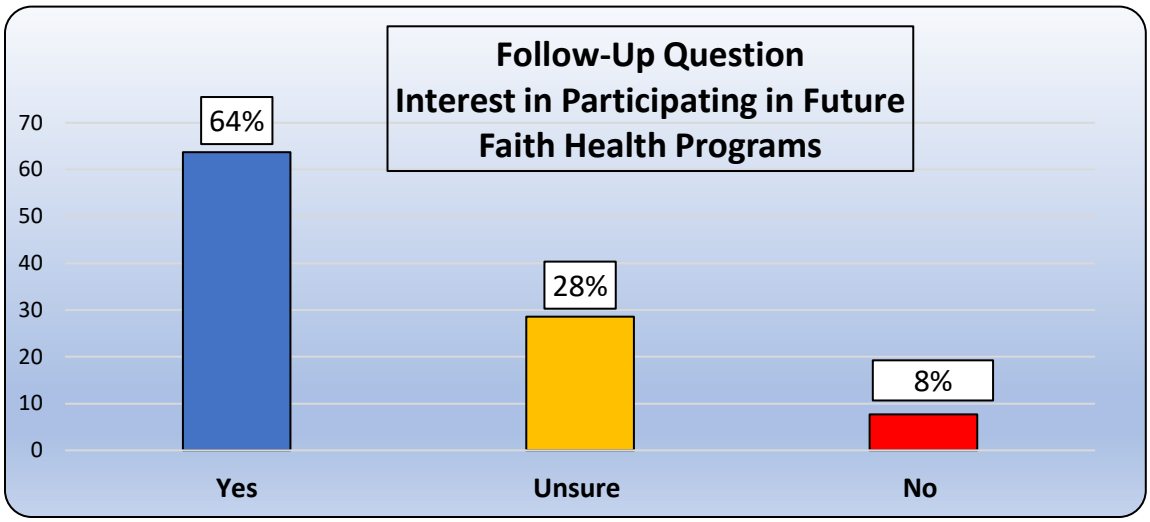



The last of the ten questions, inquired if the future plans for the FCN program at this congregation will begin with health education programs. Pretest 73% (n = 66) of the participants answered correctly, 0% answered incorrectly, and 27% (n = 25) were unsure. Posttest 97% (n = 88) answered correctly, 2% (n= 2) answered incorrectly, and 1% (n = 1) were unsure. These results exhibited a 24% increase in the knowledge that the future plan for this congregation is to initially begin with educational programing (Figure 14).

**Willingness to Participate in Future FCN Programs**

To assess parishioner's potential interested in attending faith community health programs, they were asked a follow-up question, and provide their willingness to participate in future programs when offered. These findings suggested that 64% (n = 58) of the survey participants would be interested in attending future faith health programs, 8% (n = 7) were not interested in joining future programs, and 28% were unsure if they would participate in future faith health programs when offered to the congregation (Figure 15).

**Figure 15** – Follow-Up Question - Interest in Participating in Future Faith Health Programs

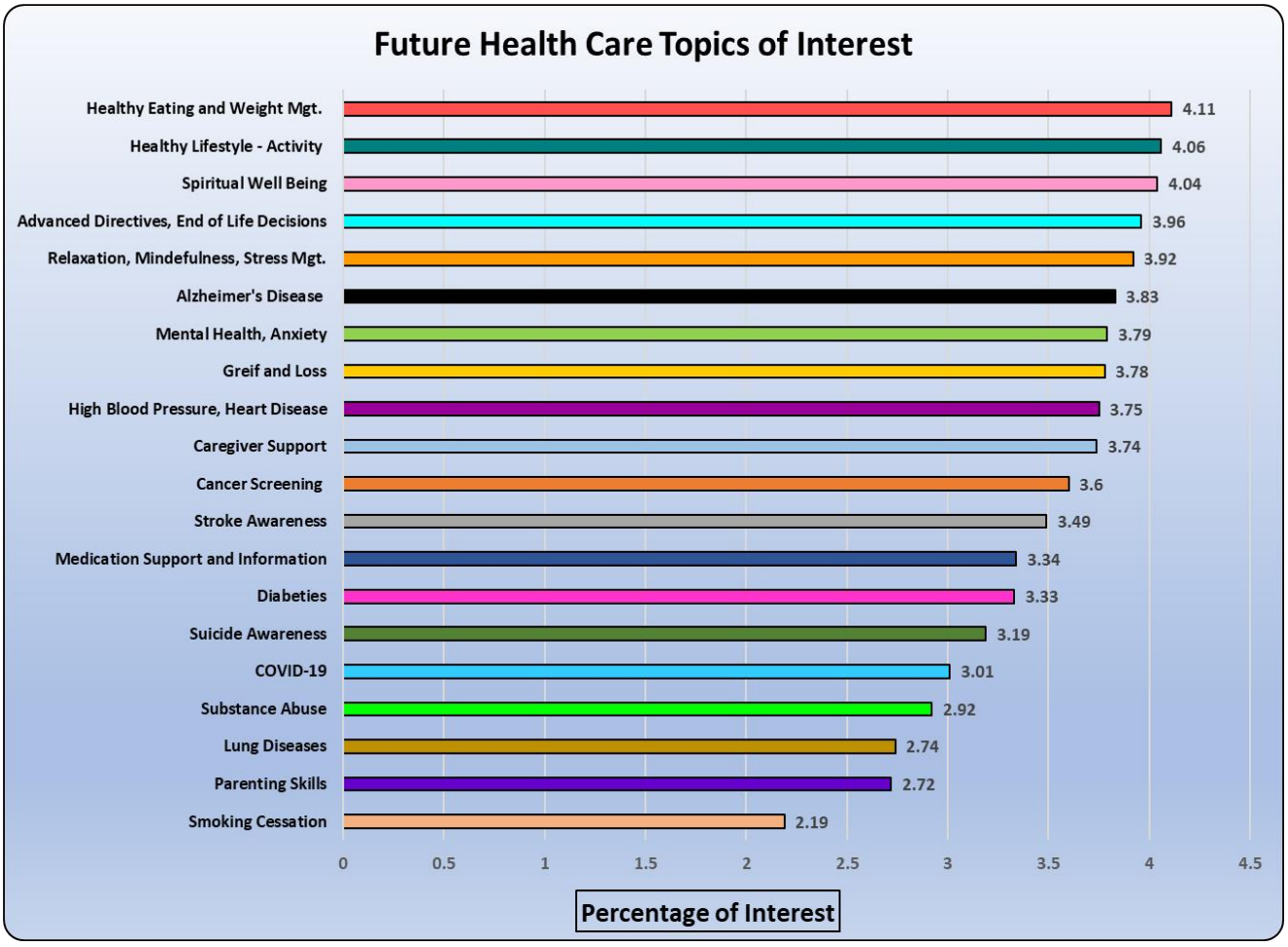



**Future Health Care Topics of Interest**

The second aim for this study, was to determine what faith-based health topics the participants expressed the most interest. Twenty potential health related topics were presented, and participants selected on a Likert scale ranging from one to five choosing which health topics they conveyed the most interest. The options were, 1= Not Interested at All, 2= Not Interested, 3= Neutral, 4= Interested, 5= Very Interested. To establish this, the mean scores for each topic were tabulated and by using a frequency analysis and the topics were ranked by mean interest. The scores for each survey item were entered into a graph along with the mean score (figure 16). These ordering of responses were used to identify the health topics that are of priority to the participants and will be considered as the priority for future healthcare programs to present to the parishioners. The additional topic of interest that were written in by the participants will be taken into consideration when providing health topic presentations. The patterns of interest are displayed in Figure 16.

A write-in section was provided at the end of the potential future topics of interest portion, to enable the participants to provide additional health topics that may be of importance. Eleven participants offered suggestions for subjects of interest. These included: advocacy for mental health and stigma, communication approaches with family and children who have fallen away from their faith and church, education on what to expect with the aging process, assisting in transitioning from home to nursing/personal care homes with dignity, eating disorders, support for patients and families during end of life, recommendations of good references for spirit and health information, coping with chronic pain, patient rights and advocacy especially for terminal and elderly, and visiting sick and elderly parishioners.

**Figure 16** – Future Health Care Topics of Interest



## Discussion of Results

### Hypothesis Testing

The initial hypothesis, which was to measure if an increase in knowledge was achieved by the participants, regarding what a faith community ministry is and what the role of a FCN was examined. An analysis of the statistical significance was not conducted for each individual question as it is difficult to ascertain based on the findings for one question. For that reason, the total pre-posttest score difference based on all ten questions was utilized.

To determine which hypothesis test is more appropriate here, a D 'Agostino's $K^2$ Test for Normality is done on the distribution of difference scores (Posttest versus Pretests scores) (figure 17). The resulting hypotheses are as follows:

$H_0$: The distribution of differences is from a normal distribution

$H_1$: The distribution of differences is from a non-normal distribution

The Normality test results in a $K^2 = 10.15$, n=91 and associated p-value of 0.0063. Therefore, the null hypothesis is rejected, in favor of the alternate which is the data is non-normal. A *paired t-test* is not appropriate and a paired non-parametric test like that of the Wilcoxon Signed Rank test is more appropriate. The data fits the assumptions made in the Wilcoxon Signed Rank test. These are:

- Data are paired and come from the same population.
- Each pair is chosen randomly and independently.
- The data are measured on an interval scale using within-pair differences

This researcher expected to see an increase in test scores given the introduction of the education therefore a One-sided test is used with the alternate hypothesis that the median score difference in the post vs pretest scores is positive. Thus, our hypothesis for the Wilcoxon Signed Rank test are as follows:

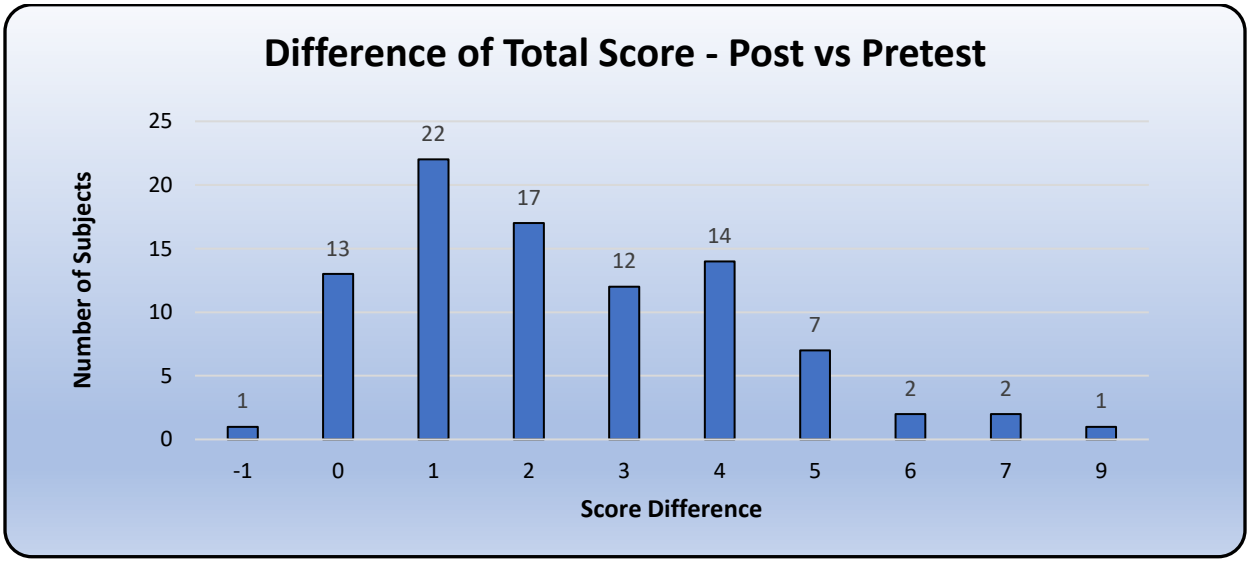
$H_0$: The median difference is zero versus

$H_1$: The median difference is positive $\alpha=0.05$

Where the median difference is Median $_{\text{Post Test}}$ - Median $_{\text{Pre-Test.}}$

The resulting test statistic is W=3069.0, n=91 with associated p-value=9.56e-15. Given the p-value associated with our test-statistics is less than 0.05, we reject the null hypothesis in favor of the alternate and thus can say with 95% confidence that the difference in post and pre-test scores is positive. This indicated that the values of the post-test scores are larger than the pre-test scores (figure 17).

**Figure 17 –** Difference of Total Score Post vs Pretest



The percentage of pre to posttest score difference on the individual questions ranged from a 3% to a 57.5% improvement in their scores. When examining the overall score, the mean pretest score was 6.7, or a grade of 67%. The pretest scores ranged from 1 to 10, or if graded ranged from a 10% to 100%. The mean posttest point score was 9.1, reflecting a 91% grade. The posttest scores ranged from 6 to 10, or a 60% to 100% grade. When examining the score differences based on the total score of all ten questions, there was an average of a 2.4 point increase in the overall score from pretest to posttest (figure 17).

**Future Health Care Topics of Interest**

In examining the second aim for this study to determine what faith-based health topics the participants expressed the most interest. The three topics that exposed a mean of 4 points or higher were, healthy eating and weight management, healthy lifestyle and activity, and spiritual well-being. There were seven topics that scored in the 3.9 to 3.7 range. These themes included information related to; advanced directives/end of life decisions; relaxation, mindfulness, and stress management; Alzheimer's disease; mental health and anxiety; grief and loss; high blood pressure and heart disease; and caregiver support. The lowest four subjects of interest which showed mean interest below 3 included: substance abuse; lung disease; parenting skills; and smoking cessation (Figure 16). These ordering of responses, in addition to the written in responses by the participants, will be taken into consideration and be a guide when developing upcoming faith-based health topic programs.

**Limitations**

Potential threats to the validity of the survey were considered. The survey was initiated during the COVID epidemic placing contagious risk with persons gathering in large bodies, this may have reduced the number of participants in this study. Due to the pandemic health

restrictions the educational program and survey was conducted online and not in person as originally planned. The online survey required the participant to access the survey via an electronic device using a link. This may have led to a limited number of participants and restricted participants who did not have the skill or knowledge of access or navigate this process, specifically older congregants. The survey participants, as previously discussed, was a fairly good representative of the of the active congregants in the population studied. These participants in this study were mainly white, three quarters were female and 64% were over 50 years of age. It may be difficult to compare the outcome results from this study and apply it to a different population in a different geographic area.

There were a total 108 subjects who voluntarily responded to the online survey. Nine subjects were eliminated due to not completing the posttest questions, the researcher was not able to compare their scores. The final sample size was ninety-one (n = 91). Prior to initiating the survey, there was concern participants would not know how to return to complete the survey after viewing the educational recording. A computer screenshot with instructions was added at the end of the video, on how to exit out of the video and complete the survey posttest. Despite these instructions nine of the participants only completed the pretest and did not complete the remainder of the survey following the video. Therefore, these participants who only completed the pretest were eliminated from the survey results.

**Summary**

Church based faith community nursing ministry programs are expanding, despite this many nurses and pastors have a lack of understanding of what the faith community nursing role involves (O'Brien, 2014, p. 311). In a qualitative study by Kuhn (2007), a FCN stated, "Spiritual nurturing contributes to improved satisfaction and quality of life, improved health, reduced

functional disability and lower levels of depression" (as cited in O'Brien, 2014, p. 323). Faith the Joint Commission has also recognized the value of assessing spiritual and religious beliefs and needs of patients (p.55). Initiating such a program will attempt to enrich spirituality, reduce health disparities, and assist in meeting the health needs within this congregation.

The framework used to guide this study was the MAP-IT tool which utilizes the steps to mobilize, assess, plan, initiate and track findings while attempting to achieve a goal. This model was developed by Healthy People 2000 initiative to provide a tool to steer projects in improving community health (Healthy People, 2020). In using this outline to guide the initiation of this Faith Community study, a Catholic community in a rural PA was mobilized, their baseline knowledge and needs were assessed, an educational program was planned, an online survey was initiated, and lastly the data and results were tracked and recorded.

The information provided in the educational session exhibited a greater than 95% statistical significance in the difference in posttest and pretest scores, indicating that the participants overall knowledge of what a faith-based community health program is, and what the role of a faith community nurse includes were greatly increased. Data collected showed an increase in knowledge in each of the ten questions the subjects answered. The percentage of pre to posttest score difference on the individual questions ranged from a 3% to a 57.5% improvement in their scores. When examining the overall score, the mean pretest score was 6.7, or a grade of 67%. The mean posttest point score was 9.1, reflecting a 91% grade. This reflected a average of a 2.4 point increase in the overall score from pretest to posttest (figure 17).

When initiating a Faith community ministry, it is essential to lay a foundation by providing and establishing baseline knowledge within the population that will be served. It is critical to know the needs of the congregation (Smothers, 2016). The most relevant health

subjects that were identified by this community included healthy eating and weight management, healthy lifestyle and activity, and spiritual well-being. These health topics will assist as guidance when lying the foundation and initiating this ministry.

# Chapter 5

## Summary, Conclusions, and Recommendations

### Summary of Findings

With the rising health care costs in the US, the emphasis on prevention and health education has spurred the justification of shifting health care delivery beyond the walls of traditional health care settings. Initiating a faith community program, led by nurses is a recognized and reliable resource for primary health care and health related services. Faith-based health promotion values the integration of the body, mind, and spirit, with health education and support programing. The goal is to promote health, prevent disease, and lower the risks for disease at the individual, community, and societal levels (Patestos, 2019). Health programs in churches especially those with older members, have helped to build therapeutic relationships, promote trust and caring as a sacred practice focused on faith and health (ANA & HMA, 2017, p. 3). There is a wealth of opportunities of services and programs that can be offered within the faith community.

The initial goals of a FCN when initiating a faith-based health program are to develop relationships, generate knowledge, and preform a needs assessment. This descriptive study involves the evaluation of participant's knowledge both baseline and post intervention, related to education of what a faith community nursing program includes, and what is the role of the FCN. Assessing the parishioner's preferences, will assist in ascertaining the priorities for providing future health related topics once the program is initiated within this parish.

A descriptive evaluative survey including 91 congregants in a rural Catholic church in PA, revealed that parishioner's knowledge improved after an educational presentation on the purpose of a faith-based health program and the role of a FCN in such a program. The ten

questions posed to the participants showed a statistically significant higher number of correct answers post intervention, with the average post score improvement of 2.38 points (figure 17). Subjects also responded to a question on their interest in attending faith community health programs in the future when offered. Findings noted that 64% (n = 58) of the survey participants would be interested in attending future faith health programs, 28% were unsure if they would participate, and 8% (n = 7) were not interested in attending future programs. Overall, this was a promising result in hopes for interest and attendance at these faith health programs when presented.

Based on the results of the subject's topics of interest it showed the 3 topmost health areas revealing a mean of 4 points or higher, based on a Likert scale of one to five, were healthy eating and weight management, healthy lifestyle and activity, and spiritual well-being. These will be the first topics of focus when the faith program is initiated. There were seven topics that scored in the 3.9 to 3.7 range. These themes included information related to; advanced directives/end of life decisions; relaxation, mindfulness, and stress management; Alzheimer's disease; mental health and anxiety; grief and loss; high blood pressure and heart disease; and caregiver support. It is necessary to tailor the interventions in terms of content and activities based on the congregation's interest.

This study reflected an increased knowledge, and interest in participation within this faith community. The needs assessment determining what health promotion and educational program interventions the participants show interest provide a clear direction when implementing programs for the faith and even broader communities.

**Implications for Nursing**

The relationship between the practice of nursing and spirituality is not a new concept. Florence Nightingale considered nursing a spiritual vocation (as cited in O'Brien, 2014). The concept of spirituality encompasses many varying definitions and perspectives. Society as well as the nursing community is searching for guidance and understanding of spirituality in relation to health and illness. The nurse's role in connection with understanding the importance of the dimension of delivering spiritual care and a client's spiritual needs is increasingly being studied. FCNs can provide new and innovative opportunities to promote community healthcare for both practicing nurses as well as an alternative model for nurses who have left the workforce. Schroepfer (2016), noted that one of the greatest strengths of FCNs is the consistency and trust that is built between the faith community and the parishioners.

Many of the early nursing theorists generally referred to spirituality of the client minimally. However, there has been a spiritual reawakening and contemporary nursing theorists recognize the importance of human spirituality, wholistic approach, and autonomy of care (O'Brien, 2014 p. 126). Spirituality is a personal concept, and spirituality is the cornerstone of wholistic nursing, nurses need to understand that their own spirituality and beliefs may differ from those they care for (p. 5).

Many practicing nurses may not feel comfortable with incorporating spiritual needs when providing care. Wright and Neuberger (2012) provide points on how to integrate spirituality into nursing care. Some of these points note how spirituality has a direct effect on health and well-being, that nurses should provide all patients with spiritual access, spiritual care goes to the heart of care, and that spiritual care is essential for the ongoing training of all nurses (as cited in O'Brien 2014 p. 120). This article hopes to raise nurse's awareness of the need to always be

sensitive to their client's spiritual needs, to increase their comfort with providing spiritual care, and to recognize the value of incorporating spirituality in contemporary nursing practice.

**Recommendations for Further Research**

Nurses are faced with challenging times in healthcare. Faith Community Nurses have the opportunity to play an essential role in the health and promotion of wholistic care and promote health and wellness in our communities. The hope is to engage faith community members where they worship and socialize to increase the likelihood of participation in these health promotion activities. Now more than ever FCNs have an auspicious opportunity to act as catalysts by emphasizing how spirituality can influence interest, participation, trust, and knowledge, by improving healthy behaviors. Callaghan (2016), stated various studies have provided evidence that health and wellness activities can lead to an increase in healthy behaviors of those who attend these programs (Callaghan, 2016).

This research was conducted to provide insight and baseline information related to specific church community. The Faith Community Nursing Curriculum (2019) notes, currently there are many opportunities for expansion of research, where initiatives are needed to identify and support outcomes relevant to the practice of FCNs. The results from this study provide a starting point, for initiating a faith community health ministry in this church community. Further research is needed to examine the outcomes of specific interventions, by testing knowledge of topics, and changes in participant's behaviors. Additional studies could explore the financial impact and implications of interventions, reducing readmissions, and how FCN can be financially supported. Studies investigating the impact of incorporating spirituality into nursing student's foundational education and clinical experiences, may be beneficial in promoting nurses

to value the importance of including spirituality in their patient care. Developing partnerships between student nurses and faith communities may be of benefit for both populations and could be investigated. The importance of and FCNs are poised to address many of these research gaps related to the incorporation of faith and health in communities (FCN C, 2019).

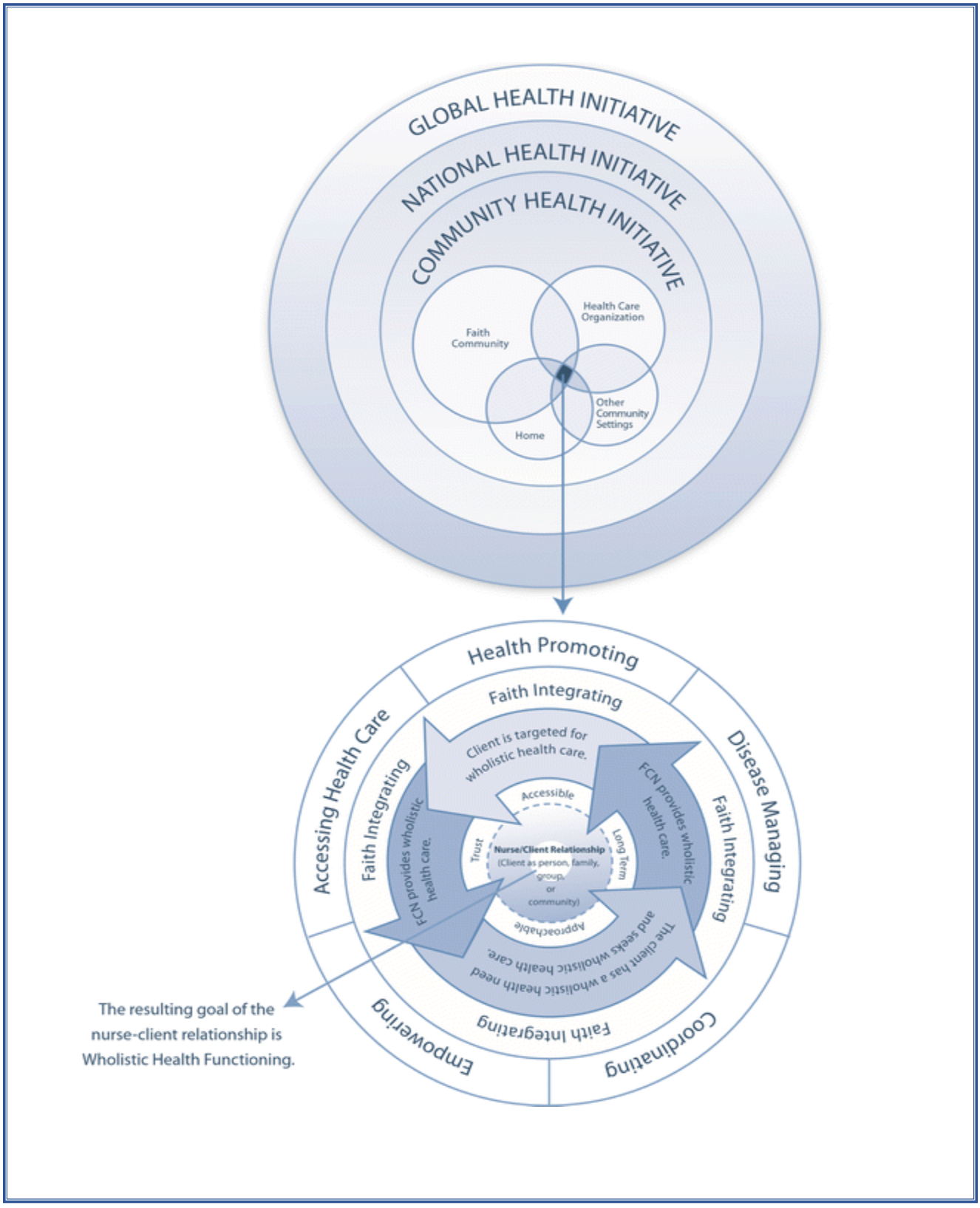
Most ministry programs such as this start slow and gradually grow. Smothers (2016), recommends that it is also crucial to be flexible, and realistic in what can be accomplished. Nurses need to be allowed to share ideas, ask questions, and voice the needs of the group and community. As this program is initiated and potentially grows, recruiting other nurses from the parish to assist with the various initiatives would be necessary. Envisioning an eventual collaboration with various health experts such as dietitians, therapists, and other community professionals to assist in presenting educational programs and projects. A program like this may be a catalyst for change while advocating for the parishioners and promoting health and safety, as desired by the community on its terms. If successful, this endeavor could serve as a model for success may provide insight, and support to other interested groups.

**Conclusions**

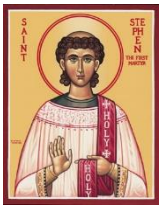
This study investigated parishioners' knowledge of what a faith community ministry is, and the role a FCN plays within a parish community. The specialty practice of faith community nursing is centered on the spiritual aspect of health promotion. In initiating a faith-based program, the faith community nurse must educate, collaborate with, and investigate the needs and desires of the individuals within the faith community. The findings of this study revealed a significantly favorable improvement, with parishioner's demonstrating increased understanding related to Faith Community Nursing. The participants also ranked potential health topics that will guide the focus of future programs undertaken when initiating the Faith Community ministry.

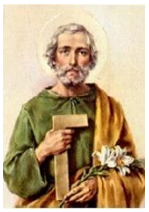
A faith community nurse's role is distinctive in focusing on the strength of spiritual beliefs while promoting health and wellness. They embody the principals of wholistic care, honoring the body, mind, and spirit to achieve wellbeing. A faith community ministry had an endless possibility with a wide range of services that can be offered to conceivably benefit parishioners. The critical challenge when initiating and building a faith community nurse ministry, is to lay a strong foundation by providing education to parishioners based on their interests and health needs. Growing parishioner trust, maintaining interest, leadership support, slowly expanding services, and recruiting assistance, will be essential in establishing and sustaining a successful faith community ministry. "Blessed is the one who trusts in the Lord, whose confidence is in him. They will be like a tree planted by the water that sends out its roots by the stream. It does not fear when heat comes; its leaves are always green. It has no worries in a year of drought and never fails to bear fruit." (Jeremiah 17:7-8).

Appendix A: New Conceptual Model: Faith Community Nursing



Appendix B: Pastor Approval Letter



St. Joseph Parish

St. Joseph Church, St. Stephen Church, St. Venantius Church, Our Lady Help of Christians Church, Calvary Cemetery, Old St. Joe's Cemetery

www.oilcitycatholic.com

February 25, 2021

To Whom It May Concern:

I am writing to provide my approval for Christina Weidle to conduct her DNP project within our Oil City Catholic Community parishioners. I have met with Christina and she has outlined the details and logistics for her project and the data she will be collecting. This project will be in collaboration with her program through Edinboro and Clarion Universities.

I understand and am agreeable with the goals for her project. We are aware that she will be providing information on what a Faith Community Nurse Program includes, and the role of the Faith Community Nurse within this program. I am also aware that she will be evaluating the attending congregants, understanding and assessing their health interests and needs. We are look forward to working with Christina in hopes of developing interests, supporting our parishioners, and ultimately promoting health and wholeness in our faith community.

In summary, we agree for Christina to complete her DNP project by presenting information on a faith-based community health program and collect data from our parishioners regarding their knowledge and interests related to this program.

If you have any questions, please contact me at 677-3020 (ext. 4).

Sincerely yours in Christ,

Father John Miller
Pastor

Appendix C: Church Bulletin Notice and Church Announcement

**Church Bulletin Notice:**

Hello, my name is Chris Weidle many of you know me, I have been a parishioner here in Oil City my entire life. I am a nurse, and I am inviting you to take part in an online survey I am conducting in coordination with Clarion University. I am a student at Clarion and Edinboro University's, and I am in the process of obtaining a Doctoral of Nursing Practice (DNP) Degree. I am pleased to invite any and all parishioners over the age of 18 to participate in this survey. discussing a program called "Faith Community Nursing Ministry". The purpose of this study is to attempt to measure the participants knowledge of a faith community program and to identify future health care topics based on your interests. I plan to eventually start a faith-based health care ministry in our parish community. I originally wanted to tell you about this ministry face to face, however, due to COVID restrictions and safety precautions I am asking you to participate and learn more about this ministry by accessing it on the internet. It is a very simple process and it can be accessed by typing in the link that is listed below into any internet browser. This link can also be easily accessed if you go to the Oil City Catholic Website and click on the link provided. This survey will take approximately 30 to 35 minutes to complete. Then there is a 20-minute video within the survey that explains the ministry program. After you watch the video there will another section of questions to answer. This link is presently available and open for you to use today and it will be open for the next three weeks and the last day to assess this survey will be May 23rd. I want to make sure you know your participation is completely voluntary and anonymous, you will not be able to be identified in any way.

I ask that you seriously consider participating in this on-line survey. I am very excited to start this ministry within our church community and look forward to all the possibilities it may provide. I also appreciate you assisting me on my doctorial project and journey. If you have any questions, I have my Ministry business cards available, with the link of the back of the card for you at the three exits if you are interested. Thank you *for your time and attention.* The link is: https://baseline.campuslabs.com/clarion/ocfaith

**Church Announcement at the Weekend Masses:**

Hello, I am speaking on behalf of Chris Weidle who is a student at Clarion and Edinboro University's. She is in the process of obtaining a Doctoral of Nursing Practice (DNP) Degree and she is inviting any parishioner over the age of 18 to take part in this online research survey called **"Faith Community Nursing Ministry"** being conducted through Clarion University. The purpose of this study is to attempt to measure the participants knowledge of a faith community program and to identify future health care topics based on your interests. She plans to eventually start a faith-based health care ministry in our parish community. Her survey can be accessed by typing in the link that is listed in the bulletin, or by going to the Oil City Catholic website, oilcitycatholic.com. and access the link provided there. All of this information and details are provided in the bulletin. If you have any questions, she has her Ministry business cards available in your pews and at the exits with the link printed on the back.

The survey will be available starting today for the next three weeks until May 23rd This survey and will take approximately 30 to 35 minutes to complete. There are a few questions to answer at the beginning of the survey, followed by a 20-minute video that explains the program. Once the video is over there are some final questions to answer, and then you are done. This link is presently available and open for you to use today. It will be open for the next three weeks and the last day to assess this survey will be May 23rd. Your participation is voluntary and completely anonymous, you will not be able to be identified in any way.

I ask that you seriously consider participating in this survey and learn more about this exciting ministry opportunity. Chris would also appreciate you assisting on her doctorial project. We are excited to start this ministry within our church community and look forward to all the possibilities it may provide. Thank you.

Appendix D: Faith Community On-Line Survey

# Faith Community Nursing Project

**Consent to Participate Statement**

* I understand that I have been asked to participate in this research project which is a study of the before and after knowledge of a faith community nursing program presentation.
* It will also help to determine health care topics of interest.
* I understand that any information obtained from this research will be kept strictly confidential.
* Information will be kept in locked files and only the principal investigator will have access to it.
* I understand that my identity will not be revealed in any description or publication of this research.
* I understand that I may refuse to participate in this study or withdraw at any time.
* I understand that I am encouraged to answer all questions, but I may skip any question that may be uncomfortable to answer.
* This study will take approximately 30 to 35 minutes to complete.
* By completing this survey I agree to be included in this research project

## About You

Your answers in this section are needed for analyzing the results of this study. Please select one answer in each category that best describes you.

**Question 1**

Age:

- 18 - 30
- 31 - 40
- 41 - 50
- 51 - 60
- 61 - 70
- 71 - 80
- 81 and over

**Question 2**

Gender:

- Male
- Female
- Other / Prefer not to say

**Question 3**

Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or other Pacific Islander
- White
- Other

## Before the Program

Please answer the following statements to the best of your ability.
Please be honest in your responses.
Select only one response for each statement.
Do NOT leave any statement unanswered.

**Question 4**

One of the best ways a faith community nurse can help a congregation is to promote health and wholeness.

- Yes
- No
- Unsure

**Question 5**

Only a Registered Nurse who is currently licensed can be a faith community nurse.

- Yes
- No
- Unsure

**Question 6**

The faith community nurse replaces the role of a home health nurse.

- Yes
- No
- Unsure

### Question 7

Most faith community nurses are paid for their work at their church.

- Yes
- No
- Unsure

### Question 8

The main focus of the faith community nurse is to intentionally care for a person's spirit.

- Yes
- No
- Unsure

### Question 9

Wholistic health is an isolated approach to treat people who have an illness.

- Yes
- No
- Unsure

### Question 10

The link between faith and health is caring for a person by integrating the body, mind, and spirit.

- Yes
- No
- Unsure

### Question 11

Some examples of activities a faith community nurse may offer are counseling, mentoring, and making referrals.

- Yes
- No
- Unsure

### Question 12

There are defined standards of care relating to the work of faith community nursing.

- Yes
- No
- Unsure

**Question 13**

The future plans for the faith community nurse program for the Oil City Catholic community are to create a supportive community and start by providing health education programs.

- Yes
- No
- Unsure

Please watch the entire video linked below. Following the video please complete the reaming two section the survey!

Video of Faith Community Nurse Presentation

The video is approximately 20 minutes in length. Thank you!

## Following the Program

Please answer the following statements to the best of your ability.
Please be honest in your responses.
Select only one response for each statement.
Do NOT leave any statement unanswered.

**Question 14**

One of the best ways a faith community nurse can help a congregation is to promote health and wholeness.

- Yes
- No
- Unsure

**Question 15**

Only a Registered Nurse who is currently licensed can be a faith community nurse.

- Yes
- No
- Unsure

### Question 16

The faith community nurse replaces the role of a home health nurse.

- Yes
- No
- Unsure

### Question 17

Most faith community nurses are paid for their work at their church.

- Yes
- No
- Unsure

### Question 18

The main focus of the faith community nurse is to intentionally care for a person's spirit.

- Yes
- No
- Unsure

### Question 19

Wholistic health is an isolated approach to treat people who have an illness.

- Yes
- No
- Unsure

### Question 20

The link between faith and health is caring for a person by integrating the body, mind, and spirit.

- Yes
- No
- Unsure

### Question 21

Some examples of activities a faith community nurse may offer are counseling, mentoring, and making referrals.

- Yes
- No
- Unsure

### Question 22

There are defined standards of care relating to the work of faith community nursing.

- Yes
- No
- Unsure

### Question 23

The future plans for the faith community nurse program for the Oil City Catholic community are to create a supportive community and start by providing health education programs.

- Yes
- No
- Unsure

### Question 24

If a Faith Community Nursing Program becomes available would you be willing to participate?

- Yes
- No
- Unsure

## Future Programming and Education

This section includes a list of 20 topics for possible future programming and education at the Oil City Catholic Faith Community Nursing Ministry.

### Questions 25 - 44

You are asked to choose your level of interest in learning more about each health topic listed below:

| | Very interested | Interested | Neutral | Not interested | Not interested at all |
|---|---|---|---|---|---|
| | **5** | **4** | **3** | **2** | **1** |
| Advanced Directives/End of Life Decisions | | | | | |

| | Very interested | Interested | Neutral | Not interested | Not interested at all |
|---|---|---|---|---|---|
| | **5** | **4** | **3** | **2** | **1** |
| Alzheimer's/Dementia | ○ | ○ | ○ | ○ | ○ |
| Caregiver Support | ○ | ○ | ○ | ○ | ○ |
| Cancer Screening | ○ | ○ | ○ | ○ | ○ |
| COVID-19 | ○ | ○ | ○ | ○ | ○ |
| Diabetes | ○ | ○ | ○ | ○ | ○ |
| Grief and Loss | ○ | ○ | ○ | ○ | ○ |
| Healthy Lifestyle - Activity | ○ | ○ | ○ | ○ | ○ |
| Healthy Eating and Weight Management | ○ | ○ | ○ | ○ | ○ |
| High Blood Pressure/Heart Disease | ○ | ○ | ○ | ○ | ○ |
| Lung Diseases | ○ | ○ | ○ | ○ | ○ |
| Medication Support and Information | ○ | ○ | ○ | ○ | ○ |
| Mental Health/Anxiety | ○ | ○ | ○ | ○ | ○ |
| Relaxation/Mindfulness/Stress Management | ○ | ○ | ○ | ○ | ○ |
| Parenting Skills | ○ | ○ | ○ | ○ | ○ |

| | Very interested | Interested | Neutral | Not interested | Not interested at all |
|---|---|---|---|---|---|
| | **5** | **4** | **3** | **2** | **1** |
| Smoking Cessation | ○ | ○ | ○ | ○ | ○ |
| Spiritual Well Being | ○ | ○ | ○ | ○ | ○ |
| Stroke Awareness | ○ | ○ | ○ | ○ | ○ |
| Suicide Awareness | ○ | ○ | ○ | ○ | ○ |
| Substance Abuse | ○ | ○ | ○ | ○ | ○ |

**Question 45**

Please list any other additional health programs or topics that may be of interest to you:

---

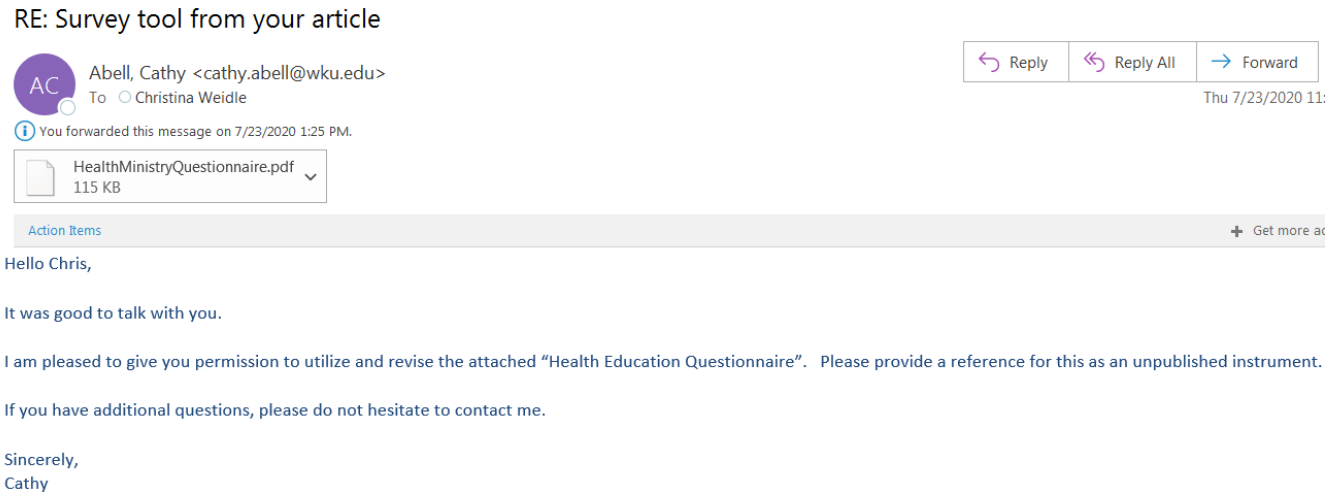
Please look for future information related to the Faith Community Nursing Ministry. Information will be in the church bulletins and on the Oil City Catholic Community website
- https://oilcitycatholic.com/

Finish

Appendix E: - Community Presentation Power Point Outline

I. Objectives
II. What is Faith Community Nursing?
Core Values
A. Spiritual Formation
B. Professionalism
C. Whole- Person Health
D. Community
III. The History of Faith and Health Connection
A. Biblical times – Jesus healing the sick
B. $12^{th}$ & $13^{th}$ Centuries - Religious orders founded hospitals
C. Florence Nightingale 1860's - physical and spiritual qualities in promoting health
D. $19^{th}$ & $20^{th}$ Centuries - Separation of Body and soul as increased scientific knowledge
E. 1978 – Parish Nurse Concept – founded Rev, Granger Westberg
F. Today - Increased importance to integrate Body, Mind & Spirit
IV. Faith Community Nursing
Who Can Qualify as a Parish Nurse?
V. What Is Wholistic and Wholistic Health Care
VI. Who is a typical Faith Community Nurse
A. Majority are unpaid volunteers
B. Many work as a nurse in a medical setting
C. Many have been a nurse for over 10 years
D. Over 17,000 nurses have been trained -
VII. Faith Nurse's Do NOT: replace the pastor, physician's, home health nurses, councilors
VIII. Main Roles of a Faith Community Nurse
A. Educator –
B. Advocate –
C. Resource Person –
D. Informal Councilor –
E. Mentor –
F. Prayer Partner –
G. Liaison –
IX. Faith Community Nursing Model
X. ANA & HMA Scope and Standards of Practice
XI. What Can Faith Nurses Do for The Community?
XII. Vision and Goals for Our Community Health Ministry
XIII. References
XIV. Questions
XV. Thank You – Please Complete Surveys

# Appendix F: Permission from C. Abell to Use Survey Tool with Modification



RE: Survey tool from your article

Abell, Cathy <cathy.abell@wku.edu>
To Christina Weidle

Reply | Reply All | Forward
Thu 7/23/2020 11:

You forwarded this message on 7/23/2020 1:25 PM.

HealthMinistryQuestionnaire.pdf
115 KB

Action Items

Get more ac

Hello Chris,

It was good to talk with you.

I am pleased to give you permission to utilize and revise the attached "Health Education Questionnaire". Please provide a reference for this as an unpublished instrument.

If you have additional questions, please do not hesitate to contact me.

Sincerely,
Cathy

Appendix G: Health Ministry Questionnaire – (C. Abell, 2016)

## Health Education Questionnaire

Age (In years):_____

Gender (Male/Female):_____

Do you believe providing health education on site at St. Mary Catholic Church would be beneficial?
Yes____ No_____

What time do you believe would be best to offer monthly health education activities? (Please mark the **ONE choice** you believe would be best.)
_____ After 8:00 a.m. mass on Monday
_____ After noon mass on Tuesday
_____ Prior to noon mass on Tuesday
_____ Prior to 6:00 p.m. mass on Wednesday
_____ After 8:00 a.m. mass on Thursday
_____After 8:00 a.m. first Saturday mass

**For each of the following health topics please indicate whether you Strongly Disagree (SD), Disagree (D), Neither Agree or Disagree (N), Agree (A), or Strongly Agree (SA) that it would be of interest to you.**

| | Strongly Disagree (SD) | Disagree (D) | Neither Agree or Disagree (N) | Agree (A) | Strongly Agree (SA) |
|---|---|---|---|---|---|
| 1. High Blood Pressure | SD | D | N | A | SA |
| 2. Heart Health | SD | D | N | A | SA |
| 3. Preparing for doctor's visit | SD | D | N | A | SA |
| 4. Colon cancer | SD | D | N | A | SA |
| 5. Prostate cancer | SD | D | N | A | SA |
| 6. Prevention of infection | SD | D | N | A | SA |
| 7. Vision care | SD | D | N | A | SA |
| 8. Dental care | SD | D | N | A | SA |
| 9. Hospice | SD | D | N | A | SA |

| | | | | | |
|---|---|---|---|---|---|
| 10. Pallative Care | SD | D | N | A | SA |
| 11. Diabetes | SD | D | N | A | SA |
| 12. Medicare | SD | D | N | A | SA |
| 13. Healthy Lungs | SD | D | N | A | SA |
| 14. Nutrition | SD | D | N | A | SA |
| 15. Sun Safety | SD | D | N | A | SA |
| 16. CPR Training | SD | D | N | A | SA |

**Thanks for taking the time to complete the survey. Please enter your name in the drawing.**

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