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The purposes of this study were to examine the impact of a faith community nursing program on a culturally diverse community and to identify nursing interventions that faith community nurses use in their specialized practice with individuals, families, groups, communities, and society. This study, based on Roy's Adaptation Model, used a qualitative design to assess the impact of a faith community nursing program. Questionnaires with open-ended questions were mailed to 112 faith community members, clergy representatives, and faith community nurses with 46% (n = 52) returned. Responses were analyzed with content analysis.

Findings indicated that this faith community nursing program had many positive health, social, educational, cultural, financial, and spiritual benefits in the lives of culturally diverse people in the faith community and in the greater community. Participants reported living healthier, helping others, increasing and sharing knowledge, using culturally appropriate behaviors, saving money, experiencing increased hope, comfort, and inspiration, and achieving balance between physical and spiritual health. The description of the program impact was complemented by over 90 nursing interventions that faith community nurses use in their practice. Faith community nurses facilitated holistic health care, promoted health and well-being, and helped prevent or minimize illnesses as they ministered to culturally diverse populations. The faith community nurses associated with this nursing program had multiple opportunities to reduce health disparities in vulnerable, underserved, minority, and at-risk populations

through innovative, collaborative, and economical strategies while simultaneously and intentionally focusing on spiritual care. Implications for nursing practice, education, and research were presented.

THE IMPACT OF A FAITH COMMUNITY NURSING PROGRAM  
ON A CULTURALLY DIVERSE COMMUNITY

by

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## APPROVAL PAGE

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## CHAPTER I

### BACKGROUND AND RATIONALE FOR STUDY

Faith community nursing has reemerged as an essential area of professional nursing practice in the past three decades (Brudenell, 2003; Catanzaro, Meador, Koenig, Kuchibhatla, & Clipp, 2007; Mosack, Medvene, & Wescott, 2006; Smucker, 2009; Tuck & Wallace, 2000; Weis, Matheus, & Schank, 1997). Through their service, faith community nurses (a) facilitate holistic health care, (b) minister to persons regardless of demographic factors, (c) provide health care for economically disadvantaged populations, (d) promote health and well-being in individuals, families, groups, communities, and society; and (e) prevent or minimize illness by integrating the care of the body, mind, and spirit. As they provide care in diverse communities, faith community nurses have potential to reduce health disparities in vulnerable, underserved, disadvantaged, or at-risk populations (American Nurses Association and Health Ministries Association, 2005; Hickman, 2006; Smucker, 2009).

#### **Previous Faith Community Nursing Research**

Previous research of faith community nursing has focused on a variety of topics. Some investigators have conducted studies which examined the roles and functions of faith community nurses. Specific topics included in this area of inquiry were (a) types of activities performed, (b) amount of time spent for specific activities, (c) aspects which

provided work satisfaction, and (d) aspects which created frustration (Kuhn, 1997; McDermott & Burke, 1993; Mosack et al., 2006; Schweitzer, Norberg, & Larson, 2002). Other studies focused on interventions provided by faith community nurses. Interventions with a religious focus included prayer, reading Scripture or other religious material, and assisting with communion or other rituals (Coenen, Weis, Schank, & Matheus, 1999; Kuhn, 1997; Maddox, 2000; O'Brien, 2006; Tuck, Pullen, & Wallace, 2001; Tuck, Wallace, & Pullen, 2001). Types of caring interventions were instilling hope, showing compassion, emphasizing the worth of every person, and offering spiritual or emotional support (Burkhart, Konicek, Moorhead, & Androwich, 2005; Coenen et al., 1999; Kuhn, 1997; Tuck, Pullen, & Wallace, 2001; Tuck, Wallace, & Pullen, 2001). Examples of relational interventions were listening, visiting, and sharing (Kuhn 1997; Maddox, 2000; O'Brien, 2006; Tuck, Pullen, & Wallace, 2001). Making referrals, teaching, problem solving, and pain management were types of practical interventions (Burkhart et al., 2005; Coenen et al., 1999; Tuck, Wallace, & Pullen, 2001).

Research also has addressed effects or outcomes of faith community nursing. Health promotion and disease prevention activities have contributed to earlier medical treatment, increased compliance with therapy regimens, effective management of chronic diseases, appropriate use of health care resources, and positive changes in health behaviors (Brudenell, 2003; Catanzaro et al., 2007; Chase-Ziolek & Gruca, 2000; Chase-Ziolek & Iris, 2002; McDermott & Burke, 1993; Rethemeyer & Wehling, 2004; Rydholm, 1997). Physical, psychosocial, and educational benefits have been documented by several scholars (Brudenell, 2003; Catanzaro et al., 2007; Chase-Ziolek & Gruca, 2000;

McDermott & Burke, 1993, O'Brien, 2003; O'Brien, 2006; Rethemeyer & Wehling, 2004; Rydholm, 1997).

Another area of research concentrated on participants' perceptions of faith community nursing. Findings have indicated that this specialized practice of nursing is appreciated, well received, useful, meaningful, effective, timesaving, cost-efficient, and essential to the ministry (Mayhugh & Martens, 2001; Scott & Summer, 1993; Tuck & Wallace, 2000; Wallace, Tuck, Boland, and Witucki, 2002). The importance of the integration of faith and health was mentioned by some faith community members (Miles, 1997; Scott & Summer, 1993; Wallace et al., 2002).

Miscellaneous topics were included in other faith community nursing research. McDermott and Burke (1993) reported the types of referrals that faith community nurses made in their practice. Kuhn (1997) identified educational needs of the nurses. Biddix and Brown (1999) described the establishment of a faith community nursing program in one large church. Coenen et al. (1999) addressed nursing diagnoses used by faith community nurses. Parker (2004) examined documentation in this specialized arena of nursing practice. Weis, Schank, and Matheus (2006) explored the process of empowerment with a sample of faith community nurses. Van Dover and Pfeiffer (2007) developed a theory explaining the processes faith community nurses use to provide spiritual care.



### **Uniqueness of This Study**

While research in faith community nursing has addressed a variety of roles and functions, the current study examined the impact of a faith community nurse program from a much broader and more comprehensive perspective in five distinct areas. First, subjects in prior faith community nursing research have been members, clergy representatives, or nurses, but no comparative study has examined the impact of a program from viewpoints of all three groups simultaneously as this study did. Next, previous research has included participants from just one or two faith communities in each study but this project included participants with a broad range of demographic characteristics from a large number of culturally diverse faith communities. Third, earlier investigations have focused on single variables pertaining to faith community nursing while this study examined the impact of a program based on health, social, educational, cultural, financial, and spiritual components. Fourth, previous inquiries have employed either cross-sectional or retrospective methods while this study used a combination of both through current data collection from participants and examination of existing annual reports. Finally, both qualitative and quantitative data were generated in the current study and evaluated through the method of content analysis.

### **Purpose Statement**

Faith community nursing was formally recognized and designated as a specialty practice in 1998 (American Nurses Association and Health Ministries Association, 2005).

That same year, a large, multi-hospital system established collaborative relationships with local faith communities. In the selected geographic area, 51 faith communities with paid or volunteer nurses were supported through a program with this local health care organization (Moses Cone Health System, 2009a). The first purpose of this study was to examine the impact of the faith community nursing program on a culturally diverse urban community in the southeastern United States from the perspectives of faith community members, clergy representatives, and faith community nurses. The second purpose was to identify nursing interventions that faith community nurses use in their practice with individuals, families, groups, communities, or society.

### **Justification of Study**

This study was warranted for several distinct reasons. Results provided information about the impact of the local faith community nurse program from the perspectives of three different participant groups. Next, findings from this project produced a multifaceted description of the program impact through examination of health, social, educational, cultural, financial, and spiritual components. Third, interventions used by faith community nurses to meet health needs of diverse communities were identified and described. Fourth, the information provided an impact assessment that was necessary for securing additional funding to sustain faith community nursing in culturally diverse communities. Finally, this study contributed to the body of knowledge for the growing specialty of faith community nursing and for the discipline of nursing.

## **Conceptual Model**

The Roy Adaptation Model (RAM) (Roy & Andrews, 1999) served as the conceptual model for this research. The RAM is based on the beliefs that the person (a) functions holistically with each item related to and affected by the other components, and (b) interacts constantly with the environment. This holistic model includes the health, social, educational, cultural, financial, and spiritual aspects of the person. The RAM provides for the assessment of independent and interrelated variables within these specific categories.

Roy based her scientific and philosophical assumptions on the following four broad, major assumptions about the person:

1. The individual person is of value, and therefore worthy of respect and care.
2. Individual persons are responsible for making decisions that influence their lives.
3. Persons are holistic, that is, their physical, thinking, and feeling processes function together in a unified expression of human behavioral patterns.
4. People function independently with other persons in environments of the earth to create societies (Roy & Andrews, 1999, p. 8).

As she developed her model, Roy based her scientific assumptions on systems theory and adaptation-level theory. In 1997, she combined and expanded her original views into the following set of scientific assumptions:

1. Systems of matter and energy progress to higher levels of complex self-organization.
2. Consciousness and meaning are constitutive of person and environment integration.
3. Awareness of self and environment is rooted in thinking and feeling.
4. Humans by their decisions are accountable for the integration of creative processes.
5. Thinking and feeling mediate human action.

6. System relationships include acceptance, protection, and fostering of interdependence.
7. Persons and the earth have common patterns and integral relationships.
8. Persons and environment transformations are created in human consciousness.
9. Integration of human and environment meanings results in adaptation (Roy & Andrews, 1999, p. 35).

Roy defined philosophical assumptions as “the values and beliefs that are the foundation of nursing knowledge and practice” (p. 4). In 1997, she redefined and expanded the philosophical assumptions of her conceptual model based on the richness of diverse cultures that represent the well-being of humankind. The five revised philosophical assumptions for the 21st century are:

1. Persons have mutual relationships with the world and God.
2. Human meaning is rooted in an omega point convergence of the universe.
3. God is intimately revealed in the diversity of creation and is the common destiny of creation.
4. Persons use human creative abilities of awareness, enlightenment, and faith.
5. Persons are accountable for the processes of deriving, sustaining, and transforming the universe (Roy & Andrews, 1999, p. 35).

The metaparadigm concepts of person, environment, health, and nursing are the basic considerations of the model. According to the RAM, the person is a holistic,

adaptive system with cognator and regulator subsystems acting to maintain adaptation in the four adaptive modes: physiologic-physical, self-concept/group identity, role function, and interdependence (p. 13).

Holistic refers to the idea that the human system (a) functions as a whole, (b) is more than the mere sum of its parts, and (c) represents unity in diversity. Adaptive means that the human system has the thinking, feeling, and coping abilities and capacities to adjust

effectively to changes in the environment and to affect the environment. A system is a set of connected parts that function as a whole for some purpose through the interdependence of its parts. The concept of person includes humans as individuals or in groups labeled as families, organizations, communities, nations, or society as a whole. The person is the focus of all nursing activities. As a holistic adaptive system, the person is both affected by and also influences the world around and within oneself. In a broad sense, this world is known as the environment (Roy & Andrews, 1999).

The environment is both physical and social. It includes all the influences, conditions, and circumstances that surround and affect the growth, development, and behavior of individuals and groups. The world around the person is described as the external stimuli while the world within a person is known as the internal stimuli. Roy further classified these stimuli as focal, contextual, and residual. The focal stimuli may be either external or internal. Focal stimuli are the ones most immediately confronting the person and are the focus of the person's consciousness and energy. Contextual stimuli are present within the situation and contribute to the effect of the focal stimuli but do not occupy the center of attention or energy. They, too, are within or outside the human system and can be positive or negative factors. These stimuli influence how the person deals with the focal stimuli. Stimuli whose effects on the situation are unclear are known as residual stimuli. The stimuli and their significance are perpetually changing, as is the interaction between the person and the environment (Roy & Andrews, 1999).

Among the stimuli is the adaptation level. The adaptation level represents the condition of life processes and is described as integrated, compensatory, and

compromised. Integrated means that the structures and functions of a life process are working systematically to meet human needs. The compensatory process includes a challenge to the integrated process. When integrated and compensatory processes are inadequate, the compromised level is reached and an adaptation problem can result. Stimuli and adaptation levels serve as the input and responses are known as the behavior. Behavior is internal or external, active or reactive, individual or collective, and adaptive or ineffective. Adaptive responses promote integrity in terms of growth, survival, reproduction, mastery, and transformations. Ineffective responses suppress integrity and adaptation in the same areas. Coping processes are the ways of responding to the changing environment (Roy & Andrews, 1999).

Roy has defined the concept of health without reference to illness or disease. Health is understood in the context of goals and purposefulness of human existence. Health is “a state and a process of being and becoming an integrated and whole human being. Lack of integration represents lack of health” (p. 54). This definition reflects a continuous adaptive process directed toward individual goals and the purposefulness of human existence. Health is manifested in the four adaptive modes of physiologic-physical, self-concept/group identity, role function, and interdependence (Roy & Andrews, 1999).

Nursing is a health care profession that uses a specialized body of knowledge to focus on promotion of health for individuals and groups. Nursing is the scientific practice that expands adaptive abilities and enhances person and environment transformation. Nursing consists of the goal of nursing and nursing activities. The goal of nursing is to promote adaptation for individuals and groups in the four adaptive modes, thus contributing to the

person's health, quality of life, and dying with dignity. The nursing process is a problem-solving approach that includes all nursing activities and serves to distinguish nursing from other disciplines. The science component of nursing deals with understanding "how" and "why" questions and has the two dimensions of basic nursing science and clinical nursing science. The art element of nursing deals with understanding and expressing the realities of life (Roy & Andrews, 1999).

In the nursing process described by Roy, the first step is the assessment of behavior with respect to four adaptive modes. Assessment of the person occurs in the physiologic-physical, self-concept/group identity, role function, and interdependence modes. The physiologic-physical mode is associated with the way a person responds as a physical being to stimuli from the environment. The nine needs of this mode are (a) oxygenation, (b) nutrition, (c) elimination, (d) activity and rest, (e) protection, and processes involving (f) the senses, (g) fluid, electrolyte, and acid-base balance, (h) neurologic functions, and (i) endocrine functions. The physical mode for groups corresponds to the physiologic mode for the individual (Roy & Andrews, 1999).

The second mode is the self-concept/group identity mode. The self-concept is for individuals and it is viewed as having the two subareas of the physical self and the personal self. The physical self comprises body sensation and body image. The personal self includes the three components of self consistency, self ideal, and the moral-ethical-spiritual self. The basic need on the individual level is the psychic and spiritual integrity. This integrity is the need to know who one is so that one can exist with unity, meaning, and purposefulness in the universe. The group identity is for groups and identity integrity

is the basic need. Identity integrity refers to relating to others with honesty, soundness, and identification with the group (Roy & Andrews, 1999).

The role function mode focuses on the roles that the individual or groups occupy in society. The basic need of the individual is social integrity and refers to the need to know who one is in relation to others. The basic need of the collective is role clarity and it refers to the need to understand and commit so the group can achieve common goals. Roy has classified roles as primary, secondary, and tertiary. The primary role determines the majority of behavior that a person engages in during a particular period in life. Secondary roles are those that a person assumes to complete the tasks associated with the developmental level and primary role. Tertiary roles represent ways in which individuals meet their obligations or accomplish minor tasks. They are normally temporary in nature and freely chosen by the individual (Roy & Andrews, 1999).

The interdependence mode is the final mode and it focuses on the close relationships of people, and the purpose, structure, and development of these relationships. The relationships involve the person's willingness and abilities related to the giving and receiving of love, respect, value, knowledge, skills, time, talents, and material possessions. The basic need is relational integrity or the feeling of security in relationships. Three processes involved in achieving relational integrity are affectional adequacy, developmental adequacy, and resource adequacy. Relationships are with significant others and support systems (Roy & Andrews, 1999).

Subsequent steps of the nursing process involve the identification of internal and external focal, contextual, and residual stimuli. Nursing diagnoses are statements based



on critical thinking that relate the behavior of the human adaptive system and the influencing stimuli. Goal setting is the establishment of clear, concise statements of the behavioral outcomes of nursing care. Intervention is the selection and completion of nursing approaches that will promote adaptation. Evaluation judges the effectiveness of the intervention and thus completes the nursing process (Roy & Andrews, 1999).

### **Assumptions of my Study**

The following four assumptions applied to this study.

1. Faith community nurses practicing in culturally diverse communities have had positive and life-changing influences on individuals, families, groups, the faith community, the greater community, and society.
2. Participants were motivated to share their personal experiences.
3. Participants responded truthfully.
4. Data reported by the participants were representative of actual experiences.

### **Research Questions**

The following two research questions were generated for this study.

1. How do faith community members, clergy representatives, and nurses describe the impact of the faith community nurse program in their communities related to health, social, educational, cultural, financial, and spiritual effects?

2. What interventions do faith community nurses provide in culturally diverse faith communities?

### **Conceptual Definitions**

Several conceptual definitions have been determined for this study. Roy's definition of the person was used for the participants in the study. Faith community members, clergy representatives, and faith community nurses are human adaptive systems with biopsychosocial characteristics in constant interaction with the environmental stimuli (Roy & Andrews, 1999). Faith community members are individuals who have interacted with or received any type of care, service, or intervention from the faith community nurse. Clergy representatives are individuals specifically ordained for religious service in the faith community organization who oversee all teachings, activities, and ministries of that organization. Within the organization, they may be known as a pastor, priest, rabbi, bishop, minister, vicar, rector, or other terms. These individuals may be described and referred to as assistant, associate, senior, music, youth, outreach, or other titles. Faith community nurses are actively licensed, registered professional nurses who are an integral part of the ministerial team in an organized faith community and who are grounded in the faith and spiritual philosophies of that organization. Within their individual settings, nurses may be referred to as the parish nurse, congregational nurse, church nurse, crescent nurse, health ministry nurse, health and wellness nurse, or by other names.

Other conceptual definitions applied to the specific features of the study. The conceptual definition for impact was the effect or outcome of an action or intervention which promotes integrity, adaptation, growth, survival, mastery, or transformation. Culturally diverse refers to the collective variety of differences between groups and their beliefs, customs, practices, traditions, behaviors, values, and goals that affects methods of adaptation, growth, and transformation. Health is the quality that includes physiological and mental structures, ongoing functions, continuous processes, changing needs, and activities of the human body that contribute to the goals and purposefulness of existence as a holistic, integrated human being. Social is the aspect that includes groups, associations, organizations, or support systems, and affects the willingness and ability to give and receive all phenomena one has to offer as a person (e.g. knowledge, skills, talents, time). Educational is the quality that includes and affects the ability to gain, increase, share, master, evaluate, or transform knowledge. Cultural is the aspect that is the total of the learned behavior shared by a particular group of people and transmitted from generation to generation. Learned behaviors include ethnicity (language, practices, customs, traditions, goals, associated values), belief systems (spiritual beliefs, philosophies, values), and socioeconomic status (lifestyles, use of material resources). Financial is the quality that includes the ability to earn money and affects the appropriate and responsible use and control of monetary resources. Spiritual is the aspect that includes the value system, belief system, and self-evaluation system so that one can exist with a sense of unity, continuity, integrity, meaning, purpose, satisfaction, and fulfillment in society and in the universe.

The faith community nurse program is “a unique, specialized nursing practice established as a collaborative relationship” between a large, local, multi-hospital health system and faith communities in the surrounding geographical region (Moses Cone Health System [MCHS], 2009a). The program “is designed to build on and strengthen capacities of individuals, families and congregations to understand and care for one another in the context of their faith and their relationship to the broader society” (MCHS, 2009b). This program uses “a wholistic approach that values each individual's potential throughout his or her life cycle” and supports “ministries of health, caring and healing which integrate spiritual, physical and emotional health” (MCHS, 2009b).

### **Operational Definitions**

The following corresponding operational definitions have been established.

1. Faith community member: an individual who selected the first option on the first item of *All About Me* (see Appendix A).
2. Clergy representative: an individual who selected the second option on the first item of *All About Me*.
3. Faith community nurse: an individual who selected the third option on the first item of *All About Me*.
4. Impact: a health, social, educational, cultural, financial, or spiritual effect described by the participants on the impact questionnaire (see Appendix B).
5. Culturally diverse: the collective responses on *All About Me* which describe the variables of gender, age, marital status, residential area, faith community

location, racial-ethnic category, educational level, employment status, household income, participation in the faith community, and involvement in the faith community nursing program.

6. Health impact: the response to item number one on the impact questionnaire.
7. Social impact: the response to item number two on the impact questionnaire.
8. Educational impact: the response to item number three on the impact questionnaire.
9. Cultural impact: the response to item number four on the impact questionnaire.
10. Financial impact: the response to item number five on the impact questionnaire.
11. Spiritual impact: the response to item number six on the impact questionnaire.

## **Summary**

Faith community nursing is a unique and specialized area of holistic nursing practice that positively influences several dimensions in the lives of individuals, families, groups, communities, and society. While the practice of this nursing specialty has grown regionally, nationally, and internationally, research that focused on faith community nursing has not experienced comparable growth. This study investigated the impact of a faith community nursing program from the perspectives of faith community members, clergy representatives, and faith community nurses through examination of health, social, educational, cultural, financial, and spiritual effects. The study also identified

interventions that faith community nurses used as they provided services to individuals, families, groups, and society in a culturally diverse community.

## CHAPTER II

### REVIEW OF THE LITERATURE

Literature relevant to “Faith Community Nursing” has been divided into several distinct sections. A historical overview of faith community nursing is provided as an introduction. The other sections have been organized conceptually by the health, social, educational, cultural, financial, and spiritual aspects of faith community nursing.

#### **History of Faith Community Nursing**

Throughout history, religious traditions, practices, and rituals have been associated with health and healing. Ancient civilizations in Egypt, China, and India combined the beliefs of Islam, Buddhism, and Hinduism to heal the sick, treat the diseases, and cure the ills of society (Hickman, 2006). Faith community nursing has its historical origins in the early work of nuns, deaconesses, and other religious sisters who promoted holistic health while working within their respective parishes. Through the centuries, churches and religious organizations have upheld their ministry to poor, suffering, and sick individuals, families, and communities while cultural, social, economic, political, and intellectual factors have influenced current approaches to health care (Hickman, 2006).

Modern faith community nursing began in the late 1960s when holistic health clinics were established in the United States. Reverend Granger Westberg, a Lutheran minister, worked on a project funded by the W. K. Kellogg Foundation that established

these clinics in churches while he was affiliated with the College of Medicine at the University of Illinois. During the next ten years, evaluations indicated that nurses were the unifying forces between the churches and health care because they understood and connected the languages of science and religion. In 1984, when maintaining these centers became economically unfeasible, Westberg proposed that nurses serve on the pastoral staff of different congregations. He approached the Lutheran General Hospital in Park Ridge, Illinois, to help him develop the institutionally based program. The hospital agreed to financially support six nurses over three years. Programs were established at two Roman Catholic churches, three Lutheran churches, and one Methodist church. During the next four years, the churches assumed increasing responsibility for the nurses' salaries. The success of this initiative was associated with the understanding that churches, temples, synagogues, and mosques are dedicated to keeping people well (Hickman, 2006; Westberg, 1986). The pilot program was successful and grew quickly. The number of faith community nursing programs has dramatically increased in the past 25 years. Today, thousands of faith community nurses are serving in multiple and diverse populations in 23 countries throughout the world (International Parish Nurse Resource Center [IPNRC], 2010).

### **The Health Component of Faith Community Nursing**

Factors that pertain to the health component of faith community nursing are found in four separate, theoretical models that were expressly developed for this arena of nursing practice. In the first model, Bergquist and King (1994) described the person as having



physiological and emotional dimensions and health characteristics. Adults aged 65 and older are the clients most frequently served by the faith community nurse. The physical and mental health dimensions are facilitated by the spiritual component. Physical, emotional, and spiritual interventions reflect the cohesion of the body, mind, and spirit. The absence, inadequacy, or disruption of unity and harmony diminishes physical and emotional well-being. Nursing actions directed toward physical health and well-being are (a) health promotion and disease prevention activities, (b) restorative care practices, and (c) interventions promoting self-care. Client outcomes related to the physical dimension include (a) engagement in health-related practices, (b) improved management of chronic illness, (c) increased compliance with therapeutic regimens, (d) improved physical lifestyle habits, and (e) increased responsibility for personal health. Nursing actions directed toward emotional health and well-being are (a) caring, (b) counseling, (c) empowerment, (d) social support, and (e) organization of support groups. Client outcomes related to the mental component include (a) decreased feelings of loneliness, isolation, and anxiety; (b) increased feelings of support, comfort, dignity, self-worth, and importance; (c) resolution of guilt, stress, and grief; (d) positive outlook on life; and (e) raised consciousness (Bergquist & King, 1994).

According to The Parish Nursing Continuity of Care Model, presented by Wilson in 1997, the person is a whole being with body, mind, and spirit facets that interact with each other to maintain optimal physical, emotional, and spiritual health respectively. Individuals and families have a variety of physical and mental health characteristics. Holistic health has physical and emotional properties, needs, and self-care. The

environment is not specifically defined. One feature of the environment has a birth to death component identified in the illustration of the model (Wilson, 1997).

In 1997, Miller introduced the third theoretical representation. The Miller Model of Parish Nursing depicts the person as being a complex entity. Physical, mental, cultural, social, emotional, and spiritual aspects are interrelated. The faith community environment can promote health by sponsoring health related activities (Miller, 1997).

The fourth theoretical model, The Circle of Christian Caring, was developed specifically for faith community nursing; the person has equal body, mind, and spirit dimensions (Maddox, 2001). Descriptors for health included medical conditions, end-of-life processes, and recovering from illness. Faith community nursing practice focuses on disease prevention and health promotion. The faith community nurse (a) conducts health-screening activities, (b) organizes health fairs, (c) provides health-related information, and (d) accompanies members to meetings with health care providers (Maddox, 2001).

O'Brien (2003) developed the Spiritual Well-Being in Illness framework to guide faith community nurses as they provide holistic care for seriously ill or disabled members. The person has a physical, psychosocial, and spiritual nature, and the ability to find meaning in and to accept pain, suffering, and illness. Health is not specifically defined but can be interpreted from the illustration of the model as severity of illness that is based on the degree of functional impairment. Ill and disabled persons have physical or psychosocial deficits that contribute to their functional impairment. The nurse functions in multiple roles as an advocate, counselor, educator, or referral agent giving necessary attention to the person's physical, emotional, and social well-being (O'Brien, 2003).

Researchers have addressed different characteristics pertaining to the health component of faith community nursing. Health promotion and disease prevention activities have contributed to earlier medical treatment, increased compliance with medication and therapy regimens, effective management of chronic diseases, appropriate use of health care resources, and positive changes in health behaviors (Brudenell, 2003; Catanzaro, Meador, Koenig, Kuchibhatla, & Clipp, 2007; Chase-Ziolek & Gruca, 2000; Chase-Ziolek & Iris, 2002; Hughes, Trofino, O'Brien, Mack, & Marrinan, 2001; McDermott & Burke, 1993; Rethemeyer & Wehling, 2004; Rydholm, 1997). Participants in several studies have reported many physical, emotional, and mental health benefits after interactions with or interventions by faith community nurses (Burkhart, Konicek, Moorhead, & Androwich 2005; O'Brien, 2003; Rethemeyer & Wehling, 2004; Rydholm, 1997; Scott & Summer, 1993; Weis, Schank, & Matheus, 2006). Other positive outcomes related to the health aspect were increased health knowledge, enhanced sense of direction for health decisions, greater personal responsibility for health behaviors, and healthier lifestyles (Brudenell, 2003; Chase-Ziolek & Gruca, 2000; Chase-Ziolek & Iris, 2002; Scott & Summer, 1993; Wallace, Tuck, Boland, & Witucki, 2002). Many scholars have concluded that health education is a necessary, major, and satisfying characteristic of faith community nursing (Chase-Ziolek & Iris, 2002; Coenen, Weis, Schank, & Matheus, 1999; Kuhn, 1997; Mayhugh & Martens, 2001; McDermott & Burke, 1993; Miles, 1997; Mosack, Medvene, & Wescott, 2006; Tuck & Wallace, 2000; Tuck, Wallace, & Pullen, 2001). Investigators have also found that health-screening activities are an essential part

of this specialized nursing practice (Biddix & Brown, 1999; Coenen, et al., 1999; McDermott & Burke, 1993; Miles, 1997; Mosack et al., 2006).

Health is a human experience and an ongoing, dynamic process that integrates the spiritual, physical, psychological, and social dimensions of the person. Spiritual health influences a person's entire being and is an essential component for physical, mental, and social health and well-being. Health and well-being can exist in the presence of illness, disease, injury, disability, and imbalance. Healing can occur without a cure for specific illness or injury (Hickman, 2006; IPNRC, 2010).

The concept of health is included in the definition of and mission statement for faith community nursing. According to the definition, two processes in faith community nursing are promoting holistic health and preventing or minimizing illness (American Nurses Association & Health Ministries Association [ANA-HMA], 2005). The mission statement for faith community nursing addresses the health dimension with wellness and the prevention and appropriate treatment of illness (Patterson, 2004).

The concept of health is fundamental to the six standards of practice based on the model known as the nursing process. Data collection activities are based on the immediate health conditions or anticipated health needs of the individual, family, or community. Nursing diagnoses are derived from identified strengths that enhance health and potential or definite threats to health. Expected outcomes are focused on patients attaining, maintaining, or regaining health and healing. The plan of care is developed with strategies that address promotion and restoration of health and prevention of illness, injury, disease, and disability. During implementation of the plan, the faith community

nurse collaborates with and empowers patients to foster healthy lifestyles, decrease illness events, modify health risk behaviors, and adapt to changes in health status. The effectiveness of planned strategies and the attainment of expected health outcomes are part of the evaluation phase (ANA-HMA, 2005).

In the role as a personal health counselor, the faith community nurse discusses health concerns during unplanned, casual, private, or formal interactions with individuals, families, and groups. The nurse also assists members with making appropriate and individualized health-related plans. Additional aspects of this role include encouraging individuals to make lifestyle changes to improve personal health and emphasizing early responses to potentially serious health symptoms. Visiting members in their homes, hospitals, and extended care facilities is another function of the personal health counselor role. Finally, the faith community nurse offers presence, support, and prayer during emotional or stressful events (Hickman, 2006; IPNRC, 2010; Westberg, 1986).

Many authors included health interventions as variables for investigation in the practice of faith community nursing. Interventions that were frequently documented were health counseling, health screening, health advocacy, or health promotion activities (Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Bokinskie & Kloster, 2008; Brown, Coppola, Giacona, Petriches, & Stockwell, 2009; Burkhart & Androwich, 2004; Chase-Ziolek & Iris, 2002; Chase-Ziolek & Striepe, 1999; Coenen et al., 1999; Farrell & Rigney, 2005; King & Tessaro, 2009; McCabe & Somers, 2009; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Miskelly, 1995; Mosack et al., 2006; Quenstedt-Moe, 2003; Rydholm, 2006; Tuck, Pullen, & Wallace, 2001; Tuck & Wallace, 2000; Tuck,

Wallace & Pullen., 2001; van Loon, 1998; Wallace et al., 2002; Weis et al., 1997). Other health interventions included (a) performing physical assessments (Bitner & Woodward, 2004; Weis et al., 1997); (b) monitoring vital signs (Bitner & Woodward, 2004; Burkhardt & Androwich, 2004; Burkhardt et al., 2005); (c) assisting individuals to access and navigate health care systems (Bard, 2006; Bokinskie & Evanson, 2009; Bokinskie & Kloster, 2008; Brendtro & Leuning, 2000; Burkhardt et al., 2005; Chase-Ziolek & Iris, 2002; Patterson, 2007); (d) providing immunizations (Chase-Ziolek & Iris, 2002; Chase-Ziolek & Striepe, 1999); (e) serving as a resource for chronic disease or medication management (Bitner & Woodward, 2004; Burkhardt & Androwich, 2004; Burkhardt et al., 2005; Chase-Ziolek & Striepe, 1999; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Weis et al., 1997.); and (f) empowering individuals concerning health behaviors and decisions (Brendtro & Leuning, 2000; Burkhardt & Androwich, 2004; Chase-Ziolek, 1999; Tuck & Wallace, 2000; Wallace et al., 2002).

### **The Social Component of Faith Community Nursing**

The social component of faith community nursing is also present in the theoretical, research, and state of the science literature. In the model developed by Bergquist and King (1994), the client (a) has an emotional quality, (b) is a member of any age group, (c) is interested in age-specific topics, (d) belongs to any socioeconomic level, and (e) can be a member of the broader community. Emotional well-being, an integral part of health, is reduced when unity and harmony are missing, insufficient, or disrupted. The faith community serves as a social support system and provides multiple opportunities for

socialization. Human beings within this particular environment experience enhanced feelings of belonging to an extended family and caring community. The faith community environment also serves as a refuge and buffer to the larger society. The nurse uses effective communication skills and demonstrates a caring attitude during interactions with the client. Nursing interventions that apply to the emotional component are (a) caring, (b) emotional and social support, (c) organization of support groups, (d) counseling, and (e) empowerment. Client outcomes in this area are (a) decreased feelings of loneliness, isolation, anxiety, and dependence; (b) increased feelings of support, dignity, self-worth, importance, and comfort; (c) positive outlook on life; (d) resolution of guilt, stress, and grief; (e) raised consciousness; and (f) more responsive communities (Bergquist & King, 1994).

According to The Parish Nursing Continuity of Care Model (Wilson, 1997), the person exists and functions within the social context of a congregation. As individuals or groups, clients have the social characteristics of different ages, backgrounds, socioeconomic levels, and developmental stages. Optimal emotional health is one element of total health, and meeting emotional needs is one factor of total wellness. Based on examination of the pictorial representation of the model, the congregation is a feature of the environment, and community services surround the person. The faith community nurse is (a) an agent of love and caring, and (b) the focal point that connects people and their needs with social resources (Wilson, 1997).

The Miller Model of Parish Nursing (Miller, 1979) described the complex person as having social and emotional components that are interrelated with the spiritual, physical,

mental, and cultural features. Health is partially defined with the concept of shalom-wholeness, and this refers to dwelling at peace and in harmony with oneself, God, other people, and the created world. Health promoting resources include God, family, friends, the faith community, health care services, social services, vocation, and recreation. The environment is made up of contexts viewed from the nurse's perspective. The local congregation and church-related activities form the primary context. The socio-cultural community, health care community, and Christian community are other context components. Love and compassion for others and co-participation with them contribute to the roles and functions of the nurse. The fifth major concept is the core-integrating concept of the triune God. The development and nurturing of harmonious relationships with other people is one purpose of God according to this model (Miller, 1997).

Another model of faith community nursing practice, the Circle of Christian Caring (Maddox, 2001) does not specifically or clearly define the person or health as having a social dimension. The environment has a social quality and it is composed of the faith community or congregation, and the broader geographic community. The realm of faith community nursing practice is an ongoing and integrative process that includes the social features of visitation, communication, counseling, networking, referrals, and support groups (Maddox, 2001).

The mid-range theory, Spiritual Well-Being in Illness (O'Brien, 2003) includes the social aspect within the concept of environment. Ever-changing and stressful life events are related to emotional or socio-cultural variables. Social support comes from family,



friends, and caregivers. Stressful life events and social support influence the person's ability to find spiritual meaning in the experience of illness (O'Brien, 2003).

Researchers have documented the social quality of faith community nursing in reports of their investigations. White, Drechsel, and Johnson (2006) wrote that the faith community serves as a unique social network for people who share common beliefs and values, and a relationship with a higher being or power. They concluded that the social support from members of a faith community contributes to wellness and positive health behavior changes.

Faith community nursing includes the social dimension within the concept of community. Community can simultaneously refer to both the people and the geographic area. Faith community nursing builds and strengthens capabilities of individuals, families, groups, congregations, and communities to care for and support one another within the context of shared values, beliefs, traditions, and practices (Hickman, 2006; IPNRC, 2010). The mission statement for faith community nursing developed in September 2000, mentions social connections with members of the congregation and with the wider community (Patterson, 2004).

The social aspect of faith community nursing is included in standards of practice related to assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Specific measurement criteria are (a) involving family, groups, and others in data collection; (b) identifying actual, perceived, or potential social strengths and threats; (c) defining outcomes in terms of family perspectives; (d) developing individualized plans considering patient characteristics, practices, situations, and relationships; (e)

collaborating with and utilizing support systems to implement plans; and (f) including significant others in the evaluative processes. Standards of professional performance that address the social dimension are quality of practice, collegiality, and collaboration. The corresponding measurement criteria are (a) implementing processes to reduce or remove social barriers in the organizational or leadership structure, (b) maintaining compassionate and caring relationships with peers and colleagues, and (c) communicating, coordinating, or partnering with other individuals, families, or groups in the provision of care and delivery of services (ANA-HMA, 2005).

Two roles related to the social aspect are volunteer coordinator and developer of support groups. When functioning as a volunteer coordinator, the faith community nurse recruits, prepares, organizes, oversees, and supports congregational volunteers who share their time, talents, and knowledge to help those in need. In the role as developer of support groups, the nurse facilitates the development of support groups for members of the faith community. Support groups provide education, resources, and companionship with others who have similar experiences (Health Ministries Association, 2007; Hickman, 2006; IPNRC, 2010; Ministry Health Care, 2006; Presbyterian Church, 2007; Westberg, 1986).

Several scholars reported on faith community nursing interventions with a social focus. Interventions that were repeatedly mentioned included making referrals, providing emotional or social support, and facilitating support groups (Bard, 2006; Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Bokinskie & Kloster, 2008; Burkhart & Androwich, 2004; Burkhart et al., 2005; Chase-Ziolek & Iris, 2002; Chase-Ziolek &

Striepe, 1999; Coenen et al., 1999; Hinton, 2009; Koenig, 2008; McCabe & Somers, 2009; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Mendelson, McNeese-Smith, Koniak-Griffin, Nyamathi, & Lu, 2008; Miskelly, 1995; Mosack et al., 2006; Quenstedt-Moe, 2003; Rydholm, 2006; Tuck & Wallace, 2000; Tuck, Wallace, & Pullen, 2001; van Loon, 1998; Wallace et al., 2002; Weis et al., 1997). Additional interventions that were frequently documented were visiting people in homes, hospitals, and care facilities, or active listening (Bard, 2006; Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Bokinskie & Kloster, 2008; Burkhart & Androwich, 2004; Burkhart et al., 2005; Chase-Ziolek & Striepe, 1999; Coenen et al., 1999; Hinton, 2009; Koenig, 2008; McCabe & Somers, 2009; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Mosack et al., 2006; Quenstedt-Moe, 2003; Rydholm, 2006; Tuck & Wallace, 2000; Tuck, Wallace, & Pullen, 2001; Wallace et al., 2002). Other social interventions included (a) coordinating volunteer activities (McDermott & Burke, 1993; McGinnis & Zoske, 2008; Rydholm, 2006); (b) establishing or strengthening relationships (Bard, 2006; Van Dover & Pfeiffer, 2007; van Loon, 1998); (c) providing violence or abuse protection support (Burkhart et al., 2005; McGinnis & Zoske, 2008; Miskelly, 1995; Rydholm, 2006); (d) enhancing socialization processes (Coenen et al., 1997); (e) counseling people concerning family issues (King & Tessaro, 2009); (f) helping with home maintenance or home safety items (Burkhart et al., 2005; McDermott & Burke, 1993); (g) assisting in the selection of nursing care facilities (Bard, 2006); and (h) transporting individuals to community organizations or activities (Burkhart & Androwich, 2004).

## **The Educational Component of Faith Community Nursing**

The educational component of faith community nursing is a prevailing feature in theoretical models for faith community nursing. Bergquist and King (1994) described the person as being interested in learning about age-specific topics. The faith community nurse has completed a role-specific educational preparation program and continually grows in personal faith through multiple and diverse learning experiences. As a health educator, the nurse teaches individuals, families, groups, and communities about health promotion and disease prevention. Related client outcomes are (a) increased knowledge of illness and treatment, (b) greater frequency of engagement in health-related practices, (c) improved management of chronic illness, (d) increased awareness of the relationship between faith and health, and (e) increased responsibility for personal health (Bergquist & King, 1994).

Wilson (1997) defined the person as having a variety of age and development stages that influence their educational potential. The faith community nurse functions from a broad, general knowledge base. One role of the nurse is to provide education for individuals, families, groups, and the community. Educational activities vary based on needs of the faith community, support of the organization, and strengths and expertise of the nurse (Wilson, 1997).

According to The Miller Model of Parish Nursing (Miller, 1997), the person has a complex mental aspect which is interrelated with other components. Mental characteristics contribute to the educational qualities of the person. Health promoting resources include personal knowledge, learning abilities, and educational activities.

Stewardship is an important concept in this model and includes being accountable for educational characteristics (Miller, 1997).

The pictorial model of The Circle of Christian Caring represents the person as having a mind component (Maddox, 2001). One process of faith community nursing practice is education. In the role of health educator, the faith community nurse (a) conducts health-screening activities, (b) organizes health fairs, (c) provides creative programs, and (d) uses a variety of media to deliver health-related information (Maddox, 2001).

Researchers have addressed the educational aspect of faith community nursing in a variety of ways. In a study conducted by McDermott and Burke (1993), the sample of faith community nurses reported that 14% of their time was spent with health education. Findings by Kuhn (1997) indicated that (a) service as a health educator was a satisfying element of the nursing role, (b) lack of participation in educational activities was a frustrating aspect of the nursing role, (c) additional and specific educational preparation for the role was considered important, (d) educational needs included a broad range of topics, and (e) number of education programs formed the basis of periodic employee evaluations. Results of another study indicated that faith community nurses who had completed the IPNRC program were statistically more likely to provide health education programs than nurses who had not participated in this activity (Mosack et al., 2006). Lashley (2006) concluded that the faith community setting offers many opportunities for creative and innovative educational experiences and serves as location where students can learn about delivery of spiritual care. Outcomes related to the educational qualities of faith community nursing were (a) enhanced knowledge of chronic illness management

(McDermott & Burke, 1993; Rydholm, 1997); (b) increased comprehension of healthy lifestyle behaviors (Chase-Ziolek & Iris, 2002); (c) greater awareness of health promotion and disease prevention strategies (Brudenell, 2003); and (d) improved understanding of signs and symptoms of life-threatening events (Rethemeyer & Wehling, 2004).

The mission statement for faith community nursing includes the educational component. Nurses have the responsibility of educating people to take positive actions related to their personal health. Education focuses on wellness, prevention of illness, and appropriate treatment of diseases (Patterson, 2004).

The fifth standard of practice and professional performance refers to educational strategies to promote holistic health and wellness, and the eighth standard addresses continuing education and maintaining practice competencies for the faith community nurse (ANA-HMA, 2005). Specific measurement criteria for the fifth standard are (a) facilitating educational programs that address current and pertinent topics; (b) using health teaching methods appropriate to developmental level, learning needs, ability to learn, and readiness to learn; and (c) evaluating the effectiveness of educational strategies used. Specific measurement criteria for the eighth standard are (a) demonstrating a commitment to lifelong learning, (b) seeking learning experiences that reflect current practice to maintain knowledge, skills, and competence, and (c) using research findings to expand knowledge (ANA-HMA, 2005).

The faith community nurse functions as a health educator. One responsibility of this role is providing opportunities for individuals and groups to learn about health and health promotion through a variety of educational programs and activities. Supplying current,

accurate, age-appropriate, and culturally sensitive written, verbal, or video information on multiple health topics is another aspect of this role. Other responsibilities of the health educator are conducting periodical screenings focused on an assortment of health matters and assisting persons to adopt healthy lifestyles (Hickman, 2006; IPNRC, 2010; Olson, 2000).

Some authors identified educational interventions in their reports about faith community nursing. The two most common were developing, implementing, and evaluating educational programs (Bard, 2006; Burkhart & Androwich, 2004; Chase-Ziolek & Iris, 2002; Chase-Ziolek & Striepe, 1999; Coenen et al., 1999; Farrell & Rigney, 2005; Hinton, 2009; King & Tessaro, 2009; Koenig, 2008; McGinnis & Zoske, 2008; Wallace et al., 2002; Weis et al., 1997) and teaching individuals, families, and groups on a variety of health topics (Bitner & Woodward, 2004; Burkhart et al., 2005; Coenen et al., 1999; Koenig, 2008; Tuck & Wallace, 2000; Tuck, Wallace, & Pullen, 2001; van Loon, 1998; Wallace et al., 2002; Weis et al., 1997). Other educational interventions included (a) serving as preceptors for students (Brendtro & Leuning, 2000; Otterness, Gekrke, & Sener, 2007); (b) disseminating information and educational materials through various media (Wallace et al., 2002; Weis et al., 1997); (c) helping clients process information from physicians or other health care providers (Chase-Ziolek & Iris, 2002); and (d) offering health system guidance (Burkhart et al., 2005).

## **The Cultural Component of Faith Community Nursing**

Theoretical frameworks specific to faith community nursing included a cultural component. In the first conceptual model, the client of nursing practice belongs to a cultural group and any age group. The faith community environment is open to and accessible by all age, ethnic, and cultural groups. Individuals experience enhanced feelings of belonging to an extended and caring cultural community (Bergquist & King, 1994).

The cultural aspect is also included in the conceptual models developed by Wilson (1997) and Miller (1997). According to the Parish Nursing Continuity of Care Model (Wilson, 1997), the individuals and families within the congregation come from a variety of cultural backgrounds. Nursing roles vary based on the cultural needs of the faith community. The Miller Model of Parish Nursing depicts the person as multifaceted with cultural features that are interconnected with the physical, mental, social, emotional, and spiritual dimensions. Health promoting resources include the cultural aspects of family, friends, and the faith community. The socio-cultural community forms part of the environmental context (Miller, 1997).

The Circle of Christian Caring does not define the concept of person as having a cultural component. Descriptors for the concept of health include holistic healing and end-of-life processes and both terms have many cultural variations. The environment surrounding the person may be comprised of a specific cultural congregation or a broader cultural community. Responsibilities of the faith community nurse include (a) visiting members in health care facilities or in their homes, (b) organizing programs on specific



topics for cultural groups, (c) facilitating communication between patients or family members and health care personnel, (d) developing cultural sensitive support groups, and (e) serving as a liaison to the community (Maddox, 2001).

Researchers also have addressed the cultural features of faith community nursing in their investigations. For many cultural groups, the faith community serves as a resource for health care and health information (Baldwin, Humbles, Armmer, & Cramer, 2001). The faith community is a location where culturally diverse and ethnic minorities have been recruited for research protocols (Drayton-Brooks & White, 2004). Otterness, Gehrke, and Sener (2007) concluded that experiences in the faith community provide unique opportunities for students to (a) expand their cultural awareness, understanding, and competence; (b) observe relationships among people of differing ethnic backgrounds; and (c) explore the ways in which cultural expressions of faith and spirituality vary.

Cultural characteristics have influenced the need, acceptance, and growth of faith community nursing. Factors identified or acknowledged by scholars are the (a) aging of the American population; (b) rapidly increasing, community-dwelling elderly population; and (c) escalating ethnic diversity of communities (Catanzaro et al., 2007; Hale & Bennett, 2003; Schank, Weis, & Matheus, 1996). Faith community settings (a) are able to reach vulnerable, neglected, underserved, and at-risk populations with culturally diverse, racial-ethnic backgrounds; (b) are well-established, available, and accessible in neighborhoods and communities; (c) display sensitivity to cultural and language barriers; and (d) serve as community centers for many racial-ethnic minorities (Hula, Jackson-

Elmoore, & Reese, 2007; Peterson, Atwood, & Yates, 2002; Reinert, Campbell, Carver, & Range, 2003).

The cultural element is one factor that contributes to the science of faith community nursing. The concept of community incorporates culture and diversity to address health and wellness concerns. Three standards of professional performance for faith community nursing address the cultural dimension. The measurement criterion for the standard concerned with professional practice evaluation is that care is provided in an age-appropriate and culturally sensitive manner. The measurement criterion for the standard concerned with ethics is that cultural beliefs and practices of patients are acknowledged and respected. The faith community nurse creates and fosters a culture of acceptance, excitement, creativity, flexibility, and quality for the standard of leadership (AMA-HMA, 2005).

Different roles of faith community nursing feature the cultural component. In the role of health educator, the nurse provides culturally sensitive opportunities for members to learn about health, health promotion, and healthy lifestyle behaviors (Hickman, 2006; IPNRC, 2010). As an advocate, the nurse listens to the concerns of culturally diverse clients and serves as their voice when they seem to have no right to be heard (Patterson, 2007).

Some writers mentioned cultural interventions by faith community nurses. One key intervention was displaying cultural awareness or sensitivity (Bokinskie & Evanson, 2009; McGinnis & Zoske, 2008). Other interventions with a cultural focus were (a) preparing multilingual educational materials (Weis et al., 1997); (b) acknowledging

others' personal beliefs, attitudes, and values (Bokinskie & Evanson, 2009); (c) reading to or writing for clients (Tuck, Pullen, & Wallace, 2001); (d) protecting patient rights (Burkhart et al., 2005); and (e) fostering the sense of belonging to the congregation (Bard, 2006).

### **The Financial Component of Faith Community Nursing**

In their respective models, Bergquist and King (1994) and Wilson (1997) describe the person as belonging to any socioeconomic level. Access to the faith community environment is available for persons of all socioeconomic categories. Client outcomes with financial implications are (a) improved management of chronic illness, (b) improved access to health care, (c) increased compliance with treatment regimens, (d) improved physical lifestyle habits, (e) increased responsibility for personal health, and (f) delayed institutionalization (Bergquist & King, 1994). In The Parish Nursing Continuity of Care Model, community resources surround the person, health, and nursing aspects. The faith community nurse connects people and their needs with appropriate resources (Wilson, 1997).

In the Miller Model of Parish Nursing, health is defined with the concept of stewardship. One meaning of stewardship concerns being accountable for all gifts and resources, including those of a financial nature. A person's vocation and ability to earn money are considered health promoting resources (Miller, 1997). One role of the faith community nurse that is described in The Maddox Model of Faith Community Nursing Practice is that of referral resource/client advocate. Functions of this role with financial

implications are to (a) match volunteers and their resources with members and their needs, and (b) refer members to community resources (Maddox, 2001).

O'Brien (2003) wrote that ever-changing, stressful life events can surround and overtake the person at any given time and these events may be related to financial variables. Support to counterbalance the impact of financial difficulties comes from family, friends, and caregivers. The faith community nurse often serves as a bridge between the member and the congregation that donates financial support (O'Brien, 2003).

Many authors have addressed the financial quality of faith community nursing in their writings. Lack of financial resources can impede the practice of faith community nursing (Bokinskie & Kloster, 2008; Catanzaro et al., 2007). Financial issues which may impact the growth and practice of faith community nursing are increasing costs of healthcare (Catanzaro, et al., 2007; Nist, 2003; Pravecek, 2005, Wallace et al., 2002); delayed or impaired access to health care resources (Fredland, 2008); inadequate or absent healthcare insurance coverage (Fredland, 2008; Pravecek, 2005); and payment mechanisms which dictate the length and scope of healthcare (King, 2004; Pravecek, 2005). Other factors with financial implications are larger numbers of older adults (Wallace, et al., 2002), greater incidence of chronic illnesses (Wallace, et al., 2002), shorter hospital stays for inpatients (Rydholm, 2006), management of care in outpatient settings (Rydholm, 2006), and the transition of healthcare to the community (King, 2004; Wallace, et al., 2002). Cost-effective features of faith community nursing include avoided visits to primary care providers or emergency rooms (Brown, 2006), averted hospitalizations (Chase-Ziolek & Gruca, 2000; Rydholm, 1997; Weis & Schank, 2000),

decreased days of inpatient hospitalization (Brown, 2006), and delayed placement into long-term care facilities (Brown, 2006, Chase-Ziolek & Gruca, 2000; Rydholm, 2006; Weis & Schank, 2000).

One of the fifteen standards of practice and professional performance refers to the consideration of costs and effectiveness of resources when planning and delivering nursing services (ANA-HMA, 2005). The faith community nurse helps individuals and families (a) become informed consumers about the costs of treatments and interventions, and (b) assists them with identifying and securing resources for specific health needs. Another standard is concerned with the quality and effectiveness of faith community nursing practice. Measurement criteria for this standard are participating in efforts to minimize costs and unnecessary duplication and analyzing factors related to cost-benefit options.

Operating in the role as referral advisor, the nurse conducts comprehensive community assessments to identify available internal and external resources. The nurse matches the needs of the congregants with appropriate and available assets, and provides referrals to congregational resources and to existing healthcare and social services within the community. Finally, the nurse serves as a liaison between community health organizations and the faith community.

Some authors identified financial interventions in their reports. The most frequently documented financial intervention was referral for financial resource assistance (Bard, 2006; Bokinskie & Evanson, 2009; Burkhart & Androwich, 2004; Burkhart et al., 2005; Coenen et al., 1999; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Rydholm,

2006; Tuck, Pullen, & Wallace, 2001; Tuck & Wallace, 2000; Tuck, Wallace, & Pullen, 2001; van Loon, 1998; Wallace et al., 2002; Weis et al., 1997). Other financial interventions were (a) transporting clients to health care facilities or community agencies (Bard, 2006; Burkhart & Androwich, 2004; Tuck, Pullen, & Wallace, 2001); (b) assisting with health insurance issues (Burkhart & Androwich, 2004; Miskelly 1995); (c) completing financial assessments (Bitner & Woodward, 2004); and (d) working to contain health care costs (McGinnis & Zoske, 2008; Miskelly, 1995).

### **The Spiritual Component of Faith Community Nursing**

The spiritual component of faith community nursing is evident in theoretical frameworks, research, and aspects related to the current science for this specialized nursing practice. Four conceptual models that are specific to the practice of faith community nursing include the spiritual dimension. Bergquist and King (1994) developed the first conceptual model and they described the metaparadigm concept of person as the client of nursing practice. As an individual, family, or group, the client has spiritual qualities and is usually a faith community participant but can also be a member of the broader community. The concept of health is defined as optimal wellness and wholeness and true health contains spiritual elements. The spiritual foundation for healthy living is belief in the sanctity of the body. The absence, inadequacy, or disruption of unity and harmony decreases spiritual well-being. The concept of environment is identified as the faith community. One characteristic of this unique environment is that the faith community serves as a spiritual support system. The faith community nurse is

characterized as a spiritually mature person who (a) continually grows in personal faith, (b) remains sensitive to the relationship between faith and health, (c) applies spiritual features to health care, and (d) counsels individuals, families, and groups about spiritual concerns. Nursing practice enhances the holistic health and well-being of the client. Physical, emotional, and spiritual interventions and outcomes reflect the cohesion of the body, mind, and spirit. Nursing activities which promote spiritual health and well-being are (a) compassion, (b) prayer, (c) religious readings, (d) listening, (e) accompanying, (f) spiritual assessments, (g) facilitation of spiritual activities or religious rituals, (h) provision of faith and hope, (i) values clarification, and (j) healing services. Client outcomes related to spiritual interventions are (a) hope, faith, trust, calmness, and peace; (b) self-esteem, self-identity, and self-actualization; (c) physical and emotional well-being; (d) mended relationships; (e) increased awareness of the relationship between faith and health; (f) spiritual growth and strength; and (g) meaning to life and death; (h) faith community participation, and (i) feelings of importance (Bergquist & King, 1994).

The Parish Nursing Continuity of Care Model was created by Wilson (1997) and serves as a second framework which also includes the spiritual aspect. The person, as individuals or families within a congregation, is a whole being with body, mind, and spirit facets that interact with each other to maintain optimal physical, emotional, and spiritual health respectively. Health is described as an evolving process with physical, emotional, and spiritual properties that (a) works to maintain balance, and (b) strives to achieve an optimal level of wellness. Wellness is holistically promoted by addressing the physical, emotional, and spiritual needs. The faith community nurse functions from a

broad, general knowledge base and must be able to offer in-depth spiritual care and enhance the spiritual growth of the client. The goal of nursing is to promote holistic health and well-being by enhancing the sense of harmony with the mind, body, and spirit within the faith community (Wilson, 1997).

Evangelical Christianity provides the philosophical foundation for the third model specific to faith community nursing, The Miller Model of Parish Nursing (Miller, 1997). The spiritual component of the person is central and the person is transformed by a spiritual relationship with the triune God. The person uses the power of God to be a responsible participant in personal health promotion. Health is defined with the two overlapping concepts of shalom-wholeness and stewardship. Shalom-wholeness refers to dwelling at peace and in harmony with oneself, God, other people, and the created world. Stewardship means being entrusted with something valuable and accountable for all gifts received from God. Health promoting resources include God, family, friends, the faith community, health care services, social services, vocation, and recreation. The faith community environment can promote health by nurturing spiritual values. Nursing is conceptualized as a mission and a ministry with philosophical and pragmatic features. The philosophies of Christian faith support the “why” aspect of the mission. Nursing practice is the pragmatic “what” and “how” of the ministry. Love, gracious compassion, co-participation, and spiritual care contribute to the roles and functions of the nurse. The Miller Model of Parish Nursing has a fifth major concept--the core-integrating concept of the triune God. The triune God is personal, sovereign, good, just, merciful, and has loving relationships with people. Everyone and everything were created good by God, and God



intended for people to have harmonious relationships with Him, others, and nature (Miller, 1997).

Maddox (2001) developed the fourth model of faith community nursing practice, identified as the Circle of Christian Caring. Based on examination of the pictorial model, three inner, overlapping circles represent the person as having equal body, mind, and spirit components, but the concept of person is neither specifically nor clearly defined. One descriptor for health gleaned from the content of the article was holistic healing and this term could be interpreted as addressing the spiritual dimension. Faith community nursing practice is envisioned as “an opportunity to combine the spiritual and physical dimensions of care-giving and to affirm the church as a place for disease prevention and health promotion” (p. 12). Maddox described roles of the faith community nurse through activities associated with each role. One responsibility of the health counselor role is listening to health and spiritual concerns of the congregation. Faith community nursing in its entirety is a circle of Christian caring which serves the congregation. The concentric circles both expand into a holistic approach for this specialty nursing practice and converge onto the body, mind, and spirit aspects. A strong point of this particular model is the inclusion of lay ministries and this strength supports the truly holistic philosophy of and approach to nursing (Maddox, 2001).

O’Brien (2003) developed a middle-range theory, *Spiritual Well-Being in Illness*, which can be used to guide the practice of faith community nurses as they provide holistic care for seriously ill or disabled members. According to this theory, the person has a physical, psychosocial, and spiritual nature, and the ability to find meaning in the

experience of illness. The person is capable of accepting and transcending pain and suffering in light of higher powers. Spiritual resources, attitudes, and behaviors affect the individual's ability to accept or embrace pain, suffering, and illness. Personal faith, spiritual contentment, and religious practices form the category of spiritual resources. Stressful life events and social support impact the person's ability to find spiritual meaning in the experience of illness. The primary ministry of the faith community nurse is to assess and support the spiritual well-being of the member through caring interactions and interventions (O'Brien, 2003).

Bringing God Near is a theory for providing spiritual nursing care in a Christian faith community. This theory emerged from a grounded theory approach used in research conducted by Van Dover and Pfeiffer (2007). This theory does not specifically define the four metaparadigm concepts but blends the elements of the nursing process with the spiritual ministry of nursing. Five separate phases make up the process for providing spiritual care within a faith community. The first phase, trusting God, is the foundation for all care giving in this ministry. Trusting God develops over time and permits nurses to see God working in their own lives and the lives of their patients. Forming relationships with the patient or family is the second phase of this theory. Naming and validating spiritual concerns was a result of building relationships. The third phase, Opening to God, could be experienced as a (a) sense of peace, (b) moment of insight, or (c) holy interlude. The relationship between God, the patient, and the nurse is essential to the provision of spiritual care. Activating or nurturing faith relates to the intervention phase of the nursing process. The person's faith is nurtured through prayer, touch, music, and use of scripture.

Interventions support the person's faith and enable them to embrace their illnesses and struggles. The final phase is recognizing spiritual renewal and growth. Both the faith community nurse and the patient experience the growth and renewal. The release from pain and fear was one perception of spiritual renewal. Bringing God Near has great potential to help faith community nurses develop insight and refine spiritual care-giving practices (Van Dover and Pfeiffer, 2007).

Many scholars have addressed the spiritual quality of faith community nursing in their research. The spiritual dimension was an integral component of faith community nursing practice (Bergquist & King, 1994; Kuhn, 1997). Participants have indicated that spiritual interventions are expected, desired, acknowledged, and appreciated (Bergquist & King, 1994; Burkhart et al., 2005; Maddox, 2002; Tuck, Pullen, & Wallace, 2001; Tuck, Wallace, & Pullen, 2001; Wallace et al., 2002). Spiritual factors identified as satisfying elements of nursing practice were personal spiritual growth, increased spiritual well-being, the connection between faith and health, and the role of spirituality in health and illness (Kuhn, 1997; McDermott & Burke, 1993; Miles, 1997; Schweitzer, Norberg, & Larson, 2002; Scott & Summer, 1993, Wallace et al., 2002). Spiritual factors associated with a successful faith community nursing ministry were personal spiritual development and personal faith beliefs (Bokinskie & Kloster, 2008).

The spiritual dimension of faith community nursing is included in many features that contribute to the current state of the science for this arena of nursing practice. The philosophical basis of faith community nursing is comprised of several beliefs and values that manifest the spiritual component. Spiritual formation is one of the major concepts

that make up the foundation. The spiritual dimension of the person is not only essential but also central to faith community nursing. All persons are sacred and must be treated with respect, compassion, mercy, justice, and dignity. Personal spiritual formation is an unending and intentional process that fosters spiritual growth. Health is an ongoing, dynamic process that incorporates the spiritual, physical, psychological, and social dimensions of the person. Spiritual health influences a person's entire being and is fundamental for physical, mental, and social health and well-being. Faith community nursing builds and strengthens capabilities of individuals, families, groups, congregations, and communities to care for one another within the context of the spiritual values, beliefs, traditions, and practices of a faith community (Hickman, 2006; IPNRC, 2010).

In September 2000, over 600 participants at the Fourteenth Annual Westberg Symposium developed a specific mission statement. The “intentional integration of the practice of faith” and “spiritual connections” are two terms that pertain to the spiritual aspect (Patterson, 2004). The definition of faith community nursing was updated in 2005 with the publication of *Faith Community Nursing: Scope and Standards of Practice* and contains “the intentional care of the spirit” (ANA-HMA, 2005, p. 1). The eleventh standard of practice and professional performance refers to collaboration with spiritual leaders. Specific measurement criteria for this standard for the faith community nurse include (a) communication with spiritual leaders regarding the care that is needed for individuals, families, or groups; and (b) partnership to enhance faith-based health care through worship, prayer, and education concerning spiritual practices (ANA-HMA,

2005). Measurement criteria for other standards that address the spiritual aspect are (a) identifying strengths that enhance spiritual well-being, (b) considering spiritual beliefs and practices when formulating outcomes, (c) teaching activities that strengthen the body-mind-spirit connection, (d) providing age-appropriate care in a spiritually sensitive manner, and (e) acknowledging and respecting tenets of faith and spiritual belief systems of the person (ANA-HMA, 2005).

The role of integrator of faith and health is the pivotal and overarching role of the faith community nurse. The focus of this role is the intentional care of the spirit. In all activities and contacts, the faith community nurse helps members (a) discover and identify the spiritual beliefs and values that affect their health, (b) understand the relationship between their faith and their health, (c) comprehend the associations between body, mind, and spirit; (d) explore the connection between attitudes, lifestyle, faith, and well-being; and (e) achieve higher levels of wellness by improving spiritual, physical, and emotional health (Hickman, 2006; IPNRC, 2010; Ministry Health Care, 2006; Presbyterian Church, 2007, Westberg, 1986).

As faith community nursing incorporates the intentional care of the spirit, multiple spiritual interventions were documented by researchers and scholars as they investigated and discussed this unique nursing practice. The most frequently documented spiritual interventions were providing spiritual support or care (Bard, 2006; Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Bokinskie & Kloster, 2008; Burkhart & Androwich, 2004; Burkhart et al., 2005; Chase-Ziolek & Iris, 2002; Coenen et al., 1999; Hinton, 2009; King & Tessaro, 2009; Koenig, 2008; McCabe & Somers, 2009; Mendelson et al.,

2008; O'Brien, 2006; Quenstedt-Moe, 2003; Rydholm, 2006; Tuck, Pullen, & Wallace, 2001; Tuck & Wallace, 2000; Tuck, Wallace, & Pullen, 2001; Van Dover & Pfeiffer, 2007; van Loon, 1998; Wallace et al., 2002; Weis et al., 1997); assisting with coping mechanisms or grieving processes (Burkhart & Androwich, 2004; Burkhart et al., 2005; Coenen et al., 1999; Koenig, 2008; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Rydholm, 2006; Weis et al., 1997); and offering presence or being available (Burkhart et al., 2005; Coenen et al., 1997; Hinton, 2009; O'Brien, 2006; Tuck, Pullen, & Wallace, 2001; Tuck & Wallace, 2000; Tuck, Wallace, & Pullen, 2001). Other interventions with a spiritual quality were (a) completing spiritual assessments (Bard, 2006; Bitner & Woodward, 2004; O'Brien, 2006; Van Dover & Pfeiffer, 2007); (b) assisting with end of life issues (Burkhart et al., 2005; McGinnis & Zoske, 2008; Quenstedt-Moe, 2003; Rydholm, 2006); (c) instilling hope (Coenen et al., 1997; Rydholm, 2006; Tuck, Wallace, & Pullen, 2001); (d) considering or clarifying the relationship between faith and health (McDermott & Burke 1993; McGinnis & Zoske, 2008; van Loon, 1998); (e) using touch (Coenen et al., 1997; Tuck, Pullen, & Wallace, 2001; Tuck, Wallace, & Pullen, 2001; Van Dover & Pfeiffer, 2007; Weis et al., 2002); (f) encouraging humor (Coenen et al., 1997; Weis et al., 2002); (g) clarifying values (Miskelly 1995; Tuck, Wallace, & Pullen, 2001); and (h) considering individual religious practices (Bard, 2006; Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Burkhart et al., 2005; Coenen et al., 1997; Kuhn, 1997; Maddox, 2000; O'Brien, 2006; Rydholm, 2006; Tuck, Pullen, & Wallace, 2001; Tuck, Wallace, & Pullen, 2001).

## **Summary**

The history, theoretical models, descriptive information, and research related to faith community nursing have provided a broad overview of this nursing practice specialty. Health, social, educational, cultural, financial, and spiritual effects were integrated within the theoretical models that were purposely designed for faith community nursing. Descriptive information that included the philosophy, definition, mission statement, standards of practice, and faith community nursing roles addressed these six components. Research findings included various outcomes related to health, social, educational, cultural, financial, and spiritual effects of faith community nursing. Nursing interventions that corresponded to these six areas were identified in some reports.

The practice of faith community nursing has expanded nationally and internationally in the past two decades but corresponding research has not experienced comparable growth. The current scientific knowledge for faith community nursing is based on either (a) the limited, separate examination of health, social, educational, cultural, financial, or spiritual effects; or (b) a combination of some, but not all six, elements concurrently. A small number of research studies have addressed nursing interventions provided by faith community nurses. Previous research participants have been faith community members, clergy representatives, or faith community nurses, but not all three groups have participated simultaneously in an individual study. Earlier research did not include participants with a broad range of demographic characteristics from a large number of individual, culturally diverse faith communities. Moreover, prior investigations have not examined the impact of faith community nursing programs associated with a large health

care system. This study has addressed these limitations through a comprehensive, integrative assessment of health, social, educational, cultural, financial, and spiritual effects of faith community nursing among faith community members, clergy representatives, and nurses.



## CHAPTER III

### METHODOLOGY

This research project was comprised of a pilot study and a main study. The pilot study portion of this project evaluated a newly developed demographic instrument and impact questionnaire for appropriateness, readability, clarity, relevance, and user-friendliness. A second purpose of the pilot study was to collect initial and limited information concerning the impact of faith community nursing on a culturally diverse community through examination of health, social, educational, cultural, financial, and spiritual effects. A final purpose of the pilot study was to identify a partial list of nursing interventions that faith community nurses use in their practice with individuals, families, groups, communities, or society. This preliminary description included the responses of (a) faith community members who had contact with or services from the faith community nurse, and (b) one clergy representative.

The first purpose of the main study was to examine the impact of the faith community nursing program on a culturally diverse urban community in the southeastern United States from the perspectives of faith community members, clergy representatives, and faith community nurses. The second purpose was to identify nursing interventions that faith community nurses use in their practice with individuals, families, groups, communities, or society. The following two research questions were generated for the main study.

1. How do faith community members, clergy representatives, and nurses describe the impact of the faith community nurse program in their communities related to health, social, educational, cultural, financial and spiritual effects?
2. What interventions do faith community nurses provide in culturally diverse faith communities?

### **The Research Design**

The pilot study and main study portion of this project used a qualitative approach to assess and describe the impact of faith community nursing on a culturally diverse community. The study design did not (a) attempt to identify causes or reasons for responses, (b) involve the manipulation of independent or predictor variables, or (c) attempt to change the participant during the research process. The pilot study was cross-sectional with data collected from individuals at one specific point in time. One component of the main study was cross-sectional with data collected from individuals at one specific point in time. Another portion of the main study used a retrospective approach that examined previously collected data included in the ten annual reports of the program. Content analysis was used to analyze the responses of participants in this project and the data in the annual reports. Content analysis is both a systematic and replicable research technique and a valid scientific tool that generates both quantitative and qualitative results (Colorado State University, 2009a; Krippendorff, 2004a; Stemler, 2001; Waltz, Strickland, & Lenz, 2005). This methodology was appropriate for condensing many words of text into specific categories and for determining trends or

patterns in documents. Based on explicit rules of coding, content analysis allowed this researcher to examine, discover, and describe individual, group, and community phenomena within the context of their use. Content analysis has been used by numerous disciplines (Colorado State University, 2009b), and research results are well documented in professional literature.

## **The Pilot Study**

### **Setting for the Pilot Study**

For the pilot study, data were collected during a two-month period from participants in two faith communities in an urban area of one county of a southeastern state. These faith communities were affiliated with a health ministry program at a large, multihospital, local health care system. Membership in the faith communities ranged from 300 to 1000 persons. The number of clergy representatives was two at one site and three at the other site. Research packets were mailed to the faith community members' home addresses. Research packets were also mailed to the clergy representatives and to one of the faith community nurses at the faith community addresses. After research packets were mailed to the participants, two weeks from the date of the final mailing were allowed for the questionnaires to be returned.

### **Population and Sample for the Pilot Study**

The target population was all adult members, clergy representatives, and nurses who are associated with the local faith communities served by the specific program. A

purposive sampling technique was used for this project. The three groups in the purposive sample were (a) members from the diverse faith communities who regularly or frequently use the services of the nurse, (b) clergy representatives from the faith communities, and (c) faith community nurses. Inclusion criteria were that participants (a) agreed to take part in the study, (b) had the mental capacity to consent, (c) were able to understand, read, and write English, (d) were 18 years of age or older, and (e) had three interactions with or services from the faith community nurse in the past year. Participants were not excluded from the study based on other demographic variables. The sample was not considered representative of all individuals who are associated with a faith community nursing program.

The estimated sample size for the pilot study was ten and included three individual members, one clergy representative, and one nurse from the two participating faith communities. The research team believed these participants in this triangular sampling approach would provide a broader assessment and give sufficient information to evaluate the instruments for use in the future main study. The actual sample ( $n = 6$ ) was smaller due to one faith community nurse not providing a list of potential faith community member participants and her request not to receive the research packet.

### **Protection of Human Subjects for the Pilot Study**

This complete project was conducted within the most recent guidelines of the university's Institutional Review Board (IRB). This researcher completed the *Human Participants Protection Education for Research Teams* online course, sponsored by the National Institutes of Health in August 2006. The researcher also participated in *IRB*

*Procedures and the Protection of Human Research Participants*, a seminar presented by the School of Nursing IRB representative Dr. Heidi Krowchuk in June 2007.

For the pilot study, the project was submitted to the IRB of the large medical center with which the two faith communities were affiliated. Research documents included with the IRB application were the (a) letter of introduction with separate versions for faith community members, and for clergy representatives and faith community nurses (see Appendix C); (b) consent form (see Appendix D); (c) demographic tool *All About Me* (see Appendix A); (d) impact questionnaire with separate versions for the three participant groups (see Appendix B); and (e) research instrument evaluation tool with separate versions for the three participant groups (see Appendix E). The letter of introduction addressed (a) the purpose of the study, (b) voluntary participation, and (c) the return of questionnaires serving as consent to use the responses. The consent form guaranteed (a) confidentiality, (b) anonymity, (c) voluntary participation, and (d) freedom to withdraw from the study without penalty. Contact information for the university's IRB and the principal investigator were included on the consent form. The readability of all research documents is presented in Table 1. There were no physical risks to participation. The IRB of the large medical center approved the study by expedited review. The approval was received on September 15, 2008 and the approval number was 200822 (see Appendix F).

Next, the project was submitted to the Nursing Research Committee in the School of Nursing. Revisions were made based on members' recommendations and the project was then submitted to the university's IRB in December 2008. As required by the IRB, this

application included letters of support from the two faith communities that agreed to participate in the pilot study (see Appendix G). These letters gave permission to collect data from individuals associated with the two faith communities. The university's IRB approval was received on January 8, 2009 and the approval number was 09-0003 (see Appendix F).

### **Instruments for the Pilot Study**

Three separate, newly developed instruments with distinct purposes were used in the pilot study. Demographic data were collected with a fixed-response instrument that was developed by the researcher (see Appendix A). This tool was revised through collaboration with the dissertation committee members and was titled *All About Me*. Variables on this tool were (a) participant group, (b) gender, (c) age, (d) marital status, (e) residential area, (f) location of faith community, (g) racial-ethnic category, (h) education level, (i) employment status, (j) income, (k) number of clergy representatives in the faith community, (l) membership of the faith community, (m) frequency of participation in faith community activities, (n) length of involvement with faith community nursing, (o) frequency that faith community nurse services are used, and (p) number of separate faith communities served by the nurse. Except for the participant group, each variable had a "prefer not to answer" option.

The questionnaire to examine the impact of faith community nursing was also developed by the researcher and had six open-ended questions specifically designed to answer the research questions. These questions addressed the health, social, educational, cultural, financial, and spiritual effects, and the conceptual definitions provided the basis

for the definitions that were included on the impact questionnaires. The first item on the impact questionnaire was used to gather information concerning the health impact of the faith community program. The conceptual definition of health was the quality that includes physiological and mental structures, ongoing functions, continuous processes, changing needs, and activities of the human body that contribute to the goals and purposefulness of existence as a holistic, integrated human being. On the pilot version for faith community members, the definition was “Health means physical and mental activities of the human body.” On the pilot version for clergy representatives and faith community nurses, the definition was “Health includes physiological and mental structures, functions, processes, needs, and activities of the human body.”

Responses to the second item on the impact questionnaire provided descriptions of the social impact. The conceptual definition of social was the quality that includes groups, associations, organizations, or support systems, and affects the willingness and ability to give and receive all phenomena one has to offer as a person (e.g. knowledge, skills, talents, time). Social was defined as “Social means people or support systems that affect what you have to offer as a person (what you know, what skills you have, what talents you have)” for faith community members. Social was defined as “Social includes individuals, families, groups, associations, organizations, or support systems and affects all one has to offer as a person (e.g. knowledge, skills, talents, time)” for clergy representatives and faith community nurses.

The educational impact was determined by the third item on the impact questionnaire. The conceptual definition of educational was the aspect that includes and affects the

ability to gain, increase, share, master, evaluate, or transform knowledge. The definition of educational was “Educational means the ability to learn and change what you know” for faith community members. The definition of educational was “Educational includes the ability to gain, increase, share, master, evaluate, or transform knowledge” for clergy representatives and faith community nurses.

The cultural impact was derived from answers to the fourth item on the impact questionnaire. The conceptual definition of cultural was the aspect that is the total of the learned behavior shared by a particular group of people and transmitted from generation to generation. Learned behaviors include ethnicity (language, practices, customs, traditions, goals, associated values), belief systems (spiritual beliefs, philosophies, values), and socioeconomic status (lifestyles, use of material resources). “Cultural means the things shared by a group of people. It includes values, customs, lifestyles, and use of material resources. These things are passed from one generation to the next” was the definition of cultural for faith community members. “Cultural includes the learned behaviors (e.g. traditions, philosophies, values, languages, customs, use of material resources) shared by a particular group of people and transmitted from generation to generation.” was the definition of cultural for clergy representatives and faith community nurses.

On the impact questionnaire, the fifth item addressed the financial impact. The conceptual definition of financial was the quality that includes the ability to earn money and affects the appropriate and responsible use and control of monetary resources. The concept of financial was explained as “Financial means the ability to earn and use



money” for the member participants. Financial was explained as “Financial includes the ability to earn, use, and control money and monetary resources” for clergy participants and nurse participants.

The final area of impact was the spiritual impact and it was investigated using the sixth item on the impact questionnaire. The conceptual definition of spiritual was the aspect that includes the value system, belief system, and self-evaluation system so that one can exist with a sense of unity, continuity, integrity, meaning, purpose, satisfaction, and fulfillment in society and in the universe. The meaning of the spiritual was described as “Spiritual means the value, belief, and self-evaluation systems so that you can exist with unity, meaning, purpose, and fulfillment in society and in the universe” for faith community members. The meaning of spiritual was described as “Spiritual includes the value, belief, and self-evaluation systems so that one can exist with a sense of unity, meaning, purpose, and fulfillment in society and in the universe” for clergy representatives and faith community nurses.

Participants were given the option to include other information that was not addressed by the six questions. Separate versions of the impact questionnaire were used for faith community members, clergy representatives, and faith community nurses as there was a small amount of variation in the questions (see Appendix B). Participants provided written responses for this questionnaire.

The third instrument was a Research Instrument Evaluation Tool. This form was developed by the researcher to determine if items on the demographic tool and the impact questionnaire were appropriate, easy to read, clear, relevant, and user-friendly. The fixed-

choice responses for each of those five categories were (a) very, (b) moderately, (c) somewhat, and (d) not. Separate versions of this tool were prepared for the three participant groups (see Appendix E).

The demographic tool *All About Me* and the impact questionnaire were pilot tested with participants in two culturally diverse faith communities in another county of the state. The pilot study was conducted to ensure the instruments were appropriate, easy to read, clear, relevant, and user-friendly. Results indicated that no revisions were necessary. The readability levels of the three instruments are presented in Table 1.

The doctoral prepared director of nursing research at a large urban hospital and a nursing professor at a private university in the state evaluated the three instruments for face validity and content validity. These individuals were selected based on their (a) doctoral education, (b) nursing research expertise, and (c) instrument design and development knowledge. Both individuals verified the face validity and content validity of the three research tools. The coordinator and the assistant coordinator of the faith community nursing program also evaluated the demographic tool *All About Me* and the impact questionnaire for face validity and content validity. These individuals were chosen based on their (a) education level, (b) nursing practice experience, and (c) faith community nursing expertise. Both individuals confirmed the face validity and content validity of the two instruments.

Several instruments that assess the spiritual dimension, and have documented reliability and validity, were examined. These tools contained a variety of constructs that apply to the spiritual component of the person. The concepts of meaning, purpose,

fulfillment, or satisfaction in life were included in instruments developed by several scholars (Daaleman & Frey, 2004; Delaney, 2005; Ellison, 1983; Gomez & Fisher, 2003; Hatch, Burg, Naberhaus, & Hellmich, 1998; Peterman et al., 2002; Seidlitz et al., 2002; Stranahan, 2007). Peace, hope, faith, comfort, harmony, or inner strength were additional terms that described the spiritual component (Holland et al, 1998; Peterman et al., 2002; Seidlitz et al., 2002; Stranahan, Underwood & Teresi, 2002; Vella-Brodrick & Allen, 1995). Relationships or connectedness with (a) God, other deity, higher power, or sacred one, (b) other individuals, (c) nature, and (d) oneself formed the basis for some questionnaire items (Delaney, Hall & Edwards, 1996). Some instruments included methods for dealing with problems, difficulties, and challenges (Daaleman & Frey, 2004; Holland et al, 1998). These terms were used to provide a foundation for establishing construct validity and for describing the spiritual impact of faith community nursing in this study.

### **Data Collection and Field Procedures for the Pilot Study**

The principal investigator conducted an internet search for the term “faith community nursing” and the name of a certain southeastern state using the Google search engine. Results from this search identified a faith community nursing program associated with a large medical center. This program was in the same southeastern state as the program involved in the main study. The researcher contacted the individual faith communities associated with this program by telephone. Only two faith communities agreed to participate in the study and provided the appropriate, required letter of support and permission to collect data from individuals associated with that specific faith community.

After the large medical center's IRB and the university's IRB approved the pilot study, the researcher contacted the nurses at the two participating faith communities and informed them of the study inclusion criteria. The researcher then requested a list of potential participants with their mailing addresses. Only one of the nurses provided the researcher with the requested list. From this list, the researcher randomly selected three individuals, and then (a) addressed the envelopes, (b) destroyed the list of names and addresses with a crosscut shredder, (c) assembled the research packets, and (d) mailed the packets to the participants at their home addresses. The research packets contained several items and were arranged in a specific order. A list of how those documents were arranged in the research packets that were mailed to potential participants is provided in Appendix H. Research packets that contained the same items arranged in the same order were also mailed to a clergy representative at the two faith community locations and to a faith community nurse at one of the locations. Through an earlier communication with the faith community nurse at the second location, she specifically requested that a research packet not be sent to her and this request was honored. After these were completed by the participants, the demographic instrument, the written responses to the impact questionnaire, and the research instrument evaluation tool were mailed back to the principal investigator in the provided stamped, addressed envelopes. Two weeks were allowed for questionnaires to be returned. Based on feedback from the pilot study participants, the demographic instrument and the impact questionnaire did not require any revisions. The researcher provided stamped, addressed envelopes for all participants to return the research instruments. Return postage was guaranteed. Returning the

questionnaires was considered as consent to use the responses for the pilot study and this implied consent was included in the letters of introduction. Written data were stored in a fireproof, locked file cabinet in the researcher's home office. Data were transcribed into individual word documents and checked for accuracy. Electronic data were stored on a password secured computer.

### **Data Analysis for the Pilot Study**

Frequency counts and some descriptive statistics were used to describe demographic characteristics of the participants in the pilot study. Data analysis of the impact questions used four separate steps of content analysis for the two participant groups. First data were coded using an *a priori* approach that included the families of impact, interventions, faith community nursing roles, and attributes of faith community nurses. ATLAS.ti software was used for the coding processes. Next, the data were examined for other recurrent themes. Third, findings that were identified during the coding process were summarized. The final component focused on patterns and relationships among the findings, and similar and different responses in the two groups.

Waltz, Strickland, Lenz, and Soeken (2005) described a process to determine content validity indices and to quantify the extent of agreement between experts who judged specific items. This same method was used to determine appropriateness, readability, clarity, relevance, and user-friendliness indices from the responses on the research instrument evaluation tools. This phase of data analysis was conducted using version 16 of SPSS.

## **The Main Study**

### **Setting for the Main Study**

For the main study, data were collected during a four-month period from individuals in 23 faith communities that participate in the faith community nursing program at a large, multihospital, local health care system. These sites were located in the central region of a southeastern state and in an urban area of that particular state. Physical locations of the faith communities included a variety of buildings where people congregate for religious worship, service, teaching, and other activities. These buildings were identified as churches, cathedrals, synagogues, temples, mosques, or by other names. Different cultural groups and religious affiliations were represented. Membership in the faith communities ranged from less than 100 to over 5000 persons. The number of clergy representatives for each faith community varied from one to six. The nurses served between one and four faith communities. Research packets were mailed to the faith community members' home addresses and to the clergy representatives and the faith community nurses at the faith community addresses. After research packets were mailed to the participants, four weeks from the date of the final mailing were allowed for the questionnaires to be returned. The physical locations were not considered representative of all cultural groups or religious affiliations that participate in the faith community nursing program.

## **Population and Sample for the Main Study**

The target population was all adult members, clergy representatives, and nurses who are associated with the local faith communities served by the specific program. A purposive sampling technique was used for this project. Purposive sampling allowed information-rich cases to be examined in greater depth. Purposive sampling also supported strategies of (a) maximum variation sampling which provides cases with the greatest differences in specific qualities, (b) extreme case sampling which involves cases that have special or unusual features, (c) critical case sampling which uses cases that can clarify information or that are crucial to the interpretation and understanding of the research topic, and (d) typical case sampling which includes cases that are considered typical of the phenomenon being studied (Wiersma & Jurs, 2005).

The purposive sample was comprised of three groups. The first group was members from the diverse faith communities who regularly or frequently use the services of the nurse. The second group was clergy representatives from the faith communities. The third group was the faith community nurses. Inclusion criteria were that participants (a) agreed to take part in the study; (b) had the mental capacity to consent; (c) were able to understand, read, and write English; (d) were 18 years of age or older; and (e) had three interactions with or services from the faith community nurse in the past year.

The estimated sample size for the main study was 255 and included three individual members, one clergy representative, and one nurse from each of the 51 participating faith communities. This triangular sampling approach provided a more comprehensive perspective of the program impact. The research team believed this approach and this

number of participants provided diverse and information-rich data that was reasonable and manageable when costs, time, and other resources were considered. The sample size was not based on the ability to generalize the findings to a larger population but on the ability to adequately capture the impact of the program from three different perspectives. The actual sample was smaller due to (a) voluntary involvement by the individual faith communities, (b) voluntary participation by the individuals who received the research packets, and (c) nurses providing services for more than one faith community.

Participants were not excluded from the study based on other demographic variables. The sample for the main study was not considered representative of all individuals who are associated with the faith community nursing program.

For the retrospective portion of the study, the researcher examined all annual reports of the program since its inception ten years ago. This approach allowed the researcher to analyze older content from the beginning of the program. This technique permitted the investigator to include data from faith communities associated with the program for one year and to look for trends and patterns that have developed during the program's ten-year existence. Finally, this method allowed the inclusion of data from faith communities that did not participate in the mailed survey portion of the study.

### **Protection of Human Subjects for the Main Study**

For the main study, the project was presented at the September 2008 meeting of the Nursing Research Committee for the local, large health care system with which the faith community nursing program is affiliated. Research documents included with the presentation were the (a) letter of introduction with separate versions for faith community



members, and for clergy representatives and faith community nurses (see Appendix C); (b) consent form (see Appendix D); (c) demographic tool *All About Me* (see Appendix A); and (d) impact questionnaire with separate versions for the three participant groups (see Appendix B). The letter of introduction addressed (a) the purpose of the study, (b) voluntary participation, and (c) the return of questionnaires serving as consent to use the responses. The consent form guaranteed (a) confidentiality, (b) anonymity, (c) voluntary participation, and (d) freedom to withdraw from the study without penalty. Contact information for the university's IRB and the principal investigator were included on the consent form. The readability of all research documents is presented in Table 1. There were no physical risks to participation. Following the review and approval by the Nursing Research Committee, the project was submitted to the IRB of the large health care system. This IRB application included a letter of support from the faith community nursing program (see Appendix I). Their expedited approval was received on October 9, 2008 (see Appendix F).

Table 1

*Readability Information for Research Documents*

Item	Flesch-Kincaid Grade Level	Flesch Reading Ease Score
Letter of introduction for faith community members for pilot study	5.7	73.8
Letter of introduction for clergy representatives and faith community nurses for pilot study	9.6	47.3
Letter of introduction for faith community members for main study	6.2	70.2
Letter of introduction for clergy representatives and faith community nurses for main study	9.3	50.0
Consent form for pilot study	7.9	60.7
Consent form for main study	7.8	60.8
Demographic instrument <i>All About Me</i>	6.8	61.6
Impact questionnaire for faith community members	8.2	59.2
Impact questionnaire for clergy representatives	12.9	30.8
Impact questionnaire for faith community nurses	13.2	32.2
Research instrument evaluation tool for faith community members	7.4	61.2
Research instrument evaluation tool for clergy representatives	9.2	49.1
Research instrument evaluation tool for faith community nurses	9.3	49.5

After the completion of the pilot study that evaluated the newly developed demographic instrument and impact questionnaire, a modification application was submitted to the university's IRB in April 2009. Letters of support from the different faith communities with permission to collect data from individuals associated with the specific faith community were submitted as required by the IRB (see Appendix G). The modifications did not alter the exempt status of the study and the submission was determined to be exempt from further review. The approval was received on May 8, 2009 and this amendment allowed four major changes to the research process (see Appendix F). First, the status of the study changed from the pilot study to the main study, and the research instrument evaluation portion was eliminated. The next change was the addition of seven more faith community sites that are associated with a large health care system. Third, the subject enrollment increased to reflect the addition of 35 participants based on the addition of three faith community members, one clergy representative, and one faith community nurse from each of the seven faith communities. Lastly, the consent form and introductory letters were changed to reflect these modifications (see Appendices C and D).

As other faith communities participating in the program provided the required letters of support and permission to collect data from individuals associated with the faith community (see Appendix G), three additional modification applications were submitted to the IRB. The second modification was approved on June 15, 2009, and added 10 faith community sites and 50 participants (see Appendix F). The third modification was approved on July 6, 2009, and five more faith community sites and 25 more participants

were added to the main study (see Appendix F). One more faith community location and five more participants were added with the final modification. This last approval was received on July 21, 2009 (see Appendix F). The four modifications yielded a final sample size of 115 participants for the main study.

### **Instruments for the Main Study**

Two separate, newly developed instruments with distinct purposes were used in this project. Demographic data were collected with a fixed-response instrument that was developed by the researcher (see Appendix A). This tool was revised through collaboration with the dissertation committee members and was titled *All About Me*. Variables on this tool were (a) participant group, (b) gender, (c) age, (d) marital status, (e) residential area, (f) location of faith community, (g) racial-ethnic category, (h) education level, (i) employment status, (j) income, (k) number of clergy representatives in the faith community, (l) membership of the faith community, (m) frequency of participation in faith community activities, (n) length of involvement with faith community nursing, (o) frequency that faith community nurse services are used, and (p) number of separate faith communities served by the nurse. Except for the participant group, each variable had a “prefer not to answer” option.

The questionnaire to examine the impact of the faith community nursing program was developed by the researcher and had six open-ended questions specifically designed to answer the research questions. These questions addressed the health, social, educational, cultural, financial, and spiritual effects, and the conceptual definitions provided the basis for the definitions that were included on the impact questionnaires. The first item on the

impact questionnaire was used to gather information concerning the health impact of the faith community program. The conceptual definition of health was the quality that includes physiological and mental structures, ongoing functions, continuous processes, changing needs, and activities of the human body that contribute to the goals and purposefulness of existence as a holistic, integrated human being. On the main study version for faith community members, the definition was “Health means physical and mental activities of the human body.” On the main study version for clergy representatives and faith community nurses, the definition was “Health includes physiological and mental structures, functions, processes, needs, and activities of the human body.”

Responses to the second item on the impact questionnaire provided descriptions of the social impact. The conceptual definition of social was the aspect that includes groups, associations, organizations, or support systems, and affects the willingness and ability to give and receive all phenomena one has to offer as a person (e.g. knowledge, skills, talents, time). Social was defined as “Social means people or support systems that affect what you have to offer as a person (what you know, what skills you have, what talents you have)” for faith community members. Social was defined as “Social includes individuals, families, groups, associations, organizations, or support systems and affects all one has to offer as a person (e.g. knowledge, skills, talents, time)” for clergy representatives and faith community nurses.

The educational impact was determined by the third item on the impact questionnaire. The conceptual definition of educational was the component that includes and affects the

ability to gain, increase, share, master, evaluate, or transform knowledge. The definition of educational was “Educational means the ability to learn and change what you know” for faith community members. The definition of educational was “Educational includes the ability to gain, increase, share, master, evaluate, or transform knowledge” for clergy representatives and faith community nurses.

The cultural impact was derived from answers to the fourth item on the impact questionnaire. The conceptual definition of cultural was the aspect that is the total of the learned behavior shared by a particular group of people and transmitted from generation to generation. Learned behaviors include ethnicity (language, practices, customs, traditions, goals, associated values), belief systems (spiritual beliefs, philosophies, values), and socioeconomic status (lifestyles, use of material resources). “Cultural means the things shared by a group of people. It includes values, customs, lifestyles, and use of material resources. These things are passed from one generation to the next” was the definition of cultural for faith community members.

Cultural includes the learned behaviors (e.g. traditions, philosophies, values, languages, customs, use of material resources) shared by a particular group of people and transmitted from generation to generation

was the definition of cultural for clergy representatives and faith community nurses.

On the impact questionnaire, the fifth item addressed the financial impact. The conceptual definition of financial was the quality that includes the ability to earn money and affects the appropriate and responsible use and control of monetary resources. The concept of financial was explained as “Financial means the ability to earn and use

money” for the member participants. Financial was explained as “Financial includes the ability to earn, use, and control money and monetary resources” for clergy participants and nurse participants.

The final area of impact was the spiritual impact and it was investigated using the sixth item on the impact questionnaire. The conceptual definition of spiritual was the component that includes the value system, belief system, and self-evaluation system so that one can exist with a sense of unity, continuity, integrity, meaning, purpose, satisfaction, and fulfillment in society and in the universe. The meaning of the spiritual was described as “Spiritual means the value, belief, and self-evaluation systems so that you can exist with unity, meaning, purpose, and fulfillment in society and in the universe” for faith community members. The meaning of spiritual was described as “Spiritual includes the value, belief, and self-evaluation systems so that one can exist with a sense of unity, meaning, purpose, and fulfillment in society and in the universe” for clergy representatives and faith community nurses.

Participants were given the option to include other information that was not addressed by the six questions. Separate versions of the impact questionnaire were used for faith community members, clergy representatives, and faith community nurses as there was a small amount of variation in the questions (see Appendix B). Participants provided written responses for this questionnaire.

The demographic tool *All About Me* and the impact questionnaire were previously tested in a pilot study with participants in two culturally diverse faith communities in another county of the state. The two instruments were evaluated for appropriateness,

readability, clarity, relevancy, and user-friendliness. Results of the pilot study indicated that no revisions were necessary. The readability levels of the two instruments are presented in Table 1.

The doctoral prepared director of nursing research at a large urban hospital and a nursing professor at a private university in the state evaluated the two instruments for face validity and content validity. These individuals were selected based on their (a) doctoral education, (b) nursing research expertise, and (c) instrument design and development knowledge. Both individuals verified the face validity and content validity of the research tools. The coordinator and the assistant coordinator of the faith community nursing program also evaluated the demographic tool *All About Me* and the impact questionnaire for face validity and content validity. These individuals were chosen based on their (a) education level, (b) nursing practice experience, and (c) faith community nursing expertise. Both individuals confirmed the face validity and content validity of the two instruments.

### **Data Collection and Field Procedures for the Main Study**

After the local, large health care system's IRB and the university's IRB approved the main study, the researcher contacted the nurses at the participating faith communities and informed them of the study inclusion criteria. The director and assistant director of the faith community nursing program assisted with this process. The researcher then requested a list of potential participants with their mailing addresses from each participating faith community.



From these lists, the researcher randomly selected three individuals, and then (a) addressed the envelopes, (b) destroyed the list of names and addresses with a crosscut shredder, (c) assembled the research packets, and (d) mailed the packets to the participants at their home addresses. The research packets contained several items and were arranged in a specific order. A list of how those documents were arranged in the research packets that were mailed to potential participants is provided in Appendix H. Research packets that contained the same items in the same order were also mailed to a clergy representative and the nurse at the 23 participating faith community locations. After they were completed by the participants, the demographic instrument and the written responses to the impact questionnaire were mailed back to the principal investigator in the provided stamped, addressed envelopes. Since the faith community sites were approved and added with four separate IRB modifications, four weeks from the date of the final mailing were allowed for questionnaires in the main study to be returned. The researcher provided stamped, addressed envelopes for all participants to return the research instruments. Return postage was guaranteed. Returning the questionnaires was considered as consent to use the responses for the main study and this implied consent was included in the letters of introduction. Written data were stored in a fireproof, locked file cabinet in the researcher's home office. Data were transcribed into individual word documents and checked for accuracy. Electronic data were stored on a password secured computer.

In addition to the mailed questionnaires, this project used a retrospective approach that examined ten annual reports of the faith community program that have been

compiled since its beginning in 1998. The annual reports contained information on program funding and collaborative relationships with hospital departments and community or state agencies. Program activities, accomplishments, and outcomes were presented. Another section of the annual reports included the responses that nurses had provided to several open-ended questions.

### **Data Analysis for the Main Study**

As questionnaires were returned, the principal investigator thoroughly read all responses, and reread all answers two days later and seven days later to increase familiarity with the data. The researcher completely transcribed all content into individual word documents and then verified the correctness of the transcription two weeks later. A research assistant also compared the written answers with the typed documents. Spelling errors and grammatical issues were not changed. Four weeks after the final response had been verified, the transcribed data were again thoroughly compared to the written responses to ensure accuracy, and at that time, only three minor modifications were necessary.

Frequency counts and some descriptive statistics were used to describe demographic characteristics of the participants in the main study. Data analysis of the impact questions used four separate steps of content analysis for each of the three participant groups. First data were coded using an *a priori* approach that included the families of impact, interventions, and faith community nursing roles. ATLAS.ti software was used for the coding processes. Next, the data were examined for other recurrent themes. Third, findings that were identified during the coding process were summarized. The final

process focused on patterns and relationships among the findings, and similar and different responses in the three participant groups. Findings were evaluated for face validity, social validity, sampling validity, and semantic validity. Analysis of the annual reports focused on identifying (a) the health, social, educational, cultural, financial, and spiritual impact; (b) factors that contributed to the program impact in these six areas; and (c) interventions provided by the faith community nurses. Interventions that faith community nurses used in their practice with culturally diverse participants in this study and that were identified in the questionnaire responses and in the ten annual reports are presented in table form. These interventions are based on Nursing Interventions Classification (Bulechek, Butcher, & Dochterman, 2008), and used with permission of the publisher (see Appendix J).

The principal investigator used deductive and inductive processes to determine specific codes for data analysis. For the deductive method, codes were established with an *a priori* approach and did not emerge during data analysis. The purposes of this study, briefly stated, were to examine the impact of a local faith community nursing program and to identify nursing interventions that faith community nurses use in their practice. The two research questions were how do faith community members, clergy representatives, and nurses describe the impact of the faith community nurse program in their communities related to health, social, educational, cultural, financial, and spiritual effects; and what interventions do faith community nurses provide in culturally diverse faith communities? The purposes and research questions provided the six impact codes and the six intervention codes. Terms in the conceptual and operational definitions were

additional topics. A basic example was the conceptual definition of social impact. Social impact was the aspect that includes groups, associations, organizations, or support systems, and affects the willingness and ability to give and receive all phenomena one has to offer as a person (e.g. knowledge, skills, talents, time). Words that pertained to this code included groups, associations, support, knowledge, skills, and talents. Additional codes were derived from the literature review and included holism, family, community, and faith community nurse roles. The data were searched for relevant phrases or sentences. Words used to locate the code of family included mother, father, sister, brother, husband, wife, son, daughter, parent, sibling, spouse, child, grandparent, grandchild, aunt, uncle, cousin, niece, nephew, and in-law. For the faith community nurse role of health educator, related terms were forms of teach, educate, learn, know, and aware.

For the inductive method, codes were chosen during and after careful examination of the data. Interesting, surprising, unexpected, or recurrent terms that related to the research questions were noted. Connection and the nurses' job description were examples of interesting codes while the multiple attributes of the nurse evoked an element of surprise. Two codes that recurred in the responses were balance and seriousness of health issues. Additional codes were identified with inter-rater reliability testing. Four of the eight codes that developed from this process were health literacy, program continuation, home safety, and Biblical principles or specific references to God. A complete list of deductive and inductive codes is available in Table 4.

The researcher used the Microsoft Office Online English Thesaurus (Microsoft Corporation, 2003) to list synonyms for codes and to locate additional, relevant content or information in the word documents during data analysis. A primary example was for the code of connection and pertinent terms included link, bond, associate, association, relate, relationship, unite, union, attach, attachment, and together.

According to Waltz, Strickland, and Lenz (2005), ten percent of the records should be coded by two or more members of the research team to assess inter-rater reliability. Burns and Grove (2009) also wrote that raters must use at least 10 items, subjects, or events to adequately judge inter-rater reliability. Responses from six faith community members, one clergy representative, and three faith community nurses were assessed for inter-rater reliability. The dissertation chairperson, a member of the dissertation committee, the assistant coordinator of the faith community nursing program, and the principal investigator independently coded these ten responses (19%) according to predetermined guidelines and categories. These three individuals were selected by the principal researcher based on their (a) educational preparation, (b) expertise with research methodology, or (c) experience with or knowledge of faith community nursing. Each person had expressed willingness to help with this process. Of the 515 items that were coded independently and prior to the group meetings, the four individuals coded 80% of those items identically and an additional 15% were coded identically by at least two of the coders. Eight new codes were identified during the group meetings and all members concurred with the decisions.

The intra-class correlation coefficient (ICC) was selected as the statistic to report the inter-rater reliability.

The ICC is the ratio of the variance between subjects (variation in participants) to the total variance (all observed variance). The corresponding equation is  $ICC = \text{between subjects variance} / (\text{between subjects variance} + \text{within groups variance})$ . The numerator can be thought of as systematic variance. The denominator can be thought of as variance attributable to both systematic differences and chance (or error) (personal communication with Dr. John Willse, November 15, 2010).

Intra-rater reliability was checked randomly and periodically during data analysis. The principal investigator acquired a comprehensive and holistic knowledge of the data. This comprehension developed through repetitively reading the questionnaire answers, and completely transcribing all written responses into individual typed word documents. Two other processes that contributed to knowledge of the data were the thorough comparison of the written content with the transcribed material to ensure accuracy, and the careful verification of the correctness of the transcription a second time four weeks later. Responses from five participants were assessed for intra-rater reliability and this content was initially coded by the principal investigator, recoded a second time two weeks later, and recoded a third time four weeks later. The percentage of agreements between the different coding processes was calculated. Intra-rater reliability was influenced by learning and memory that occurred as the researcher developed familiarity with and knowledge of the data, and during data analysis.

## **Limitations**

The use of a convenience sample limits broad generalizations of the findings. Purposive sampling does not produce a sample that is representative of a larger population. While the response rate for the pilot study was very high for mailed surveys (67%), the actual sample size was very low ( $n = 6$ ). In the main study, the sample size was very small compared to the number of individuals who interact with or use the services of faith community nurses in this program.

The specific study inclusion criteria were another limitation and multiple groups did not contribute to the findings. The impact of the program was not examined from the perspectives of individuals who have occasionally participated in health-related activities sponsored by the faith community but who have not had at least three interventions or services during a specific time. The study did not include people (a) unable to read, write, and understand English; (b) not actively associated with a faith community; (c) under the age of 18; and (d) associated with the other 28 faith communities participating in the program but not in this project.

The phrase “positively influences” on the impact questionnaire for clergy representatives and faith community nurses may have introduced some bias into the research process. Some individual sentences on the consent form and the impact questionnaire may have been written at a level higher than some participants’ reading abilities.

Many faith communities in this study adhere to philosophies of Christian faith. Some faith communities have been associated with this program since its inception while others

have only recently become involved. The newer individual programs had less input into the annual reports.

The limited geographical area served by the faith community nursing program and the limited time in which data were collected may have affected results. The process of allowing the faith community nurses to supply names and addresses of potential study participants is another limitation. The quality and quantity of self-reported data may have been influenced and limited by (a) numerous factors affecting completion of questionnaires, and (b) motivation to share personal experiences.

Finally, the nature of a study that serves as a doctoral dissertation is another limitation. The complete data set was coded and the themes were identified by the doctoral student and the analysis was initially reviewed by the dissertation chairperson and subsequently by the other three members of the dissertation committee. This process contributed to consistency in the method and limited interpretations but did not allow for multiple viewpoints from a large variety of individuals with a wide range of opinions or assorted degrees of expertise.



## CHAPTER IV

### RESULTS

This research project was comprised of a pilot study and a main study. The pilot study portion of this project evaluated a newly developed demographic instrument and impact questionnaire for appropriateness, readability, clarity, relevance, and user-friendliness. A second purpose of the pilot study was to collect initial and limited information concerning the impact of faith community nursing on a culturally diverse community through examination of health, social, educational, cultural, financial, and spiritual effects. A final purpose of the pilot study was to identify a partial list of nursing interventions that faith community nurses use in their practice with individuals, families, groups, communities, or society. This preliminary description included the responses of (a) faith community members who had contact with or services from the faith community nurse, and (b) one clergy representative.

The first purpose of the main study was to examine the impact of the faith community nursing program on a culturally diverse urban community in the southeastern United States from the perspectives of faith community members, clergy representatives, and faith community nurses. The second purpose was to identify nursing interventions that faith community nurses use in their practice with individuals, families, groups, communities, or society. The following two research questions were generated for the main study.

1. How do faith community members, clergy representatives, and nurses describe the impact of the faith community nurse program in their communities related to health, social, educational, cultural, financial and spiritual effects?
2. What interventions do faith community nurses provide in culturally diverse faith communities?

## **Results of the Pilot Study**

### **Sample Characteristics**

Two faith communities associated with the faith community nursing program of a large health system located in southeastern United States agreed to participate in the pilot study. The estimated sample size was ten and included three individual members, one clergy representative, and one nurse from the two participating faith communities. The actual sample had six potential participants. This number was lower than the estimated sample size because one nurse did not provide the names and addresses of potential participants. During a phone conversation and in an electronic communication with that nurse, she specifically requested that the researcher not send her the research packet and this request was honored.

Four of the six participants in the pilot study who received research packets returned the documents within two weeks, and this yielded a 67% response rate. Three respondents were females who have received services from the faith community nurse and the fourth respondent was a male clergy representative. Ages of the participants ranged from 45 to 61. All participants indicated (a) married as the marital status, (b) city

as the location of the faith community nursing program, (c) white as the racial-ethnic category, (d) completion of an undergraduate or graduate degree as the highest educational level, and (e) more than one year but less than three years as the length of time involved with faith community nursing. Additional demographic characteristics of the pilot study sample are included in Table 3.

### **Findings Based on the Impact Questionnaire**

The pilot study participants provided limited, initial information about the impact of the faith community nursing program. All participants included some information about the health impact. Concepts related to this area included (a) health news, (b) health screenings, (c) health habits, (d) health benefits, and (e) importance of wellness. Participants did not provide specific facts about positive health benefits such as (a) decreased blood pressure, (b) weight loss, (c) improved medication compliance, (d) increased mobility, or (e) enhanced coping.

The social impact question was answered by two participants. One person wrote that feedback from the nurse is beneficial for individuals, families, and the faith community. The second person mentioned that it was “very comforting” to have the nurse available.

The educational impact was mentioned by every pilot study participant. A female member wrote, “The health fair was an informative tool that made me aware of different aspects of my health both physical and mental.” One participant included learning about the importance of wellness while two participants mentioned the informative monthly newsletters.

Only one participant gave an answer for the specific cultural impact question. The clergy representative wrote, “Good health habits can and should be passed on to others. Enabling people to develop such habits instills the importance of good practices to the succeeding generation.” In another section of the impact questionnaire, a participant referred to the culture of women’s health and how women experience cardiac events different from men.

Limited information about the financial impact was derived from the pilot study data. The three female members did not respond to that specific question. The clergy representative addressed the financial impact by writing, “Healthy people are much more productive than those who suffer illness.”

The final item on the impact questionnaire addressed the spiritual impact. One participant wrote about the connection between physical wellness and spiritual health. A second individual mentioned the ability to impact society using individual gifts. Another respondent wrote about the willingness of the nurse to volunteer her skills and demonstrate her Christian love.

A limited number of nursing interventions was derived from the responses of the pilot study participants. These interventions are based on Nursing Interventions Classification (Bulechek, Butcher, & Dochterman, 2008), and used with permission of the publisher (see Appendix J). Nursing interventions identified from the pilot study data are presented in Table 7.

## **Findings Based on the Research Instrument Evaluation Tool**

Participants in the pilot study used the research instrument evaluation tool (see Appendix E) to indicate their opinions about all items on *All About Me*, the demographic tool used in this study (see Appendix A), and on the six items on the impact questionnaire (see Appendix B). The five categories for each item were (a) appropriateness, (b) ease of reading, (c) clarity, (d) relevance, and (e) user-friendliness. The fixed-choice responses were very, moderately, somewhat, and not. These were scored with four, three, two, and one points respectively. Overall, 74% (n = 326) of all responses were rated “very”, and only 2% (n = 9) were rated “not”. Only one participant rated items as not appropriate or not relevant.

The four pilot study participants rated all 16 items on *All About Me*. This yielded a total of 320 items rated and 64 ratings for each category. For appropriateness, 55 of 64 items (86%) were rated as very or moderately appropriate. The items concerning living area and household income were rated as not appropriate by only one individual. For the second category, 57 items (89%) had the highest rating of being very easy to read. One participant indicated the group item was only somewhat easy to read. The clarity of items on the tool was the third category and 97% (n = 62) of items were reported as very (n = 55) or moderately (n = 7) clear. One participant reported the living area as somewhat clear and the group item received this same rating by a second participant. For relevance, 55 of 64 items (86%) were rated as very or moderately relevant. One participant rated seven of the demographic items as somewhat relevant and the household income item as not relevant. The final category was user-friendliness and 56 (88%) of the items were

reported as very user-friendly while the remaining eight items (12%) were rated as moderately user-friendly. When all five categories were combined, the items on *All About Me* had 246 (77%) “very” ratings, 53 (17%) “moderately” ratings, 18 (6%) “somewhat” ratings, and 3 (<1%) “not” ratings.

The four pilot study participants also rated the six items on the impact questionnaire in the five categories. This yielded a total of 120 items rated and 24 ratings for each category. For appropriateness and relevancy, 18 of 24 items (75%) were rated as very or moderately appropriate and relevant. One individual rated the social impact, cultural impact, and financial impact items as somewhat appropriate and somewhat relevant. Another individual rated these same three items as not appropriate and not relevant. For the second, third, and fifth categories, 18 items (75%) had the highest rating of being very easy to read, very clear, and very user-friendly. One participant reported the health impact, educational impact, and spiritual impact items as moderately easy to read, moderately clear, and moderately user-friendly. The social impact, cultural impact, and financial impact items were reported as somewhat easy to read, somewhat clear, and somewhat user-friendly by that same participant. When all five categories were combined, the items on the impact questionnaire had 80 (66%) “very” ratings, 19 (16%) “moderately” ratings, 15 (13%) “somewhat” ratings, and 6 (5%) “not” ratings.

Waltz, Strickland, and Lenz (2005) described a process to determine content validity indices and to quantify the extent of agreement between experts who judged specific items. This same method was used to determine appropriateness, readability, clarity, relevance, and user-friendliness indices. The four pilot study participants were considered

as the “experts.” Separate alpha coefficients were calculated for (a) each of the five categories for the demographic tool, (b) each of the five categories for the impact questionnaire, (c) each of the five categories when both tools were combined, (d) the combination of the five categories for the demographic tool and the impact questionnaire, and (e) all categories on both tools combined. Results of the alpha coefficients are presented in Table 2.

Table 2

*Alpha Coefficients for Research Instrument Evaluation Tool*

Category	Demographic Tool	Impact Questionnaire	Both Tools
Appropriateness	0.907	0.929	0.933
Readability	0.681	0.978	0.908
Clarity	0.591	0.978	0.872
Relevance	0.923	0.929	0.941
User-friendliness	0.733	0.978	0.897
All categories	0.861	0.975	0.945

## Results of the Main Study

### Sample Characteristics

Twenty-three faith communities associated with the faith community nursing program of a large health system located in southeastern United States agreed to participate in the main study. The estimated sample size of the main study was 115 and included three individual members, one clergy representative, and one nurse from each of the 23 participating faith communities. The actual sample had 112 participants. This

number was lower than the estimated sample size because one nurse did not provide the names and addresses of potential participants.

Fifty-two of the 112 participants returned the questionnaires within four weeks of the final mailing, and this yielded a 46% overall response rate. Thirty-five respondents were individual members who have received services from the faith community nurse (67%), six respondents were clergy representatives (12%), and eleven respondents were faith community nurses (21%). The response rate was 53% for members, 26% for clergy representatives, and 48% for faith community nurses.

Two participants wrote “unknown”, “cannot answer”, or “N/A” as their answers for all six impact questions. One male participant wrote that there was not a faith community nurse at the church he attends. Another male respondent indicated that he was not involved with the faith community nursing program. A third man returned a completely blank impact questionnaire. These five responses from individual members were omitted from data analysis. Two other individuals returned the demographic data collection tool but not the impact questionnaire. Major findings are reported on the impact responses from 45 participants.

Four individuals provided some information for their lack of participation in this study. One female participant telephoned the investigator and stated that she has problems writing due to Parkinson’s Disease. A second woman sent the researcher a post card that indicated she was not able to participate at this time. Another individual sent an email that stated “I decline to participate.” One male participant telephoned the investigator and asked for clarification concerning length of involvement with faith



community nursing. After hearing the explanation, he stated that he does not receive any services from a nurse at his faith community and is therefore not involved with the program. Finally, two research packets could not be delivered as addressed and they were returned unopened to the researcher. Since participation in this study was voluntary, the researcher assumed that all other individuals to whom research packets were mailed did not want to participate in this project.

For this project, the operational definition of culturally diverse was the collective responses on *All About Me* that described many characteristics of the sample. Based on the responses, the sample in the main study was culturally diverse. Sixty-two percent ( $n = 32$ ) of the sample was female. Ages of the participants ranged from 31 to 90. For those participants that provided their ages, 35 percent were 70 years old or older while 20 percent were less than 50 years old. A majority of participants was married (62%), lived in the city (69%), and identified white as the racial-ethnic category (77%). All options for highest educational level were indicated by at least one participant. Business, counseling, music, pharmacy, community health, sociology, education, zoology, economics, history, political science, and optometry were specific disciplines reported by those participants who chose to provide this information. All choices for employment status, household income level, and length of time involved with the faith community nursing program were selected by at least one participant. Membership in the faith communities ranged from less than 100 people to over 6000 people. Additional demographic characteristics of the main study are presented in Table 3.

Table 3

*Demographic Characteristics of Study Population*

Category	Pilot Study	Main Study All	Main Study Members	Main Study Clergy	Main Study Nurses
<b>Group</b>	4	52			
Member	3	35	35		
Clergy	1	6		6	
Nurse	0	11			11
<b>Gender</b>					
Female	3	32	20	1	11
Male	1	18	13	5	0
<b>Ages</b>					
Range	45 – 61	31 – 90	31 – 90	35 – 85	47 – 67
Mean	51.5	64	68	54	58
<b>Marital status</b>					
Never married		3	3		
In committed, unmarried relationship		1	1		
Married	4	32	16	6	10
Divorced		3	3		
Widowed		11	10		1
<b>Living area</b>					
City	3	36	27	5	4
County	1	14	6	1	7
<b>Faith community area</b>					
City	4	46	33	5	8
County		4	0	1	3
<b>Racial-ethnic category</b>					
African-American		6	5		1
Asian-American		3	2	1	
White	4	40	25	5	10

Category	Pilot Study	Main Study All	Main Study Members	Main Study Clergy	Main Study Nurses
<b>Education</b>					
Eight grades or less		2	2		
Some high school		1		1	
Received GED		2	2		
High school graduate		6	6		
Some college		5	5		
Completed undergraduate degree	3	20	11		9
Some graduate school		3	3		
Completed graduate degree	1	10	3	5	2
<b>Employment</b>					
Unemployed		1	1		
Disabled	1	4	4		
Part-time (self)		3	1		2
Part-time (company)	1	5	2		3
Full-time (self)		1		1	
Full-time (company)	1	11	5	4	2
Retired--working	1	7	2	1	4
Retired--not working		18	18		
<b>Income</b>					
Less than \$10K		4	3		1
\$10K - < \$25K		7	7		
\$25K - < \$50K		8	6	1	1
\$50K - < \$75K	1	11	3	4	4
\$75K - < \$100K	1	5	2		3
Over \$100K	2	3	1	1	1
Not answered		14	13		1
<b>Number of clergy</b>					
One		19	12	3	4
Two	2	14	9	1	4
Three	2	4	2		2
Four		5	3	1	1
Six or more		3	2	1	

Category	Pilot Study	Main Study All	Main Study Members	Main Study Clergy	Main Study Nurses
<b>Membership of faith community</b>					
Less than 100		11	8		3
> 100 and < 300		14	6	4	4
> 300 and < 500	1	6	5		1
> 500	2	8	5	1	2
Specific number > 1000	1	9	7	1	1
<b>Participation in activities</b>					
Less than monthly		5	5		
Monthly		3	3		
2 - 3 times monthly	1	11	4	2	5
Weekly	2	8	8		
2 - 3 times weekly		14	9		5
Daily	1	5	1	4	
<b>Involvement with faith community nursing</b>					
Less than one year		9	7	1	1
One to three years	4	14	8	3	3
Three to five years		10	5	1	4
Five to seven years		4	3		1
Seven to nine years		5	3		2
More than nine years		5	4	1	
<b>Frequency of services from faith community nurse</b>					
	2	12	11	1	
Less than monthly	2	2	2		
Monthly		9	7	1	1
2 - 3 times monthly		6	4	2	
Weekly		5	4	1	
2 - 3 times weekly					
<b>Number of faith communities served</b>					
One					6
Two					4
Four or more					1

## **Coding Processes**

As questionnaires were returned, the principal investigator thoroughly read all responses, and reread all answers two days later to increase familiarity with the data. The researcher completely transcribed all content into individual word documents and then verified the correctness of the transcription two weeks later. A research assistant also compared the written answers with the typed documents. Spelling errors and grammatical issues were not changed. Four weeks after the final response had been verified, the transcribed data were again thoroughly compared to the written responses to ensure accuracy, and at that time, only five minor modifications were necessary.

The principal investigator used deductive and inductive processes to determine specific codes for data analysis. For the deductive method, codes were established with an a priori approach and did not emerge during data analysis. The purposes of this study, briefly stated, were to examine the impact of a local faith community nursing program and to identify nursing interventions that faith community nurses use in their practice. The two research questions were how do faith community members, clergy representatives, and nurses describe the impact of the faith community nurse program in their communities related to health, social, educational, cultural, financial, and spiritual effects; and what interventions do faith community nurses provide in culturally diverse faith communities? The purposes and research questions provided the six impact codes and the six intervention codes. Terms in the conceptual and operational definitions were additional topics. A basic example was the conceptual definition of social impact. Social impact was the component that includes groups, associations, organizations, or support

systems, and affects the willingness and ability to give and receive all phenomena one has to offer as a person (e.g. knowledge, skills, talents, time). Words that pertained to this code included groups, associations, support, skills, and talents. Additional codes were derived from the literature review and included holism, family, community, and faith community nurse roles. The data were searched for relevant phrases or sentences. Words used to locate the code of family included mother, father, sister, brother, husband, wife, son, daughter, parent, sibling, spouse, and child. For the faith community nurse role of health educator, related terms were forms of teach, learn, and know.

For the inductive method, codes were chosen during and after careful examination of the data. Interesting, surprising, unexpected, or recurrent terms that related to the research questions were noted. Connection and the nurses' job description were examples of interesting codes while the multiple attributes of the nurse evoked an element of surprise. Two codes that recurred in the responses were balance and seriousness of health issues. Additional codes were identified with inter-rater reliability testing. Four of the eight codes that developed from this process were health literacy, program continuation, home safety, and Biblical principles or specific references to God. A complete list of deductive and inductive codes is available in Table 4. Table 4 also shows the frequency that the codes were identified by the three participant groups as well as the total for all participants. The researcher used the Microsoft Office Online English Thesaurus (Microsoft Corporation, 2003) to list synonyms for codes and to locate additional, relevant content or information in the word documents during data analysis. A primary

example was for the code of connection. Pertinent terms included link, bond, associate, association, relate, relationship, unite, union, attach, attachment, and together.

Table 4

*Frequency of Codes that Were Identified*

	Frequency the code was identified by faith community members	Frequency the code was identified by clergy representatives	Frequency the code was identified by faith community nurses	Frequency the code was identified by all participants
<b>Deductive Codes</b>				
Health Impact	142	30	82	254
Social Impact	134	24	72	230
Educational Impact	134	21	43	198
Cultural Impact	71	13	43	127
Financial Impact	53	16	47	116
Spiritual Impact	116	22	62	200
Health Intervention	56	18	64	138
Social Intervention	48	24	49	121
Educational Intervention	40	21	40	101
Cultural Intervention	2	6	10	18
Financial Intervention	10	5	17	32
Spiritual Intervention	36	15	54	105
Health Advocate Role	48	24	37	109
Health Counselor Role	36	9	23	68
Health Educator Role	55	25	20	100
Integrator of Faith and Health Role	30	13	24	67
Referral Agent Role	16	8	14	38
Developer of Support Groups Role	6	3	9	18
Trainer of Volunteers Role	16	0	3	19
Community	27	9	29	65
Family	42	8	15	65
Holism	24	8	15	47

	Frequency the code was identified by faith community members	Frequency the code was identified by clergy representatives	Frequency the code was identified by faith community nurses	Frequency the code was identified by all participants
<b>Inductive Codes</b>				
Nurse Attributes	71	21	54	146
Biblical Principles/References to God	34	8	11	53
Program Continuation	34	5	12	51
Health Literacy	29	10	14	53
Individualized Care	13	1	14	28
Home Safety	7	0	2	9
Access to Health Care	26	14	36	76
Connection	47	16	30	93
Communication in General	24	8	35	67
Communication with Health Care Team	48	8	32	88
Job Description	20	5	18	43
Balance	32	6	17	55
Seriousness of Health Issues	28	14	37	79
Collaboration	29	10	42	81
Outreach	15	4	14	33
Helping Others	41	2	15	58
Unity	14	0	10	24
Relationships with Others	35	9	34	78
Vulnerable Populations	25	17	38	80
Wellness	4	2	0	6
<b>Total</b>	1718	482	1237	3437

### Findings Related to Reliability

**Inter-rater reliability.** Responses from six faith community members, one clergy representative, and three faith community nurses were assessed for inter-rater reliability.

Four individuals independently coded these ten responses (19% of all responses)



according to predetermined guidelines and categories. These individuals had advanced nursing degrees, expertise with research methodology, and experience with and knowledge of faith community nursing. The four individuals identically identified 80% of the coding decisions completed prior to the inter-rater reliability meetings. An additional 15% were identically identified by at least two of the four coders. Eight new categories were identified during the group meetings and all members concurred with the decisions. The additional categories were (a) health literacy, (b) vulnerable populations, (c) where the individual is/individualized care, (d) people helping others, (e) program continuation, (f) wellness, (g) home safety, and (h) Biblical or God references.

Data from the inter-rater reliability process were additionally analyzed using SPSS 16.0 to estimate the strength of the coding decisions among the four individuals. The ten responses had 515 separate codes and were designated as identified or not identified by each of the four individual coders. The intraclass correlation coefficient (ICC) was selected as the statistic to demonstrate this feature of reliability. The analysis yielded a value of 0.421 for the ICC.

**Intra-rater reliability.** Intra-rater reliability was also assessed periodically during data analysis. The primary investigator independently initially coded all data used for inter-rater reliability (responses from ten participants). Next, data from five of those participants (three members, one clergy, and one nurse) were recoded and compared with the first coding results. In the third process, all data from all participants were coded. Data from the same five participants were compared with results from the second coding process. Four weeks later, data from the same five participants were recoded in the fourth

process and compared with results from the second coding process. The agreement percentage was obtained through dividing the number of coding agreements by the total number of codes and the results are presented in Table 5.

Table 5

*Intra-rater Reliability Results*

<b>Item</b>	<b>Compared to</b>	<b>Percent Agreement</b>
Data from M-14 coded for inter-rater reliability testing (first process)	Data from M-14 (member) (second process)	96% (44 of 46)
Data from M-18 coded for inter-rater reliability testing (first process)	Data from M-18 (member) (second process)	95% (54 of 57)
Data from M-33 coded for inter-rater reliability testing (first process)	Data from M-33 (member) (second process)	94% (58 of 62)
Data from M-16 coded for inter-rater reliability testing (first process)	Data from M-16 (clergy) (second process)	94% (46 of 49)
Data from M-40 coded for inter-rater reliability testing (first process)	Data from M-40 (nurse) (second process)	95% (81 of 85)
Data from M-14 (member) (second process)	Data from M-14 when all study data were coded (third process)	96% (44 of 46)
Data from M-18 (member) (second process)	Data from M-18 when all study data were coded (third process)	96% (55 of 57)
Data from M-33 (member) (second process)	Data from M-33 when all study data were coded (third process)	98% (61 of 62)
Data from M-16 (clergy) (second process)	Data from M-16 when all study data were coded (third process)	94% (46 of 49)
Data from M-40 (nurse) (second process)	Data from M-40 when all study data were coded (third process)	96% (82 of 85)
Data from M-14 (member) (second process)	Data from M-14 (member) (fourth process)	98% (45 of 46)
Data from M-18 (member) (second process)	Data from M-18 (member) (fourth process)	96% (55 of 57)
Data from M-33 (member) (second process)	Data from M-33 (member) (fourth process)	98% (61 of 62)
Data from M-16 (clergy) (second process)	Data from M-16 (clergy) (fourth process)	100% (49 of 49)
Data from M-40 (nurse) (second process)	Data from M-40 (nurse) (fourth process)	96% (82 of 85)

### **Findings Related to Validity**

Findings were evaluated for face validity, social validity, sampling validity and semantic validity. According to Krippendorff (2004b), face validity in content analysis has four distinct characteristics. First, face validity is an obvious and common truth that is sensible and plausible. Second, face validity is not synonymous with research expectations. Next, face validity is an individual's judgment with an underlying assumption that others will agree the assessment is correct. Finally, common sense forms the foundation for face validity (Krippendorff, 2004b). On a very fundamental level, the findings from this research make sense and are believable as answers to impact questions obviously described the impact of the faith community nursing program from the participants' point of view. Detailed reasons for the responses and complex interpretations pertaining to the responses are neither necessary nor should be expected where face validity is concerned. Based on the researcher's examination of the data, face validity is confirmed for this study. Finally, the methods and the results of data analysis did not violate the principal investigator's common sense.

Findings were also evaluated for social validity. Krippendorff (2004b) defined social validity as "that quality of research findings that leads us to accept them on account of their contribution to the public discussion of important social concerns" (p. 314). Examples of social concerns are television violence, discrimination against certain groups, antisocial messages in music, racism in public presentations, lack of civility in politics, and psychological consequences of research. The likelihood that findings from this project will contribute to social concerns of this caliber is very low. The social

validity of this content analysis will most likely not be debated, subjected to any negotiating process, or become a matter of great public concern. However, findings from this study do have relevance and meaning beyond a generic academic audience. Results may be used to (a) attract attention to, (b) educate the public and private sectors about, (c) increase participation in, or (d) generate funding for the faith community nursing program. For these reasons, a certain amount of social validity is present.

Third, findings from this research were assessed for sampling validity. According to Krippendorff (2004b), sampling validity is concerned with the extent that a population is accurately represented by the sample. The sample has to be a subset of members from the population of interest. In this situation, evidence for sampling validity is affected by the amount of sampling error and the error becomes a measure of the sample's *invalidity*. Sample size is the first factor that contributes to sampling error, and larger sample sizes decrease sampling error and increase sampling validity. Population diversity is the second characteristic that determines the amount of sampling error. A sample that is drawn from a more diverse population has a greater degree of sampling error and a lower level of sampling validity. Third, sampling error is reduced and sampling validity is enhanced as the proportion of the population sampled becomes more inclusive (Krippendorff, 2004b). Findings of this study were evaluated for sampling validity. The sample was a subset of the population of interest. The potential for sampling error was extensive since (a) the sample size was small, (b) the sample was from a diverse population with a great degree of variation in demographic variables, and (c) the proportion of the sample to the population was small. The sampling plan for this study was not designed to ensure

representativeness through the use of strategies to reduce sampling error or to make generalizations to a larger population based on validity principles but rather to describe the impact of the faith community nursing program from a broad range of perspectives. For these reasons, the degree of sampling validity in this study was limited and study results cannot be assumed to accurately represent the population of interest.

Finally, results were evaluated for semantic validity. As indicated by Krippendorff (2004b), semantic validity is concerned with the extent that the categories of analysis accurately describe meanings and uses within the selected context. Semantic validity is a serious issue in content analysis but seldom is it formally tested as a method of evaluating the evidence from a study. Several principles apply to attempts to establish semantic validity. First, semantic validity can be hindered or avoided through research efforts that control the range of permissible answers. This is common in psychological testing and survey research. Second, efforts to verify the interpretation of the data with the participants demonstrate concern for semantic validity. Third, semantic validity is based on the identification of all relevant units and only those units of text that are pertinent to the context. Fourth, units of text that are placed in different categories must differ in relevant meanings. Fifth, descriptions of categories are more general and less abstract than the objects they categorize. Finally, users of the texts can potentially serve as sources to validate the evidence (Krippendorff, 2004b). No attempt was made to control the range of permissible answers to items on the impact questionnaire. Verifying the meaning of the questions and the interpretation of the data analysis with the participants was not part of the study protocol. Relevant units of text may have been inadvertently

omitted during data analysis. Multiple portions of text were placed in different categories but these categories may have had similar meanings. Finally, no effort was made to define abstract concepts such as hope, self-esteem, family dynamics, balance, or spiritual growth that participants included in their responses. For these reasons, the study results demonstrate some degree of semantic validity but they cannot be presumed to completely and accurately describe meanings and uses in the context of the faith community nursing program.

### **The Health Impact**

**Definitions and coding decisions.** The description of the health impact of the faith community nursing program was derived from responses to the first item on the impact questionnaire. This item included specific definitions of health based on the conceptual definition of health. The conceptual definition was the aspect that includes physiological and mental structures, ongoing functions, continuous processes, changing needs, and activities of the human body that contribute to the goals and purposefulness of existence as a holistic, integrated human being. The specific definitions were “physical and mental activities of the human body” for faith community members and “physiological and mental structures, functions, processes, needs, and activities of the human body” for clergy representatives and faith community nurses. A fundamental example pertained to blood pressure since the regulation of blood pressure is a continuous physiological process of the body. Content that addressed blood pressure or hypertension, the term used to describe an elevated blood pressure value, was considered as health impact even when this subject matter was located in another area of the impact questionnaire. Additional

information concerning the health impact was based on deductive codes that were established prior to data analysis and inductive codes that emerged during data analysis. Examples of deductive codes for this area of impact were (a) health impact, (b) health intervention, and (c) the faith community nursing roles of health advocate and health counselor. The seriousness of health issues and health literacy were two examples of inductive codes that applied to this area of impact. Finally, the description of the health impact was based on synonyms of terms in the conceptual definitions, the specific definitions, and related deductive and inductive codes. The Microsoft Office Online English Thesaurus (Microsoft Corporation, 2003) was used to list synonyms for various terms and the word documents were examined for related content. An example for this area of impact was the term “health” and synonyms included (a) physical condition, (b) physical shape, (c) fitness, (d) wellness, and (e) wellbeing.

**Health impact related to the conceptual model.** According to the Roy Adaptation Model (Roy & Andrews, 1999) health is generally defined as the complete well-being and integrity of a person. Within the RAM, health is specifically referred to as “a state and a process of being and becoming an integrated and whole human being. Lack of integration represents lack of health” (p. 54). From a broad perspective, study participants described the health impact in a holistic manner with multiple references to overall well-being and not the absence of illness, injury, disease, or disability. Numerous health-related activities contributed to the process of becoming more integrated as a human being with greater purposefulness in human existence. More specifically, the description of the health impact of the faith community nursing program was related to the first of

four adaptive modes of the RAM. In the physiologic-physical mode, the person manifests physical and chemical processes necessary for the functions and activities of a living creature in nine separate, interrelated categories. The first five of the categories are considered needs and include oxygenation, nutrition, elimination, activity and rest, and protection. The final four categories are complex processes involving (a) senses; (b) fluid, electrolyte, and acid-base balance; (c) neurologic function; and (d) endocrine function (Roy & Andrews, 1999). Factors derived from data analysis that pertained to oxygenation, the first need of the physiologic-physical mode, were exercise and smoking cessation. Exercise is a stimulus that increases the oxygenation demands while smoking cessation is a stimulus that improves oxygenation. Several variables that corresponded to the second need, nutrition, included specific diets, weight management and weight loss, availability of and resources to obtain food, cultural preferences regarding food, and social activities involving eating. Features of the data that were associated with the physiologic-physical need of activity and rest were general mobility, joint mobility, muscle strength, exercise, and physical comfort. The provision of immunizations and safe physical environments are related to the need of protection which maintains and enhances the defense processes of the body. Examples that pertained to the complex processes of the senses were (a) visual screenings, (b) provision of glasses to individuals with impaired vision, (c) physical touch, (d) pain relief, and (e) fall prevention measures. References to fluid, electrolyte, and acid-base balance included fluid volume excess with the presence of edema, the need to maintain hydration during exercise, and effects of medications on electrolyte values. Neurologic function includes being aware, learning,



thinking, and remembering. Health impact is based on the ongoing abilities of awareness, knowledge development, contemplation, and memory. The final physiologic-physical process is endocrine function and the health impact for this area included the obtaining, maintaining, and monitoring of normal blood pressure, glucose, and cholesterol values. Health impact as it might relate to elimination was not evident in the data. These illustrations show how the health impact corresponded to the RAM. The RAM effectively provided for the assessment of the health impact in this study. Results indicate a high level of consistency and compatibility between the RAM and the health impact as reported by the study participants.

**Brief summary of health impact.** Study participants described the health impact with a variety of themes. In their responses, all three participant groups reported (a) healthier lifestyles; (b) specific physical and mental health benefits such as weight loss and decreased anxiety; (c) avoidance of physician office or emergency department visits, hospitalizations, or nursing home placements; and (d) connections between physical, mental, and spiritual health. Faith community members and faith community nurses identified (a) advantages of participation in activities, (b) averted potential heart attacks or strokes, and (c) early or life-saving interventions. Other themes reported by faith community members were personal health counseling and health system navigation. Additional topics from the nurses' data were management of chronic diseases and care for the body.

**The health impact according to faith community members.** As indicated by faith community members, the health impact of the faith community nursing program was

healthier living. Healthier living was a recurring theme that appeared in answers to all six impact questions. Healthier living according to the health impact responses included (a) participation in physical activity, (b) dietary modifications, (c) weight loss, and (d) compliance with prescribed medications. One individual answered the question with “The impact that faith community nursing has on my health is to help me maintain a healthy state by encouraging weekly exercise in a positive, interactive group.” Participants also reported promoting healthier living with families, friends, and other faith community members.

The responses of three people included life-saving interventions provided by the faith community nurse. One man reported, “I have had a hypertensive crisis, discovered by the nurse. Without this knowledge, a stroke or cardiac arrest were going to kill me.” Two answers mentioned averted hospitalizations and two other answers included prevented physician visits.

Several people reported that they experienced a health impact through the many activities organized, sponsored, or provided by the faith community nurse. One participant wrote, “I benefit physically and mentally by taking advantage of the programs and screenings the parish nurse offers our congregation.” Another individual gave this example.

The nursing program also provides relevant speakers on such matters as preparing our wills, the effects of laughter on our health and choosing the best insurance for seniors. We also share a healthy lunch, provided by the program, once a month and attend several health fairs a year.

Five participants indicated the faith community nurse was available and willing to advise or counsel concerning health issues. The response of one woman was “The willingness and availability of a health care professional to consult and receive hands on advice.” Another participant wrote, “I have been able to go to her for question and advice regarding any health issue. She was always willing & helpful. I felt confident with her. It was also convenient to have a faith community nurse.” A third individual provided the following example.

I found the community nurse very helpful to me when I was seriously ill last year. She helped me find resources to help me & spent time talking with me & setting up appointments for me. I know I can always call on her for help & advice.

One woman described the health impact with principles related to home safety in the following response.

From my personal experience with my parish nurse, I can sincerely say that she has had a huge impact on my life and my health. Not only has she routinely called to check on me, she has visited me and helped me do a little house re-arranging for my safety. Removing those “throw rugs”, putting “things” where they are more convenient for me, even getting into my bath tub to double check my new shower stool = all stand out as such important helpful things she has done for me. She has loaned me some grab bars for my bath, and a nice cane.

Another participant reported a more rapid post-operative recovery with the nurse’s interventions in the following scenario.

She came as soon as I called her and took me to my doctor’s office. From there she took me to the hospital as ordered where I soon thereafter had by-pass surgery. She helped me choose my surgeon and was very attentive to my needs including lining up home nursing care when I was allowed to come home. She helped my daughter line up the medications that were prescribed. I would never have recovered so fast and so

fully without her help. Having her on our staff has made a tremendous difference in our church.

Twelve individuals referred to the combination of health and spiritual aspects. One person answered, “The position of a congregational nurse is so special and unique with the capacity to address both physical and spiritual matters.” Another participant mentioned that having the nurse available is reassuring and builds confidence to “to improve yourself in all aspects of your life (spiritually, emotionally, and physically).” A woman wrote, “As a person who is basically homebound, and our congregational nurse (CN) is very important. She is one who provides both faith, spiritual care as well as physical and medical care.”

Participants described the health impact as (a) huge, (b) helpful, (c) positive, (d) welcomed, and (e) minimal. Specific benefits were (a) controlled blood pressure, (b) improved emotional coping, (c) improved mental well-being, (d) improved physical health, and (e) decreased anxiety. Other types of health impact were (a) taking personal health more seriously, (b) detecting health problems earlier, (c) requiring lower dosages of medicines, (d) using preventative health measures, (e) talking about good health with others, (f) navigating the health system, and (g) controlling the progression of diseases and their effects.

**The health impact according to clergy representatives.** The six clergy representatives who returned the questionnaires provided a second perspective of the impact of the faith community nursing program. This group of participants referred to the health impact several times. Specific examples of physical health impact were that

recipients (a) felt better, (b) experienced improved health conditions, (c) implemented healthier eating practices, (d) improved compliance with medications, (e) required less medication, (f) needed fewer doctor visits, (g) avoided hospitalization, and (h) pursued preventative health behaviors. Mental health benefits reported by the clergy representatives were that faith community members (a) displayed good attitudes in the course of illness, (b) enjoyed more comfortable and less stressful daily living conditions, and (c) obtained ongoing, positive, personal well-being. One clergy representative described the health impact with the following response.

The congregational nurse has provided a wealth of information to our church members. As Christians, we are called to keep our physical beings as a holy temple to our Lord, Jesus Christ. The information and services provided help provide a balance between our physical health and our spiritual health.

**The health impact according to faith community nurses.** Faith community nurses and their interventions have made an impact in the health of many people based on responses from faith community nurses. Education and personal counseling sessions have helped “members in making or modifying health behaviors.” Nurses reported that their clients were (a) “transforming the information into action,” (b) “applying what they learned,” or (c) “integrating the information I have given them into their own life styles.” Additionally, one nurse wrote, “education has often prompted congregants to seek further evaluation” for an assortment of health issues.

Physical exercise and its advantages was one area with multiple improvements. The nurses in this study cited participation in physical exercise programs 15 times. Physical

health benefits included (a) eight references to weight loss, (b) five mentions of increased mobility, (c) three remarks of increased activity tolerance or endurance, (d) two statements of rapid post-operative recovery or rehabilitation, (e) six comments of decreased blood pressure, (f) one report of relieved pain, and (g) eight accounts of reduced blood glucose, cholesterol, or triglyceride values. Mental health benefits were documented through four remarks of decreased stress or anxiety. Two nurses gave illustrations of decreased medication requirements because of exercise and weight loss. Three nurses described how individuals had developed the habit of walking and were continuing this activity. An illustration of increased mobility is in the following exemplar.

Two men, each had strokes involving their left side of the body, joined the chair exercise program. One gained about 12 inches of elevation with his left arm. The other gentleman hadn't been able to use his left arm for 30 plus years. He now is able to open door with it.

Improved compliance with management of chronic diseases was another theme derived from the nurses' responses to the health impact question. One nurse wrote that clients have demonstrated "improved compliance with treatment regimen because they have someone they can ask questions." The answer of another nurse was "clients who were not taking their medication consistently are now taking meds appropriately." According to the nurses' comments, individuals were (a) documenting medication dosages and times taken, (b) keeping records of blood pressure readings, (c) changing their eating strategies, (d) controlling blood glucose values, (e) obtaining follow-up care

with the nurses or primary care providers, and (f) making other lifestyle changes to live healthier with chronic physical conditions.

The “identification of medical problems before they become serious and/or expensive” was the next recurring topic. Undiagnosed hypertension was the most common problem and nurses mentioned this situation nine times. Clients were referred for immediate treatment and these interventions averted potential strokes and heart attacks. Other disease processes detected during health screenings were (a) diabetes, (b) hypercholesterolemia, (c) osteoporosis, (d) depression, (e) dementia, and (f) vision and hearing disorders. One nurse described how a potential suicide of a young African woman was prevented because “we had developed a good relationship and she allowed me to take her to the Emergency Mental Health Clinic.” Another nurse summarized that “many would not seek medical care and would not get the early intervention if this program were not available.” Two other nurses expressed that same belief in their answers.

One answer to the health impact question was that without the nurses’ interventions, some people would have been placed in skilled nursing facilities instead of being able to remain at home. Another response addressed finding resources for healthcare, substance abuse treatment, and medications. A third nurse wrote that the health impact was “averting ED visits--by assessing issues and triaging to more appropriate care.” Nurses further described the health impact as clients were (a) “promoting healthy living and medical care to others in the community,” (b) “thinking more about health and healthier

life styles,” (c) “seeking care and screenings more often where they were not previously,” (d) “lowering the risk of stroke and heart disease,” and (e) “caring for the body.”

Three responses pertained to the overall impact. One answer was, “The FCN is the resource for the town/community working with all age groups, to improve mind, body, and spirit.” A second nurse wrote, “The most important aspect is to have some person who will listen. People come for weekly blood pressure checks and diabetic follow up and other chronic or acute problems. But relationship care is the link.” Comments to the question from a third nurse summarized the health impact of the faith community nursing program. She wrote, “Acceptance of each person whatever their circumstance, and a genuine caring attitude has made it possible to make interventions that impact health.”

**The health impact according to the annual reports.** Each annual report included information about the health impact of the faith community nursing program. Categories for the health impact were goals, activities, lessons learned, and specific examples of impact or benefits. Initial goals for the program focused on the health of the members and the greater community. Goals developed and reported in the first annual report were that nurses would (a) function as health advocates, (b) serve as health educators, (c) work as personal health counselors, and (d) conduct health screening activities. A fifth goal was to develop support groups to address multiple physical and mental health issues. A final goal was to address healthy lifestyles, wellness, and disease prevention using a holistic approach.

Four groups of activities met these goals and contributed to the health impact. The first category was health screenings with many individuals referred to other health care



providers for further evaluation and management of various health conditions.

Assessments completed during home visits or personal counseling sessions made up the second group. The third type was educational programs that focused on a number of health issues that included health needs for young adults, skin cancer, hypertension, diabetes, and conditions affecting the prostate gland. The final category was the establishment of fitness, exercise, or walking programs.

Several lessons were learned during the first year and were identified in the annual report. One example was that faith community nursing should be regarded as a healthcare ministry, a much broader perspective than merely nurses in churches. Another lesson was that successful health promotion relied on collaboration with and support from community resources. A third insight was that the program must maintain a vision of its potential positive health impact on the community through a variety of holistic approaches.

The initial annual report included some specific examples of positive health impact achieved through a faith community nurse's intervention. First, the nurse located affordable medical care for a woman with dangerously high blood pressure and the member received appropriate and ongoing treatment. In a second case, a nurse advocated for a female member experiencing loss of appetite, malaise, and weight loss to obtain medical evaluation and begin appropriate treatment with an oncologist. An additional example described how the nurse persuaded a woman with a two-day history of chest pain to seek immediate medical attention. The woman had a cardiac catheterization that same day and coronary artery by-pass surgery the next day. Many faith community

members expressed that the nurse's involvement, care, and intervention saved the member's life (Hamilton & Moore, 1999).

Many items that referred to the health impact were included in the next three annual reports. Additional program goals at individual faith communities for the second year were to (a) expand the ministry to different age groups, (b) coordinate vaccination clinics, and (c) assist medically underserved individuals with health care access (Hamilton & Moore, 2000). Third year goals were to (a) empower people to be proactive with healthcare issues, (b) provide assistance and support for caregivers, and (c) determine effective methods to identify individuals and families at risk (Hamilton & Moore, 2001). Supporting members who were experiencing different types of health crises was a goal of one faith community in 2002 (Hamilton & Moore, 2002).

During these years, faith community nurses continued screening, counseling, educational, referral, and visitation activities. They coordinated health fairs for adults and children that addressed a variety of health issues. Topics of educational activities included osteoporosis, eating disorders, immunizations, sexually transmitted diseases, heat stroke, colds and flu, anxiety or panic disorders, and depression. Some nurses developed support groups for members with chronic diseases, and others partnered with community agencies to provide influenza vaccinations. All nurses provided ongoing care to culturally diverse groups (Hamilton & Moore, 2000, 2001, 2002).

One documented lesson from 2000 was that health ministry programs that meet the unique needs and expectations of a congregation will impact the health and wellness of the community (Hamilton & Moore, 2000). An example of a lesson learned the next year

mentioned that providing help to some people might also enable them to remain in less favorable conditions (Hamilton & Moore, 2001). Two health impact lessons from the fourth annual report were that (a) health related activities competed for attention and attendance with non-health related faith community activities, and (b) individuals requested blood pressure checks when they really wanted help with other health concerns (Hamilton & Moore, 2002).

The documentation of positive health benefits continued in these reports. Many individuals had (a) improved blood pressure, (b) better control of blood glucose levels, and (c) decreased cholesterol values. Other people started and maintained regular participation in exercise activities, and lost weight. Several persons obtained medical treatment for a variety of health conditions (Hamilton & Moore, 2000, 2001, 2002).

The annual reports for the fifth, sixth, and seventh program years continued the health impact focus. Promoting health and wellness, and preventing disease and disability through education, counseling, screenings, and referrals were ongoing program goals. Topics of educational activities included dietary supplements, Alzheimer's Disease, acupuncture, domestic violence, poison ivy, the nervous system, seizures, hyperactivity disorders, and autism. Multiculturalism was another focus and goals included the development of programs for and ministry to members of culturally diverse populations. Nursing interactions addressed health issues in all age groups. Many interventions were directed toward health issues of older adults, and focused on medications, safety, and chronic disease management. Some nurses provided health equipment to members and others in the community (Hamilton & Moore, 2003, 2004, 2005). Other activities had a

both a national and global outreach. Nurses coordinated the collection of medical supplies for hurricane relief in North Carolina and Florida, and for other countries. Nurses also participated in overseas medical mission trips (Hamilton & Moore, 2004). An example of a new insight nurses gained was the need to leave time for the unanticipated health needs of the faith community members (Hamilton & Moore, 2004, 2005). Many of the positive health benefits in these three years were similar to those reported in previous years. Faith community members were more compliant with (a) continuous monitoring of selected health conditions, and (b) correctly taking prescribed medications. The seventh annual report indicated that 17 lives were saved through faith community nurses' interventions since the program began (Hamilton & Moore, 2005).

Annual reports for the three most recent years had several references to the health impact of the faith community nursing program. In 2006, goals with a physical health focus were to (a) increase the number of persons participating in exercise and CPR classes, and (b) identify individuals with increased risks for common diseases and provide strategies to reduce those risks. An additional intent was to broaden the focus on mental health. Two other goals that incorporated the spiritual component of health were to (a) emphasize the connection between faith and health in all encounters, and (b) intentionally include the spiritual component in all areas of ministry (Hamilton & Moore, 2006). The next year, two of the program goals were to (a) recruit new members into health ministries, and (b) expand the outreach to disadvantaged populations (Hamilton & Moore, 2007). Goals for 2008 were to (a) collaborate with the social work program to provide services to faith community members, (b) apply for grants to increase working

capital, (c) increase the number of support groups to meet needs of individuals and caregivers, and (d) plan intergenerational events to involve more youth (Hamilton & Moore, 2008). Activities to meet these goals included (a) increased collaboration with other faith community nurses in planning, organizing, and presenting health activities (Hamilton & Moore, 2006); (b) ongoing educational, counseling, screening, and referral activities (Hamilton & Moore, 2007); and (c) improved access to written information about health issues and community events (Hamilton & Moore, 2008). Disease prevention, emergency preparedness, flu precautions, food borne illnesses, water related illnesses, tuberculosis, and sleep apnea were the subjects of several educational programs.

Three lessons addressed the health impact. The first identified lesson was that some individuals do not want or choose assistance with health issues or they do not want the specific health-related help the nurse may think they need. The second lesson was that the impact on an individual's health is not necessarily measured by numbers (Hamilton & Moore, 2007). A third lesson was gains or improvements that are small are still positive health benefits (Hamilton & Moore, 2008).

Several areas of health impact were identified in the final three annual reports. Many individuals began regular exercise or weight control programs. Documented changes in dietary practices that people implemented were (a) eating more vegetables and fresh fruits, (b) drinking more water, (c) reducing the amount of fried foods, (d) choosing healthier snacks, and (e) selecting foods with lower sodium, lower fat, and higher fiber content. Health benefits realized through these measures were (a) weight loss, (b) improved flexibility, mobility, and muscular strength, (c) greater activity tolerance with

increased energy, (d) lowered blood pressure, (e) reduced blood glucose and cholesterol values, and (f) reduced medication requirements. Other positive health outcomes were (a) improved compliance with medications and chronic disease management, (b) increased empowerment to seek appropriate care for a variety of health issues, (c) more positive attitudes toward wellness and disease prevention, (d) greater participation in weight control and regular exercise programs, and (e) decreased alcohol, tobacco, and drug use (Hamilton & Moore, 2006, 2007, 2008). Needy or disadvantaged individuals received vision examinations, glasses, or glucometers. Free influenza vaccinations were given to immigrant populations, homeless individuals, and elderly persons (Hamilton & Moore, 2006, 2008). People received early and appropriate treatment from health care providers for a variety of acute and chronic conditions. Serious and debilitating health situations were averted, emergency room visits and hospitalizations were prevented, and lives were saved (Hamilton & Moore, 2006, 2007, 2008).

### **The Social Impact**

**Definitions and coding decisions.** The description of the social impact of the faith community nursing program was derived from responses to the second item on the impact questionnaire. This item included specific definitions of social based on the conceptual definition of social. The conceptual definition was that aspect which includes groups, associations, organizations, or support systems, and affects the willingness and ability to give and receive all phenomena one has to offer as a person (e.g. knowledge, skills, talents, time). The specific definition was “people or support systems that affect what you have to offer as a person (what you know, what skills you have, what talents

you have)” for faith community members. The specific definition was “individuals, families, groups, associations, organizations, or support systems and affects all one has to offer as a person (e.g. knowledge, skills, talents, time)” for clergy representatives and faith community nurses. Words that pertained to this code included groups, associations, support, knowledge, skills, talents, and time. A fundamental example pertained to time and content that addressed spending time, saving time, using time, or having a good time was considered as social impact even when this subject matter was located in another area of the impact questionnaire. Additional information concerning the social impact was based on deductive codes that were established prior to data analysis and inductive codes that emerged during data analysis. Examples of deductive codes for this area of impact were (a) social impact, (b) social intervention, and (c) the faith community nursing roles of referral agent and developer of support groups. Connection was an example of an inductive code that applied to this area of impact. Finally, the description of the social impact was based on synonyms of terms in the conceptual definitions, the specific definitions, and related deductive and inductive codes. The Microsoft Office Online English Thesaurus (Microsoft Corporation, 2003) was used to list synonyms for various terms and the word documents were examined for related content. One example for this area of impact was the term “skill” and synonyms included (a) ability, (b) competence, (c) knack, and (d) know-how. An additional illustration was for the inductive code of connection and pertinent related terms included link, bond, association, relationship, unite, union, attachment, and together.

**Social impact related to the conceptual model.** The social impact of the faith community nursing program was related to the self-concept/group identity mode, the role function mode, and the interdependence mode of the RAM. The self-concept/group identity mode focuses on the psychological aspect of the human system. The foci of the role function mode are the roles that individuals occupy in society while the foci of the interdependence mode are the relationships of people as individuals, families, groups, and communities. From a broad perspective, study participants described the social impact in a holistic manner with multiple references to their individual selves and to others. Many social activities contributed to the process of becoming more integrated as a human being with evidence of growth, understanding, involvement, and unity. Specific factors were derived from data analysis that pertained to the self-concept/group identity. The two subareas of the self-concept mode are the physical self and the personal self. Personal beliefs about health and wellness and the types of coping strategies and their use to maintain adaptation were part of the physical self component. Individual capabilities and internal perceptions regarding self-esteem were factors pertaining to the personal self component. Factors that motivated individuals to pursue social interaction and participation in group activities with members sharing similar goals, expectations, or values were associated with the group identity aspect of this mode. In the RAM, the role function mode includes primary, secondary, and tertiary roles. The primary role is determined by age, gender, and developmental stage. Secondary roles are assumed so individuals can complete specific tasks associated with the primary role. The social impact was related to the role function mode with several examples of individuals in



secondary roles as parents, spouses, or as employees. Tertiary roles are freely chosen by an individual, usually temporary in nature, associated with current developmental tasks, and normally related to secondary roles. The social impact was additionally related to the role function mode with many descriptions of individuals as group members, caregivers, class participants, faith community volunteers, and recipients of the faith community nurse's care. The interdependence mode focuses on relationships between people that satisfy the needs of affection, security, development, and resources. These relationships involve the willingness and ability to share knowledge, skills, time, talents, and resources. Many statements in the data referred to meeting these needs of others in a variety of ways. Some examples were helping immigrants, caring for economically disadvantaged individuals, visiting older adults, being present with faith community members during crisis situations, building or sustaining relationships among family members, and reducing social isolation for long-term care facility residents. These examples indicate how the social impact corresponded to the RAM. The RAM was a satisfactory framework for the assessment of the social impact in this study. Results suggest a suitable degree of congruency between the RAM and the social impact as reported by the study participants.

**Brief summary of the social impact.** Individuals who returned questionnaires described the social impact with an assortment of themes. All three participant groups reported (a) social support, (b) social interactions, (c) helping or meeting needs of others, (d) improved communication, (e) stronger relationships, and (f) visits to homes, hospitals, and long-term health care facilities. Clergy representatives and faith community nurses

mentioned the topics of assistance from community agencies, and personal characteristics of self-esteem, self-confidence, and self-support. Other themes that faith community members included were assisting with events and activities at the faith community. A recurrent concept in answers from clergy representatives described the social impact as positive. Additional topics from the nurses' data were connection and specific benefits such as decreased loneliness.

**The social impact according to faith community members.** Faith community members addressed the social impact of the nursing program in several ways. Helping other people was one recurring theme and it was mentioned 16 times. Four individuals responded about using their talents, skills, or abilities to help others. One male participant wrote, "It brought out skills that I did not know I had that can help others." A member who is a retired nurse answered, "The parish nurse program has allowed me the opportunity to continue my life-long desire to help and serve others." One woman answered that helping others served as therapy for herself because she was thinking about others and not about her own personal issues. Six participants included helping family members, friends, or other members in their responses. One member asserted, "you never know who, what anyone has that could help another person."

Helping with events and activities at the faith community was another area of social impact. Two people wrote about helping with health fairs and two more people mentioned serving on a health ministries committee. One woman responded, "As often as I can, I volunteer to help at the flu clinics, blood drives, bone density checks, etc that she

sponsors.” An answer from another woman was, “We offer our limited time to our church to volunteer to organize church functions, set up before mass & other necessary needs.”

Social interaction was a third topic and one person declared, “The nurse’s visits provide a unique opportunity for social interaction.” Another person gave the following answer.

The social impact of faith community nursing on me is to provide contact with 10 or 12 people on a weekly basis where we share exercise and a “story reading” each week as well as a monthly luncheon. We also keep up with the well being of others in the church & occasionally make new contacts as we meet speakers & friends of participants.

Three additional participants indicated meeting new people through the nursing program and two other individuals mentioned establishing or building relationships with different people. Five people included ongoing contact with others in the faith community. One woman wrote about laughing and having fun together during the chair yoga activity. The answer of another woman was being “able to interact with others without feeling superior or inferior.” One of the youngest participants in the study was an African-American male and he wrote, “I always considered myself an outgoing person and friendly but the nursing program has developed those characteristics in me a little more.” In a later section, he referred to social interaction again as he responded, “I believe that I have good people skills and that I have a natural ability gift to make people around me fill relax and open to talk to.” Finally, an elderly man included social interaction with peer groups as he mentioned, “Overall, having the program gives a good,

comfortable feeling as well as a bragging point (“sinful” though it may be to do this) with peer groups without a program.”

Social support was a theme that four participants had in their responses. An elderly man expressed a feeling of security based on the support from the program. One woman linked social support from the nurse with maintaining her sanity. An additional woman wrote, “She helped me utilize & grow my support system. I have no family in (specific location omitted) or this area--& I live alone.” A third woman gave this answer for the social impact question.

Faith community nursing has been beneficial to me socially because of the support I have received when I was working and preparing for retirement. Having someone available to you as a resource has been very reassuring and makes you feel more confident.

Several participants completed the phrase “the social impact is” with a variety of endings. Adjective answers were (a) enjoyable, (b) beneficial, (c) helpful, (d) understanding, (e) encouraging, and (f) severe. Activity responses were (a) groups of people working together on various projects, (b) wise use of talents and skills, (c) participation or involvement in faith community programs, and (d) visits with hospitalized or nursing home members. Endings with a communication focus were (a) contacting the nurse to help with problems, (b) reporting accomplishments of weight loss, increased physical activity, or nutritional changes to the nurse; (c) spreading the word of her presence and availability, and (d) giving advice so best decisions are made by all parties involved. One male participant responded, “The social impact is basically that I am able to talk to a parish nurse and she knows me and can generally look at me and

know something is not right.” Another middle-aged man answered, “The social impact is the availability of having access to the nurse. Clearly there are other avenues of medical advice (i.e. internet), but a human touch is usually better.” The answer of a homebound woman was “Her concern/care enables me to remain centered and focused on the things that I can still do. The end result is that I am able to remain a (relatively) reasonably well-functioning member of society.”

**The social impact according to clergy representatives.** Clergy representatives included the social impact in their answers. Three of these participants reported the social impact as “positive.” One male clergy member wrote that stronger community relationships were the result of support groups facilitated by the faith community nurse. Four clergy representatives mentioned the help that individuals or their loved ones had received from various community agencies after referral by the nurse. One response to the social impact question was “Our nurse has put several church members in contact w/ agencies that have helped in different areas. She has brought in several speakers for different groups that has provided educational information to those that need it.” Another group of three responded about the benefits of visits to hospitalized, nursing home, and shut-in members. One specific benefit was members had “relief from being alone.” Finally, two clergy representatives answered that the services the nurse rendered had helped members either “achieve self-support for themselves” or “take pride in being self-supportive and productive.”

**The social impact according to faith community nurses.** Faith community nurses described the social impact of their practice in six different categories. Six responses

focused on the theme of connection. One nurse wrote that she connects the congregation to community activities and services. A second answer referred to the nurse extending the connection between the pastor and the congregation through home and hospital visits. Another nurse replied that she connects both the client and the family to the right people, places, and information. A fourth answer mentioned maintaining connections between the client and out of town family members to facilitate long distance decision making. The fifth nurse wrote that she was “a connecting link for homebound clients to the church.” In a final example, a nurse referred to the connection between organizational-leadership skills and experience in faith community nursing that enabled her to minister to her congregation.

The nurses mentioned the topic of social interaction eight times. One nurse wrote that the nurse is the main source of social interaction for homebound individuals and skilled nursing facility residents. Programs, activities, and classes provided multiple opportunities for socialization. A nurse reported that an elderly man enjoyed more rapid post-operative rehabilitation because of social interaction. According to one nurse, social interaction could, “be done on a friendship style, not a me vs them.”

Several other answers were related to the concept of support. Based on nurses’ responses, participants in educational programs and health activities supported each other. Nurses supported individuals and family members during unexpected financial circumstances and end-of-life situations. Support from a nurse helped a person with depressive symptoms avoid hospitalization. One nurse related how a female member called her “mother” because “I had given her more emotional support than anyone had,

including her mother.” In another situation, the nurse described how the faith community minister supported her health care and health promotion work with an African-American congregation. Several nurses documented that faith community members attended disease specific support groups. One nurse wrote a letter of support for a young lady to qualify for a scholarship. Nurses described support as appreciated, invaluable, well received, and stabilizing.

Communication principles were the fourth category of social impact descriptions. Nurses wrote that (a) having someone to listen was the most important characteristic, (b) being a better listener meant accepting people, and (c) having the time to listen led to more and better listening. Answers included that individuals were (a) “comfortable discussing their own situations and they were glad to have someone they could talk to,” (b) “more likely to open up and discuss difficult issues with me that they would not want even the pastor to know,” and (c) “able to unload a lot of old baggage they had been carrying around for years.” Removing barriers to communication and having more discussion on sensitive health topics were two more descriptions of social impact.

Miscellaneous social benefits made up the next group. Three responses mentioned improved self-esteem and one included increased self-confidence. Two nurses wrote about improved parent-child relationships and two more mentioned promotion of healthier relationships. One nurse described how personal visits or phone contact with the faith community nurses reduced loneliness for the clients. Four answers were about people sharing information they learned at a program with others. An answer related to

sharing information was, “Several of my patients are now promoting healthy living and medical care to others in the community.”

The final category of social impact was meeting the needs of others. Meeting needs of others applied principles of (a) group involvement, (b) acceptance of others, (c) outreach to others, and (d) willingness to serve. One response was, “I have helped find resources for medication, healthcare, food shelter, and even substances abuse treatment.” Another nurse wrote, “Between the two churches I have a food pantry at one and a clothing bank at the other which helps me to meet those individual needs too.” A third answer was “We can put care teams in place to allow caregivers some time off or help with meals or child care. Getting church members involved like this puts our faith in action.” One nurse summarized the social impact of the faith community nursing program and wrote, “Social impact is demonstrated by the way the program has addressed the needs of individuals, families, and the congregation in general.”

**The social impact according to the annual reports.** The social component was mentioned throughout the ten annual reports and greatly contributed to the impact of the faith community nursing program. Ten categories of social impact were identified in these documents. References were made to (a) group activities that increased social interactions, (b) collaboration with social support providers or systems, (c) establishment or continuation of connection, (d) family dynamics, (e) use of volunteers, (f) visitation, (g) social goals, (h) environmental issues, (i) networking opportunities, and (j) lessons learned. Examples of the social impact of the faith community nursing program in each of these areas are presented in the following paragraphs.



Several references were made to group activities that increased social interactions for individuals, families, and groups in the community. The sons of a homeless family were able to attend summer camp after the faith community nurse intervened (Hamilton & Moore, 2001). Another nurse reported that a school-aged boy enjoyed more frequent participation, greater fun, and better performance in social sports activities after she intervened during a vision screening and he acquired glasses (Hamilton & Moore, 2001). Support groups have been established to address a variety of health issues. Group encouragement was available for persons participating in weight loss activities or experiencing grief, depression, chronic diseases such as cancer or heart disease, substance abuse, and other physical or mental health issues (Hamilton & Moore, 1999, 2002). A variety of ongoing exercise programs provided multiple opportunities for social interactions for participants (Hamilton & Moore, 1999, 2002, 2006, 2007). One report mentioned that a dancing for exercise activity helped participants get to know individuals from many ethnic backgrounds in an informal, relaxed environment (Hamilton & Moore, 2008). Trust and camaraderie formed as a faith community provided lunches for individuals with HIV/AIDS (Hamilton & Moore, 2002). Another nurse arranged for her faith community to provide meals on Wednesday evenings for homeless individuals (Hamilton & Moore, 2004). Other interventions with a social impact have allowed individuals to begin or resume participation in faith community activities including worship services, fellowship opportunities, group meetings, and day camp events (Hamilton & Moore, 1999, 2002, 2004, 2007). Every year many faith communities have increased social interactions through sponsored community health fairs with health

screenings, community resources, educational materials, and referrals for follow-up care for all age groups (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008).

The second category concerned collaboration with social support providers or systems. An elderly woman experienced decreased social isolation and continued to live independently after a faith community nurse advocated on her behalf, collaborated with community agencies, and facilitated the woman's enrollment in Services for the Blind (Hamilton & Moore, 2000). Early in its existence, the faith community nursing program developed collaborative relationships with hospital departments, and community and state agencies. These relationships have been maintained and new relationships have formed during the program's ten-year duration. Hospital departments that participated in the collaborative relationships included (a) Behavior Health Services that provided educational programs, (b) Heart and Vascular Education Program that assisted with cholesterol screenings, (c) Medical Library that provided computer training for medical websites, (d) Pastoral Care Services that worked with program development, and (e) Staff Education that provided CPR training (Hamilton & Moore, 2006). The variety of community and state agencies that have been affiliated with the faith community nursing program include (a) American Red Cross, (b) Bureau of Alcohol, Tobacco, and Firearms, (c) Center for New Carolinians, (d) Greensboro Housing Authority, (e) Guilford County Coalition on Infant Mortality, (f) Health Ministry Association, (g) North Carolina Department on Aging, (h) Triad Project for Health Disparities, (i) The University of North Carolina at Greensboro School of Nursing, and (j) Urban Ministry (Hamilton &

Moore, 2006). Finally, one nurse wrote, “Collaborate. Working together is fun and you get a lot more for your money” as a new belief due to service to her faith community (Hamilton & Moore, 2006).

Outcomes also addressed the establishment or continuation of connection between people and other people or organizations. Involvement of a faith community nurse helped homebound individuals stay connected to the faith community (Hamilton & Moore, 2002). In 2002, one faith community nurse promoted a “Turn off the TV Week” so individuals and families could establish connections, increase interactions, and build relationships with others (Hamilton & Moore, 2002). Two years later, a nurse started a women’s book club to provide diversion from winter blues for individuals prone to seasonal affective disorder. This intervention created social bonds and connections between participants (Hamilton & Moore, 2004). In another example, the nurse assisted a client to become connected with Lifeline. This action enabled the person to remain at home and eliminated a potential care facility placement (Hamilton & Moore, 2007).

The fourth type of social impact was related to family dynamics. Through one nurse’s advice, intervention, and caring, a woman was able to leave an abusive relationship and to establish a new life and new opportunities for herself and her children (Hamilton & Moore, 2000). An imprisoned son was able to visit his dying mother and attend her funeral through the faith community nurse’s involvement with the family (Hamilton & Moore, 2002). Another nurse helped to reestablish the relationship between elderly woman diagnosed with Alzheimer’s disease and her previously estranged daughter

(Hamilton & Moore, 2004). Increased contact between family members was the result of another nurse's service to individuals in her faith community (Hamilton & Moore, 2006).

Another topic pertained to the use of volunteers. People shared their time, talents, skills, knowledge, and resources with others. One example in the third annual report described how the faith community nurse connected one member with specific disease knowledge as a volunteer "buddy" to another member newly diagnosed with the same disease (Hamilton & Moore, 2001). A man who participated in an osteoporosis-screening clinic was referred to a physician and started on appropriate medication had a social impact as he volunteered his time and energies and became a crusader urging men in the congregation be screened for this potentially disabling disease (Hamilton & Moore, 2001). One faith community created a volunteer program called "Helping Hands" and this program connects people with certain talents to those individuals who need help (Hamilton & Moore, 2002). A married woman with depression experienced decreased feelings of loneliness after she began volunteering her time and talents in faith community activities and in the greater community projects (Hamilton & Moore, 2006). A third example described the situation where a female member voluntarily shared her knowledge of the proper technique for breast self-examination with family and friends (Hamilton & Moore, 2007).

Visitation was a theme that also contributed to the social impact of the faith community nursing program. Visits by the faith community nurse to shut-in or sick members in their homes, hospitals, and long-term care facilities have increased social contact for many individuals (Hamilton & Moore, 2000). One nurse developed a "new

baby” visitation program to help families in that special situation (Hamilton & Moore, 2002). Another nurse developed a “Fellowship Meals” ministry for sick and shut-in persons (Hamilton & Moore, 2005).

For the category of social goals, the documents repeatedly mentioned building a sense of community among groups (Hamilton & Moore, 2000, 2001, 2003, 2005, 2007, 2008). One specific goal of a faith community was to increase involvement of elderly members with their peers in activities outside of the home setting (Hamilton & Moore, 2006). Another goal was to provide personal counseling and advocacy for homeless populations and clients with limited income (Hamilton & Moore, 2007).

The eighth area of social impact dealt with environmental issues. In the third annual report, a nurse identified an unsafe home environment and collaborated with several people to resolve the situation while allowing the member to maintain control and retain personal dignity (Hamilton & Moore, 2001). Another nurse worked with hospital discharge planning to prevent one client from being discharged from the hospital to an unsafe home environment (Hamilton & Moore, 2007). Other nurses worked with multiple elderly individuals to get them out of unsafe home environments and into more appropriate or optimal living situations (Hamilton & Moore, 2008). Additional nurses intervened with people in domestic violent environments and located community resources to help them (Hamilton & Moore, 2008). A final example of social impact related to an environmental issue is the nurse who presented a program on emergency preparedness to identify people who lack support system for managing environmental situations such as a severe thunderstorm or ice storm (Hamilton & Moore, 2008).

Networking opportunities formed the next category of social impact. Monthly program meetings were established in May 1999 and gave social networking opportunities to the faith community nurses (Hamilton & Moore, 1999). In 2002, a luncheon for clergy of participating faith communities gave them a social opportunity to share and network (Hamilton & Moore, 2002). Ongoing monthly meetings with faith community nurses have continually provided networking opportunities and encouraged professional growth. Since the nurses have a variety of gifts, talents, and skills, they have shared their program and activity ideas, and served as resources for each other.

The final theme involved lessons learned that individual nurses reported. Individuals had personal benefits when they used the nurse as a support and resource person (Hamilton & Moore, 2000). Three lessons learned that were mentioned in the fourth annual report were that (a) friendships and support of team efforts can flourish during uncertain times, (b) communication processes need ongoing monitoring and improvement, and (c) relationships with interfaith agencies and community organizations must be maintained (Hamilton & Moore, 2002). One repeated lesson emphasized that good communication is imperative to program success (Hamilton & Moore, 2000, 2001, 2005). Another lesson indicated that program success was directly related to the support of clergy and church staff. An additional lesson stressed that there is great value in networking with other faith community nurses (Hamilton & Moore, 2006).

Many people attended a variety of educational activities that are directly related to the social impact of the program. Some specific examples of these programs were (a) Effects and Hazards of Smoking, (b) Substance Abuse and Adults, (c) AIDS Education, (d) Gun

Control, (e) Body Image, (f) Peer Pressure, (g) Sexually Transmitted Diseases, (h) Avoiding Illness on Vacation, (i) Depression, (j) Coping with the Holidays, (k) Domestic Violence, (l) Anger Management and Conflict Resolution, (m) Families Eating on the Run, and (n) Relationships and Communication. The changes, accomplishments, and outcomes that transpired in the lives of individuals and families because of these activities are most likely beyond imagination and description.

### **The Educational Impact**

**Definitions and coding decisions.** The description of the educational impact of the faith community nursing program was derived from responses to the third item on the impact questionnaire. This item included specific definitions of educational based on the conceptual definition of educational. The conceptual definition was that aspect which includes and affects the ability to gain, increase, share, master, evaluate, or transform knowledge. The specific definitions were “the ability to learn and change what you know” for faith community members and “the ability to gain, increase, share, master, evaluate, or transform knowledge” for clergy representatives and faith community nurses. A fundamental example pertained to learning and content that addressed gaining knowledge, increasing awareness, or sharing information with others was considered as educational impact even when this subject matter was located in another area of the impact questionnaire. Additional information concerning the educational impact was based on deductive codes that were established prior to data analysis and inductive codes that emerged during data analysis. Examples of deductive codes for this area of impact were (a) educational impact, (b) educational intervention, and (c) the faith community

nursing roles of health educator and trainer of volunteers. Health literacy was an example of an inductive code that pertained to this area of impact. Finally, the description of the educational impact was based on synonyms of terms in the conceptual definitions, the specific definitions, and related deductive and inductive codes. The Microsoft Office Online English Thesaurus (Microsoft Corporation, 2003) was used to list synonyms for various terms and the word documents were examined for related content. An example for this area of impact was the term “educate” and synonyms included (a) teach, (b) instruct, (c) inform, (d) train, (e) explain, (f) demonstrate, (g) show, and (h) guide.

**Educational impact related to the conceptual model.** The educational impact of the faith community nursing program was related to three of the four adaptive modes in the RAM. From a broad perspective, study participants described the educational impact with multiple references to (a) increasing knowledge, (b) becoming aware, (c) sharing information, (d) participating in educational activities, (e) attending classes, and (f) applying learned material to lifestyle behaviors. Many educational activities contributed to the process of becoming more integrated as a human being with evidence of knowledge and understanding. This area of impact was first associated with the complex processes of neurologic function in the physiologic-physical mode. The ability to increase awareness, process information, use language skills, develop memories, transform knowledge, and apply learning in order to change behaviors were some examples from the data that applied to neurologic functions. Second, the educational impact was related to the self-concept/group identity mode. One of the processes of this mode used by individuals to adapt, integrate, and to foster integrity is the developing self. The



developing self process is partially based on cognitive development and learning styles, preferences, and behaviors. Cognitive development is an ongoing process and many study participants that were older than 70 commented on the ability to continue to learn. Responses on the questionnaires indicated that participants were involved in a variety of group activities and were developing a degree of group identity as they shared goals, expectations, values, and relationships within the group. Next, the educational impact was related to the role function mode with many responses indicating tertiary roles of class participant and instructor for family members and friends. Faith community nurses reported service as health educators and facilitators of educational activities. These examples indicate how the educational impact corresponded to the RAM. The RAM was suitable for the assessment of the educational impact in this study. Results indicate an acceptable level of compatibility between the RAM and the educational impact as reported by the study participants.

**Brief summary of the educational impact.** Study participants described the educational impact with several different themes. Faith community members, clergy representatives, and faith community nurses addressed (a) increased knowledge, awareness, or understanding concerning health issues; (b) positive changes in health of individuals or families; (c) shared knowledge; and (d) integration of information into personal lifestyles. Clergy representatives and faith community nurses mentioned the subjects of empowerment because of educational activities, and personal health counseling with specific answers for questions. Faith community members included themes of (a) health literacy, (b) seriousness of health issues, and (c) the combination of

educational features with spiritual aspects. Clergy representatives addressed the availability of published literature. Additional themes from the nurses' responses were collaboration, future benefits, techniques to make information available, and personal learning.

**The educational impact according to faith community members.** The nursing program has had educational effects on the members of the faith community. Participants who identified themselves as members mentioned increased knowledge, awareness, or understanding concerning health issues 15 times. One person responded, "The nurse has provided valuable information that has helped me better understand my current medical condition." A second individual wrote, "I have learned alot [*sic*] about procedures, medicines, new treatments, etc which otherwise I would never have known." Another example provided by a woman was, "It has made me more aware of both physical health and mental health and what my body and mind needs to be healthier. I am aware that in all my activities I want to stay healthy."

Several participants addressed specific areas in which learning had occurred. A homebound female member mentioned five separate areas of learning. Her response was, "The visits by our CN keep me on fairly stable ground emotionally. Because of this, I am free to continue to learn and grow in new areas, such as cooking, computer knowledge, sewing, and needlework, and current events." One topic of increased knowledge reported by participants was available programs or resources for referral purposes. An example from one individual was, "I also have become aware of the many programs that my church offers its members and that I can refer members to." One person answered about

becoming aware of personal talents and skills, and the need to use them wisely. The answer of a woman was “It has helped me learn my limitations and needs as a human being.” Another woman mentioned budgeting practices and wise use of her income. A male participant wrote about learning new ways of dealing with problems. Certain other topics were (a) aging adults, (b) good health habits, (c) diet and weight loss, (d) medication, (e) lifestyle changes, and (f) coping mechanisms.

Sharing knowledge with others was another theme of the educational impact. Eight participants included this topic in their responses. One person wrote, “I never want to think that I know it all but always ready to learn and grow from other people.” The answer of a retired pharmacist was that he “can make a difference in others lives by helping them to understand the importance of taking care of their health.” A woman responded to the educational impact question with, “It has helped me learn from others who have had different lifestyles and experiences than me. I am more open to older and younger ideas and values.”

One female participant included the potential educational impact on family members. She described this situation.

There appears to have been an increase in the number of members who donate blood (to Red Cross). Several members have gotten CPR/First Aid Certification & are aware that it is a member of one’s own family who is most likely to be the benefactor of one’s CPR skills. Most members--including children & youth-- can verbalize a “heart healthy” diet & the benefits of regular physical activity. Four people answered that the educational impact involved matters of health literacy.

One woman described this area with, “She has been willing to cut through the ‘doctor-speak’ and give helpful lay terminology.” Another person indicated that the faith community nurse was able to dispel myths and misinformation.

Additional participants addressed nutritional issues as a portion of the educational impact. The response of one woman was, “Working mothers appear more aware of ‘bad’ eating habits--fast foods--and more aware of benefits of fruits & veggies for snacking.” In another section, this same woman continued, “Members are aware of labels on cans and know that buying foods in season are more economical.” Another individual wrote, “It has taught me to rethink what I think I know and relearn my things I need to know such as nutrition, eating habits.” One person supplied the sentence, “She keeps us up on latest news about such things as flu and how to protect ourselves from contracting it” before she continued her response on nutrition, exercise, and weight control. A fourth example referred to the spiritual aspect and this participant answered with “Learning about nutrition, disease prevention coupled with the spiritual adds a dimension to our congregation where many members have benefitted.”

Four other individuals included spiritual component with the educational impact. The first example is from an elderly woman who answered, “Through education by the parish nurse, I have a better understanding of the whole person, i.e. my physical, mental, and spiritual well-being.” Another participant wrote, “I am so much more aware that I am a child of God and needed in the world and in society.”

The answer of one participant showed great insight concerning the educational impact of the faith community nursing program. In other sections of the impact questionnaire,

this young man wrote that he “had no idea that my high blood pressure affects so many other areas of my health” and “had no idea how expensive high blood pressure can be even with insurance.” The following is his complete answer to the educational impact question.

The knowledge the access of the nursing program is very valuable to me because it makes me more health conscious. It is my opinion that we as individual must take health issues more seriously than we do. The part in this question where it states **change what you know** is very interesting because as a society we do not change from our habits and rutens [*sic*] easily. When it comes to our thinking and knowledge it is sometimes stubbornness as well. It is and always been my belief that I want to be a humble person and transparent. I never want to think that I know it all but always ready to learn and grow from other people. My health is the most important thing that I can do for myself (**after accepting Christ**) that will have a great impact on me now and in my future.

Three people completed the phrase “the educational impact is” with (a) learning to question information from physicians, (b) being aware of the difference between real needs and desires, and (c) having programs about Medicare information. Individuals described the educational impact as (a) good, (b) varied, (c) wonderful, (d) helpful, and (e) valuable. Benefits identified by the participants were (a) a more stable mental/emotional state, (b) improved actions concerning health, (c) healthier living, (d) better health, and (e) opportunity to broaden talents and skills.

**The educational impact according to clergy representatives.** All clergy representatives addressed the educational impact. Five of them wrote about enhanced awareness and increased understanding of parishioners relative to a variety of health issues. Individuals were able to get specific answers for their questions and concerns from the nurse. One male clergy member responded that increased awareness of

differences facilitated togetherness and mutual respect among the congregation. Another participant praised the availability of published literature in his answer to the educational impact question. Two clergy representatives mentioned the general benefits of educational components for the faith community while another asserted that community empowerment was a benefit of educational activities. An additional man addressed the practical application of education provided by the nurse as he wrote, “there has been an emphasis on not just taking in the information provided, but putting it into action.”

**The educational impact according to faith community nurses.** The educational impact question yielded an assortment of answers from the faith community nurses. Many nurses described how education had caused changes in the health of individuals or families. Educational offerings prompted congregants to seek further evaluation of health conditions and gave them the information to understand and cope with their personal health situations. One nurse reported, “Many in my congregation are integrating the information I have given them into their own life styles.” Modifications attributed to education were (a) healthier choices in food, (b) improved management of blood pressure and diabetes, (c) greater consistency in taking prescribed medications, and (d) more frequent exercising. Health benefits included (a) lowered cholesterol and glucose levels, (b) weight loss, (c) increased energy, (d) pain relief, and (e) reduced anxiety and stress.

Nurses described some social and cultural features of the educational impact. Educational opportunities (a) empowered individuals to ask questions, (b) generated more discussion on sensitive health topics, and (c) facilitated fellowship among

participants. Members in learning activities developed appreciation for the cultural differences among themselves.

Educational programs had some practical applications. Topics of some classes were (a) safety with fireworks, (b) outdoor cooking precautions, (c) eating healthy on a low budget, (d) protecting yourself from swine flu, (e) health insurance options, and (f) community resources. Some responses pertained to specific situations. One nurse mentioned a series of programs on dementia. She wrote, “The practical skills such as how to approach someone with dementia, hand over hand method of feeding or shaving someone, etc. were very valuable.” These same classes “gave one family the self-confidence to grant their mother’s wish to come back home for a visit.”

The following examples pertained to the nurse’s role as a personal health counselor.

During osteoporosis counseling a great number of individuals did not know the recommended dose for Calcium. They were also unaware that they should divide the dose and take vitamin D to allow for better absorption. I feel they will have better results because of the counseling.

In another situation, a nurse described the following educational impact.

Recently a newly diagnosed diabetic requested help with his diabetes. The client and I reviewed the basics of diet, exercise, medication and need for weight loss. I also talked to his wife about meal planning and gave her information about the glycemic index. They are transforming the information into action. In the last two months, he has lost 23 pounds.

The educational impact did not just affect the faith community members. One nurse mentioned the collaboration between the department of social work at a local university and the faith community nursing program. She wrote, “The start of the Congregational

Social Work Education Initiative has been a great help to both the students and the congregational nurses.” Two nurses described some educational benefits they had experienced. One wrote, “I am a Catholic in a Presbyterian church learning new words, new ideas, new models, how different church works. Many of these people have been here for over 5 years and have a lot of history to offer me.” In the second and following scenario, the nurse described how she learned about customs of families from Cameroon.

One of our Cameroon families had a family member to die in Cameroon. I was given the honor of being invited to the family memorial celebration at the family’s home. It was there that I learned of some of their customs. One was that if you only ate one plateful of food it was an insult to the cook. I learned to take very small amounts the first time so I could go back for seconds. Before I left the gathering, I went to the family elder and squatted down at eyelevel beside him to say good bye. I learned later that the elder felt I had paid him great respect by bowing down to him as a woman should do.

Faith community nurses in this program used several techniques to make information available to others. One nurse wrote that education resources were provided through “presentations, speakers on specific subjects, pamphlets, newsletters, bulletin boards, weekly health tips, and one on one counseling.” Education occurred spontaneously with individuals and in structured settings with large groups.

Three nurses reported how participants in educational activities did not keep the new knowledge to themselves. Two mentioned how people would share what they learned with their family members or other people. One nurse wrote, “It was exciting as the children would share what they had learned in school about the food pyramid with the older people!”



One nurse provided four examples of future educational benefits. First, she wrote that “Vision deficits found before school starts should help the children have a better school year.” She continued with an example of helping a young woman continue her education that would remove her from the culture of poverty. In a third situation, the nurse wrote that helping children to stay in school may allow them to actually break the poverty cycle. Her final example focused on how helping adult family members obtain their General Equivalency Diploma gave them a greater chance for better employment and a better future.

A final example explained how evidence-based practice is apparent in this specialized type of nursing and in this particular program. Research for a monthly newsletter article indicated that challenges to brain activity were a factor that could enhance memory retention. The nurse collaborated with a parishioner who is a retired college professor “and thus ‘brain games’ was born. We meet twice a month to play games that stimulate our minds.”

**The educational impact according to the annual reports.** Educational features of the faith community nursing program were also evident in the ten annual reports. Different educational elements have significantly contributed to the program impact. Five categories of educational impact were identified in these documents. References were made to (a) principles for educational activities, (b) educational offerings or programs, (c) ongoing activities, (d) general and specific accomplishments, and (e) lessons learned. Examples of this impact of the faith community nursing program in these areas are presented in the following paragraphs. The first category pertains to principles for

educational activities. Six principles should be considered when planning educational offerings that will have an impact on individuals, families, groups, or the community. First, programs should be relevant to individual faith communities. Next, activities should address healthy lifestyle choices. Third, offerings should utilize a holistic approach to health, and fourth, address wellness and disease prevention. Fifth, programs should address the interests of multiple age and cultural groups. Finally, information should also be available in written format through articles in newsletters, bulletins, and on bulletin boards (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008).

The next category is the variety of educational programs offered. Several themes were identified and specific programs applied to the different themes. “Saving Money on Health Care” was an educational offering that was categorized as having a financial focus. “Reducing the Stress in College” pertained to the theme of specific age groups. “Anxiety and Panic Disorders” targeted a mental health condition while “Diabetes from A to Z” addressed a physical health condition. Other examples are presented in Table 6 (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008). Only a few of the programs presented during the past ten years are included. Thousands of individuals have attended these educational offerings and the impact of the shared knowledge is potentially impossible to imagine or describe.

Table 6

*Educational Offerings Listed in the Annual Reports*

Category	Program Title	Year
General Information on Faith Community Nursing	Parish Nursing and Wholistic Health Ministry	2000
	What is Congregational Nursing?	2002
	Communication Between Nurses and Congregation	2005
	Purpose of the Parish Nurse	2007
Specific Age Groups	Adolescent Nutrition	2000
	Depression in the Elderly	2001
	Reducing the Stress in College	2005
	Eat Healthy for Children	2007
	Childhood Illness	2008
Specific Cultural Groups	Native American Spirituality, Religion, and Food	2002
	Black Women and Depression	2004
	Black Women and Stroke	2005
	HIV/AIDS is Now a Black Disease	2006
Physical Health Conditions	What is High Blood Pressure?	2000
	Stroke Awareness	2001
	Diabetes from A to Z	2002
	Colon Cancer	2003
	Osteoporosis	2004
	HIV/AIDS Awareness	2005
	Heart Disease	2006
	Tuberculosis	2007
	Influenza	2008
Mental Health Conditions	Stress Management	2000
	Anxiety and Panic Disorders	2001
	Sharing Stories for Emotional Health	2004
	Depression	2005
	What is Healthy Mental Health Anyway?	2006
	Do Our Minds Create Our Stress?	2007
	Grief and the Holidays	2008
Contact With Members of the Health Care Team	Going to the Doctor	2000
	Your Pharmacist, Your Friend	2002
	When to Call the Doctor	2004

Category	Program Title	Year
Family Components	Nutrition for Parents of Children 5-18 Years of Age	2000 2004
	Caring for Aging Parents	2005
	Loving Relationships	2006
	Accident Prevention in the Home	2007
	Families Eating on the Run	2008
	How to Communicate with Your Children	
Financial Components	Saving Money on Health Care	2002
	Financial Aid for Medications	2004
	Financial Health and Welfare Reform	2007
Nutritional Components	Antioxidants as Dietary Supplements	2000
	Vitamins and Minerals	2001
	Super Foods--Try Them!	2004
	Food Tips to Prevent Food Poisoning	2005
	Eating Smart on the Run	2006
	Fats: The Good and the Bad	2007
	Reading Food Labels	2008
Spiritual Components	Spirituality and Health	2000
	Spirituality in Everyday Life	2002
	The Power of Prayer on Healing	2004
	Being Thankful	2005
	Spiritual Health of Children	2007
	Spirituality and Depression	2008
Social Components	Coping with the Holidays	2000
	Don't Touch a Gun	2001
	Compassionate Communication	2004
	Substance Abuse and Adults	2005
	Anger Management and Conflict Resolution	2006
	Self Esteem	2007
	Care of the Care-Giver	2008
Insurance/Medicare/Medicaid	Medicaid, Medicare, and In Home Care	2004
	Medicare Part D	2005
Bible Referenced	Healing, Nutrition, & Supplements Based on Leviticus	2000
	Let the Bible be Your Compass	2002
	Depression Bible Study	2004
Employment Components	Dealing with Job Stress	2000
	Babysitting the Safe Way	2003

Category	Program Title	Year
Environmental Conditions	Severe Weather and Tornado Plan for the Shelter Building	2000
	Environment and Health	2002
	Fire Safety	2003
	Environmental Issues: Lead, Radon, & Mosquitoes	2004
	Summer Safety--Heat Related Illness	2005
	Skin Protection	2007
	Emergency Preparedness	2008
Medications Information	Know Your Meds	2001
	Medications Safety & Drug Interactions	2004
	Generic Versus Trade Drugs	2006
Legal Components	Legal Issues and Confidentiality for Caregivers	2002
	Lunch With a Lawyer from Elder Law	2003
End of Life Issues	Dealing with Death and Dying	2002
	Updating Your Will	2003
	Death and Funerals	2004
	Advanced Directives	2005
Complimentary or Alternative Therapies	Acupuncture and Oriental Medicine	2003

Ongoing activities made up the third area of impact. Monthly meetings for the faith community nurses began in May 1999. These ongoing meetings focused on providing continuing education for the nurses. These educational offerings helped nurses expand their knowledge and skills related to addressing community needs. For several years, faith community nurses and the program coordinator have served as preceptors or mentors for nursing students, nurses working on advanced degrees, and social work students attending local colleges and universities. Faith community nurses have attended the Basic Parish Nurse Preparation Course that provided specialized nursing foundation needed to develop effective health ministry programs. The Congregational Nurse Coordinator and a number of nurses have gone to the Westburg Symposium. This annual event has offered educational activities and networking opportunities for faith community

nurses for many years (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008).

Many general educational accomplishments, results, or changes were repeated during the ten years of the program's existence. Faith community members expressed interest in learning about personal health issues. Information was readily available at the faith community locations and in the greater community in a variety of formats. Health literature was dispersed throughout neighborhoods. Educational programs and activities covered a broad range of topics and issues that were of interest to multiple populations. In 2002, 51% of the 929 responses on a program evaluation tool indicated attendance at an educational program (Hamilton & Moore, 2002). Members also reported increased knowledge, understanding, and awareness of disease processes, medications, and preventative health behaviors. Many individuals made lifestyle changes on the basis on health education interventions and improved their physical, mental, and spiritual health. Nurses were described and commended as valuable resources for converting medical terms, conditions, and instructions into less technical, practical, and understandable terms for congregational members (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008).

Examples of specific educational impact were also included in the annual reports. One faith community nurse provided practical information, electronic informational sources, and nursing knowledge about a specific disease and its treatment, associated dietary changes, and methods of coping with a chronic disease that allowed a female member to manage her disease more effectively (Hamilton & Moore, 2001). A male

patient had decreased fears about open-heart surgery after the faith community nurse educated him on the pros and cons of the surgery (Hamilton & Moore, 2002). Because of a faith community nurse's involvement in and contribution to a wellness program, one member wrote, "I really learned so much about my health that I did not know before" (Hamilton & Moore, 2004). One faith community nurse reported that she had received positive feedback about articles in the newsletter. Members had used that information and corrected safety hazards, improved their diets, and received the influenza vaccination (Hamilton & Moore, 2006). An additional nurse experienced an educational impact through her interventions with a domestic violence victim. The faith community nurse reported that she learned more about community resources available to this vulnerable population after she helped a member with this situation (Hamilton & Moore, 2006).

The final section of educational impact focuses on the many lessons learned by the nurses during their service to their faith communities. One of the first examples was that community agencies and hospital educators welcomed the opportunity to promote wellness through educational activities in faith communities (Hamilton & Moore, 1999). The following examples were included in the second annual report. First, educational programs should be based on member requests and should address their specific and unique interests, needs, and expectations. Next, people are more likely to attend programs that are held at a familiar location. Then, educational programs may have poor attendance even if thoroughly planned and with excellent presenters. Fourth, educational events planned for and open to multiple groups are more effective. Fifth, quick response times for information requests are essential. Lastly, sometimes small things reap the largest

benefits (Hamilton & Moore, 2000). Additional things that the faith community nurses reported learning were documented in the next three annual reports. First, participants have responded favorably to educational offerings sponsored at the familiar location of the faith community that are not as intimidating at the healthcare setting. Next, the community at large should be included in educational offerings whenever possible. Third, the first year that a program is in effect is a time of learning and discovering what works and what does not work (Hamilton & Moore, 2001). The measure of success of an educational activity cannot be based on the number of attendees (Hamilton & Moore, 2002). Faith community nurses should be sure that educational presenters are familiar with subject matter and able to present the facts. Finally, children will bring parents to educational activities if the programs are directed toward the entire family (Hamilton & Moore, 2003). The next two years continued the pattern with reports of lessons learned. One example was that innovative approaches are needed to keep people involved in educational activities, especially during winter months when prefer to stay home. Another lesson was that educational needs should be assessed on an ongoing basis (Hamilton & Moore, 2004). A third reported lesson was that maintaining communication and enthusiasm was essential for a successful ministry (Hamilton & Moore, 2005). Other lessons were mentioned in the final three annual reports. First, estimating the number of people who will attend educational programs is an unrealistic expectation. Next, educational programs should be based on the expressed needs of the members and not on what the faith community nurse desires (Hamilton & Moore, 2006). Limiting planned programs and activities is necessary in order to take advantage of opportunities that come



from unexpected sources (Hamilton & Moore, 2007). Then, program evaluators should not underestimate the impact because there may not be immediate results. Nurses should capture the teachable moments when and where they are. Finally, with challenges come knowledge “to apply to the next bump in the road” (Hamilton & Moore, 2008).

### **The Cultural Impact**

**Definitions and coding decisions.** The description of the cultural impact of the faith community nursing program was derived from responses to the fourth item on the impact questionnaire. This item included specific definitions of cultural based on the conceptual definition of cultural. The conceptual definition was that aspect which is the total of learned behavior shared by a particular group of people and transmitted from generation to generation. Learned behaviors include ethnicity (language, practices, customs, traditions, goals, associated values), belief systems (spiritual beliefs, philosophies, values), and socioeconomic status (lifestyles, use of material resources). “Cultural means the things shared by a group of people. It includes values, customs, lifestyles, and use of material resources. These things are passed from one generation to the next” was the specific definition of cultural for faith community members.

Cultural includes the learned behaviors (e.g. traditions, philosophies, values, languages, customs, use of material resources) shared by a particular group of people and transmitted from generation to generation.

was the specific definition of cultural for clergy representatives and faith community nurses. A fundamental example pertained to the concept of generation. Since families have generational members, content that meant an individual in a family, such as a

spouse, parent, or child, was considered as cultural impact even when this subject matter was located in another area of the impact questionnaire. Additional information concerning the cultural impact was based on deductive codes that were established prior to data analysis and inductive codes that emerged during data analysis. Examples of deductive codes for this area of impact were cultural impact and cultural intervention. Program continuation pertained to the culture of the faith community nursing program and served as an example of an inductive code for this area of impact. Finally, the description of the cultural impact was based on synonyms of terms in the conceptual definitions, the specific definitions, and related deductive and inductive codes. The Microsoft Office Online English Thesaurus (Microsoft Corporation, 2003) was used to list synonyms for various terms and the word documents were examined for related content. An example for this area of impact was the term “tradition” and related words were (a) practice, (b) habit, (c) routine, and (d) pattern described with the adjective “normal.”

**Cultural impact related to the conceptual model.** The cultural impact of the faith community nursing program was related to all four of the adaptive modes in the RAM. From a broad perspective, study participants described the cultural impact with references to cultural similarities and differences, traditions and values, and cultural sensitivity and diversity. Cultural behaviors, beliefs, and belonging to groups contributed to the process of becoming more integrated as a human being. This area of impact was first related to the need of nutrition in the physiologic-physical mode. Cultural behaviors influence eating, drinking, cooking, nutritional practices, and dietary intake. Factors derived from

data analysis included dietary modifications based on perceptions of increased health risks related to specific ethnic groups. Second, the cultural impact was related to the self-concept/group identity mode. Community cohesiveness is an adaptive process of group identity that is based on a common bond, and includes support, trust, affection, and similar norms, goals, and values. Cohesiveness is a manifestation of positive and effective adaptation. Many references mentioned the concepts of support, community, and connections among and between individuals, families, groups, and the greater community. Responses on the questionnaires indicated that participants were involved in a variety of group activities and were developing a degree of group identity as they shared goals, expectations, values, and relationships within the group. Next, the cultural impact was related to the role function mode with many references to tertiary roles. Participants indicated belonging to (a) specific racial or ethnic groups; (b) immigrant, elderly, disadvantaged, or vulnerable populations; (c) community organizations; and (d) cultural groups based on age, gender, employment status, similar social situations, or similar health conditions. Finally, the cultural impact was related to the interdependence mode. The interdependence mode focuses on relationships between people and these relationships are with significant others and support systems. Significant others are those people or things that are given the most meaning and the highest level of importance, and can be family members, friends, God, material possessions, or animals. Support systems are the people, groups, or organizations that people associate with to achieve specific purposes or accomplish definite goals. Participants described the cultural impact in terms of family relationships, connection to God, the importance of the faith community, and

the benefits of involvement with the faith community nurse. These examples indicate how the cultural impact corresponded to the RAM. The RAM effectively provided for the assessment of the cultural impact in this study. Results indicate a high degree of consistency between the RAM and the cultural impact as reported by the study participants.

**Brief summary of the cultural impact.** Study participants described the cultural impact of the program with an assortment of themes. Individuals in each of the participant groups addressed (a) cultural traditions, values, beliefs, customs, behaviors, standards, norms, myths, communication, or information; (b) families, hereditary issues, or generational topics; (c) cultural similarities or differences; and (d) health risks, health practices, or health care. Topics related to society and living in a culturally diverse community were included in responses from faith community members and clergy representatives while clergy representatives and faith community nurses made references to learning needs of different groups. Faith community members mentioned the concepts of togetherness and lifestyles, and faith community nurses included nutritional practices of ethnic or cultural groups and their future implications.

**The cultural impact according to faith community members.** The faith community members had a variety of answers to the cultural impact question. People mentioned sharing (a) information and medical advice with children, extended family, and friends; and (b) traditions and values with grandchildren. Other answers were sharing (a) cultural or historical aspects with other group members; (b) similar health problems with others; (c) time with people who adhere to the same set of values; (d) beliefs in

multiculturalism with other members; and (e) news of certain events with interactive group participants. The answer of a certain female member was, “The cultural impact of faith community nursing on me is the exposure to people who speak another language who, at times share some cultural or historical aspects.”

Other answers that had a similar theme were (a) working together on various projects, (b) living together as friends, (c) preparing meals together as a family, and (d) eating and singing together during group activities. A specific example for togetherness was “It proves that people from different cultures can live together as friends and that if people can get past skin color, we can learn we really are not all that different from one another.”

Additional answers pertained to the topic of society. One woman shared the following scenario.

Working mothers appear more aware of “bad” eating habits--fast foods--and more aware of benefits of fruits & veggies for snacking and of taking time to prepare a nutritious meal in the evenings after work with assistance from dads & the children.

One man who indicated his highest educational level was “Received GED” responded, “The cultural impact of FCN own [*sic*] me has been good. It made me think more about society and how we can slow down diseases and their effects by knowing our history and condition.”

The subject of family was evident in the responses for cultural impact. Two members referred to involvement with genealogy. One female participant reported that the nurse’s “visits and interest enable me to remain in touch with my extended family.”

A second woman wrote, “Parents know to lock up medications & chemicals but not make-up or other safety issues.” Another woman mentioned her mother in a nursing facility and indicated the important cultural aspect was, “to have someone that will talk to me about my concerns with aging adults, the medical knowledge that she has.” A member who is now a retired nurse wrote, “I strongly believe that activities such as our Intergenerational Tea and Grandparents Camp have help [*sic*] build stronger bonds between me, my children, and grandchildren.” One of the youngest participants replied about the desire to have a better attitude toward his health for the future of his family.

The concept of healthcare appeared in some of the answers for the cultural effects of the faith community nursing program. One participant responded about being able “to live a more healthful life, and become more involved in others lives (health).” An Asian-American woman wrote, “I’ve learned to be more aware of the time such as be on time for your appointment. Be more aware of cultural differences of westernize medicine & the way system work in U.S.” A man expressed that “Our health is the backbone of our life we have to take it more seriously as African Americans.” Another section of his response was “health issues are not only hereditary but it can also be prejudice.” A fourth participant mentioned being helped in many ways and pointed “in the right direction medically.” The following illustration was from one woman who mentioned healthcare and other issues in her response to the cultural impact question.

In this community, medical education & nutrition education is non-existent. People are learning but it is a slow process. It is an old community so people will still use old (disgusting) remedies. What ever the doctor says is gospel truth and they are learning to question information. People do not want to ask their doctors about “that.” It may seem dumb or too personal. So they ask the FCN.

Two participants referred to the concept of lifestyle. One woman wrote, “It has helped me learn from others who have had different lifestyles and experiences than me. I am more open to older and younger ideas and values.” A man reported, “I know that my lifestyle have to change if I want have good health.”

**The cultural impact according to clergy representatives.** The cultural impact question produced a variety of responses from the group of clergy participants. An Asian-American clergy representative wrote, “I am from a different country with different standards and norms, but have had information that is relevant for positive living in America as shared and taught by the nurse.” Two of the clergy respondents mentioned living in a culturally diverse community and how the nurse has addressed health risks and learning needs for different groups. One male clergy representative wrote that involvement with the faith community nurse had a cultural impact by helping people make a distinction between legitimate health practices and myths or cultural traditions that are factors in health care. Another man answered that cultural unity and respect developed from knowledge of cultural differences. The female clergy participant emphasized the culture of an overweight society. She described how the nurse had encouraged and assisted individuals with weight loss programs.

**The cultural impact according to faith community nurses.** The cultural impact question had a variety of responses from the faith community nurses. Two answers with a nutritional focus described how ethnic or cultural groups were (a) eating more fruits and vegetables and less red meat, pork, and fried foods; (b) limiting sodium and fat during

food preparation; and (c) enjoying healthier choices with traditional foods. One nurse mentioned how these changes would have future implications as she declared, “This should help lower obesity, heart problems, and diabetes for the generations.”

One nurse described the cultural impact she experienced serving in a faith community with a religious affiliation different from her own. Her response indicated that she had learned new words, ideas, and models. Learning how a different church works was an added benefit. She included the advantage of learning from the faith community members as she answered, “Many of these people have been here for over 5 years and have a lot of history to offer me.”

For this study, cultural was defined as learned behavior shared by a particular group of people and transmitted from generation to generation. Learned behaviors are not just passed from older people to younger people. The reverse is true as one nurse provided the following illustration.

A couple of years ago--presented a health component for an inter-generational vacation Bible School--I did a series on “The Temple of God”--focusing on nutrition, exercise, sleep, & self-esteem. It was exciting as the children would share what they had learned in school about the food pyramid with the older people!

Another nurse indicated her faith community was primarily African-American. Her answer to this question included their (a) traditions that influence health practices, (b) beliefs that interfere with seeking health care, and (c) suspicion of health care providers. She concluded her answer with “I am impressed with the depth of understanding they have about the ‘traditional’ cultural traditions and customs as it relates to their health.”



The responses of other nurses demonstrated a variety of perspectives. One nurse responded that the cultural impact meant removing barriers to communication between generations and promoting more discussions on sensitive health topics. Another nurse answered the question with “We have learned to appreciate the cultural differences from each other.” A third example was, “Our church has a very integrated community who practice their customs with each other.” A fourth nurse mentioned (a) relating to the population, (b) assessing individual needs, and (c) providing materials based on a person’s values and customs. An additional description included (a) being nurtured by a loving congregation, (b) taking the job more personally, (c) becoming a better listener, (d) accepting people, and (e) caring for people as if they were family.

**The cultural impact according to the annual reports.** From the beginning, the cultural component was an important part of the faith community nursing program. This was evident in the ten annual reports as many statements addressed different cultural components. Selection of the initial six faith communities was based on congregational diversity and diversity of goals. These faith communities were multicultural with African-American, Asian, Caucasian, Hispanic, and Native American members. Some were located in low-income or ethnically diverse communities (Hamilton & Moore, 1999). As the program grew and more faith communities became involved, diversity remained a constant but a new requirement was that approval to participate in this program required ministry to vulnerable, disadvantaged, and at-risk or high-risk populations, and those with financial need. Homeless people, immigrants, elderly on

fixed incomes, and the working poor are members of these susceptible populations and can belong to a variety of cultural groups.

The five different categories identified in the annual reports that pertained to the overall cultural aspect were the culture of (a) specific age groups; (b) specific racial or ethnic groups; (c) specific gender groups; (d) individuals with similar social circumstances such as homelessness, domestic violence, or substance abuse; and (e) persons with similar health situations such as cancer, diabetes, or depression. The sixth category concerned miscellaneous characteristics in an assortment of cultural factors. Examples of the cultural impact of the faith community nursing program in each of these areas are presented in the following paragraphs.

The first category of a specific cultural group was based on individuals in similar age classifications. Examples of cultural references to specific age groups included (a) infants, (b) younger children, (c) older children, (d) adolescents, (e) young adults, (f) middle-aged adults, (g) the “sandwich generation”, (h) seniors, and (i) the elderly. Goals that pertained to younger age groups were (a) beginning visits to families with new babies and addressing family adaptation, and (b) promoting safety for children. Addressing self-esteem issues in adolescents and focusing on health needs of young adults were targets for additional age groups. Relevant goals for older age groups were (a) facilitating coping skills for the “sandwich generation”, (b) sponsoring health screenings and education for older adults, and (c) serving as advocates for the senior population. One goal for all age groups was promoting intergenerational relationships through an assortment of activities. Educational activities that targeted the culture of

specific age groups included (a) SIDS Prevention, (b) Halloween Safety for Children, (c) Identifying Sexual Abuse in Children, (d) Food Pyramid and Portion Sizes for Adolescents, (e) Family Life and Changing Bodies in Adolescence, (f) Reducing Stress in College, (g) What to Expect When Expecting, (h) Dealing with Job Stress, (i) Caring for Your Aging Parents, (j) Issues for the Sandwich Generation, (k) Common Problems with Aging--Where's Hope?, and (l) Depression in Old Age (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008). One specific accomplishment for a selected age group that supported the impact of the faith community nursing program was that problems with infant and car safety seats were identified and corrected (Hamilton and Moore, 2003).

A second cultural category included individuals that belonged to specific racial or ethnic groups. Examples of references to specific racial or ethnic groups included (a) African-Americans, (b) Cambodians, (c) Hispanics, (d) Montagnards, (e) Native Americans, (f) Koreans, and (g) immigrants or refugees from unnamed global areas or specific countries such as Russia and Sudan. Goals for specific racial or ethnic groups included (a) providing health education materials for minority groups, (b) beginning activities geared towards Native American spirituality, (c) exploring needs of Latin-American families, and (d) promoting health in the African-American community. Educational activities that addressed specific racial or ethnic health situations included (a) Diabetes--A Special Problem in the Black Population, (b) Black Women and Depression, (c) The Hispanic Health Fair, and (d) HIV/AIDS is Now a Black Disease. Several accomplishments attested to the impact of the faith community nursing program

for specific racial or groups. Nurses worked with Montagnard individuals and families and provided health education materials for them. Many members of the Montagnard community received influenza vaccinations. One Montagnard family received assistance with health and transportation needs. Teaching, counseling, and referral services for African, Laotian, and Vietnamese groups were maintained. Health screenings and educational activities were conducted for Cambodian people. Faith community nurses assisted with patient care in clinics and hospitals during a visit to Afghanistan. Medical supplies and pharmaceuticals were collected and sent to Cuba. Members of the Hispanic community (a) participated in screenings for diabetes and osteoporosis, (b) were involved in a child identification project with photographs and fingerprints, and (c) received free eye or vision examinations and glasses (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008).

The third category of the overall cultural aspect addressed the two gender groups. Goals for the gender groups were to increase participation in specific self-examination and screening activities and to begin support groups for breast or prostate cancer. Educational offerings that addressed women's health included programs on (a) women and heart disease, (b) women's nutritional issues, (c) breast self-examination, breast cancer, and mammograms; and (d) menopause and hormone replacement therapy. Organized activities included well-women outings to a variety of community locations. One faith community nurse sponsored "Girls on the Run." This activity was for girls in third, fourth, and fifth grades and topics included nutrition, peer pressure, and developing a spiritual life (Hamilton & Moore, 2007). Programs and activities that focused on

specific areas of men's health included "Men of the Church: Health Ministry and You", and offerings on men's nutrition and fitness, and prostate and testicular cancer. Mother's Day and Father's Day had special recognitions at some faith communities. Men participated in prostate specific antigen testing, women obtained mammograms, and both groups participated in blood pressure, glucose, cholesterol, osteoporosis, vision, and hearing screenings. Those with abnormal findings were referred to health care providers for further care (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008).

Other statements focused on the culture of individuals with similar social circumstances such as homelessness, multi-generational families, domestic violence, or substance abuse. Goals that were relevant to these situations were to (a) establish a volunteer medical team to provide health care to the indigent in the community, (b) provide free influenza vaccinations for homeless individuals, (c) host smoking cessation networks and facilitate support groups, (d) increase awareness about caring for aging parents, and (e) offer drug abuse education for youth groups. Educational activities and presentations that focused on this cultural group included (a) Effects and Hazards of Smoking; (b) Anti-Drug, Alcohol, & Smoking; (c) Partners in Public Health: Violence; (d) Elder Abuse, Neglect, Exploitation for Caregivers; (e) Severe Weather and Tornado Plan for the Shelter Building; and (f) Today's Grandparents. Several accomplishments for this cultural group were described in the annual reports. One faith community nurse reported on an organized health care team that provided service to indigent individuals. Health ministries were started for homeless families in the community. Counseling

services and referral to community resources helped several families in crises situations. Individuals and families received assistance in locating to emergency shelters. Free influenza vaccinations were given to homeless individuals. Collections of clothing and health care supplies contributed to hurricane relief (Hamilton & Moore, 2004). Nurses sponsored a substance abuse symposium and organized activities that raised money for Habitat for Humanity and the Clare House for Battered Women (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008).

The fifth component was the culture of persons with similar health situations such as pregnancy, cancer, diabetes, or depression. Other chronic conditions included heart disease, hypertension, osteoporosis, HIV/AIDS, and Alzheimer's Disease. Goals related to this category were to (a) help members with chronic disease management, and (b) provide assistance, support, and respite for caregivers. Examples of educational offerings applicable to this group were (a) What to Expect When Expecting, (b) Difference Between a Diabetic Coma and Insulin Shock, (c) Hypertension and Heart Disease, (d) Colon Cancer, (e) Bone Health, (f) AIDS 101, and (g) What People of Faith Need to Know about Depression. Many individuals improved their compliance with medication and chronic disease management. Nurses worked in their individual faith communities as they provided meals, social interaction, and support for individuals with HIV/AIDS. Several people participated in support groups organized and facilitated by the faith community nurses for physical and mental conditions. Examples of support groups included those for individuals with (a) breast or prostate cancer, (b) cerebral vascular

accidents, (c) Alzheimer's Disease, (d) anxiety or panic disorders, and (e) grief (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008).

The final category consisted of miscellaneous characteristics that pertain to an assortment of cultural factors. The electronic culture of society was addressed by one nurse who linked health-related websites to the faith community's website (Hamilton & Moore, 2001). One nurse sponsored "Turn Off the TV" week. This initiative promoted interactions and building relationships with others and encouraged physical activity (Hamilton & Moore, 2002). As a nation, the citizens of the United States of America became members of a post-terrorist attack culture following the events of September 11, 2001. The report for the fourth year provided some references to these attacks. An appropriate educational program was "The Bible as a Source of Strength in the 9-11 Tragedy" (Hamilton & Moore, 2002). The annual reports included many references to the societal culture of obesity. Educational programs that addressed this issue were (a) Big as Life--Obesity in America, and (b) Making Wise Choices at Fast Food Restaurants (Hamilton & Moore, 2007). Finally, one of the reports from a specific faith community indicated that "a nurse can be a catalyst for creating a culture of health awareness in a congregation" (Hamilton & Moore, 2007).

### **The Financial Impact**

**Definitions and coding decisions.** The description of the financial impact of the faith community nursing program was derived from responses to the fifth item on the impact questionnaire. This item included specific definitions of financial based on the conceptual definition of financial. The conceptual definition was that aspect which includes the

ability to earn money and affects the appropriate and responsible use and control of monetary resources. The specific definitions were “the ability to earn and use money” for faith community members and “the ability to earn, use, and control money and monetary resources” for clergy participants and nurse participants. A fundamental example pertained the use of monetary resources and content that addressed buying food, paying for medications, spending for the children, or saving for retirement was considered as financial impact even when this subject matter was located in another area of the impact questionnaire. Additional information concerning the financial impact was based on deductive codes that were established prior to data analysis and inductive codes that emerged during data analysis. Examples of deductive codes for this area of impact were (a) financial impact, (b) financial intervention, and (c) the faith community nursing role of referral agent. Attributes of the faith community nurse were an inductive code and concepts that applied to this area of impact were cost-effectiveness, cost-efficiency, cost savings, and wise spending. Finally, the description of the financial impact was based on synonyms of terms in the conceptual definitions, the specific definitions, and related deductive and inductive codes. The Microsoft Office Online English Thesaurus (Microsoft Corporation, 2003) was used to list synonyms for various terms and the word documents were examined for related content. An example for this area of impact was the term “buy” and synonyms included (a) pay for, (b) purchase, (c) shop for, (d) get, and (e) obtain.

**Financial impact related to the conceptual model.** The financial impact of the faith community nursing program was related to three of the four adaptive modes in the RAM.



From a broad perspective, study participants described the financial impact with multiple references to (a) obtaining resources, (b) health care costs, (c) saving money, and (d) the concept of free. This area of impact was first associated with physical subarea of the physiologic-physical mode. The physical mode is for humans in groups and one area of adaption pertains to capital resources and fiscal adequacy. Capital resources are necessary for significant and infrequent purchases necessary to support adaptation and the ongoing integrity of the human system. Significant purchases may refer to nutritional items, and pharmaceutical materials necessary for oxygenation, elimination, or endocrine functions. Infrequent purchases may pertain to costs for major health care issues. Activity and rest processes impact the ability to acquire capital resources. As fiscal adequacy changes into fiscal inadequacy, the integrity of the system is compromised and the result is manifested through ineffective behaviors. Study participants mentioned (a) the lack of financial resources to pay for health care; (b) the ability to save money as a result of interactions with the faith community nurse; and (c) the importance of free health care, health education, health advocacy, and health counseling provided by the faith community nurse. Each of these factors support and maintain effective adaptation and integrity of human systems. Next, the financial impact was related to the role function mode. One secondary role is the job position or employment status of the person. This role is relevant to obtaining and using resources. The ability to work and financially provide for family members and the decreased amount of time lost at work due to illness were examples of financial impact in this adaptive mode. The third adaptive mode that the financial impact pertained to was the interdependence mode. This mode is concerned

with relationships between people that involve the willingness and ability to share material possessions and financial resources. Many statements in the data referred to sharing material and financial resources in a variety of ways. Some examples were (a) helping with basic needs of food, clothing, shelter, and medications, (b) assisting economically disadvantaged populations, and (c) meeting needs of others in the faith community setting. These examples indicate how the financial impact corresponded to the RAM. The RAM was a satisfactory framework for the assessment of the financial impact and results indicate satisfactory degrees of integration between the RAM and the financial impact as reported by the study participants.

**Brief summary of the financial impact.** Individuals who returned questionnaires described the financial impact with several different themes. In their responses, all three participant groups reported (a) the concept of free, (b) saving money, (c) budgeting principles, (d) ability to work, (e) economically disadvantaged individuals, and (f) costs versus benefits. Faith community members and clergy representatives included the costs of having the nursing program while the faith community nurses included lack of payment for their services. Faith community members mentioned the financial crisis of society and lack of health insurance benefits. Clergy representatives mentioned the importance of being self-supportive and productive. Responses from nurses focused on access to health care, locating resources for financial assistance, health care costs avoided through their interventions, and future financial benefits of education. Only faith community members indicated no financial impact from the nursing program.

**The financial impact according to faith community members.** Faith community members gave a variety of answers for the financial impact of the nursing program. Four participants mentioned the ability to work or continue working. One woman answered, “Financial impact for me is finding county services that help with aging adults, like Hospice, which allows me to work and have someone to help with aging adult.”

Four people referred to the concept of free. One participant mentioned that the program had provided free health care and information. One man indicated the benefit of getting his “blood pressure checked without cost.” A third person responded, “Yes the program help a lot of our people but most of the people didn’t qualify for certain things but the free things help.” The fourth answer for this category was, “Being elderly & retired, I appreciated that all the help I received was at no charge.”

Several participants gave answers that pertained to saving money. One man wrote that he saved money through (a) health fairs, (b) health screenings, (c) regular blood pressure checks, (d) early detection of health problems, and (e) lower dosages of required medicines. A woman referred to faith community activities and responded,

There have been various topics and speakers at our monthly luncheons that have saved me money now and in the future regarding Medicare, living wills, and prevention of serious illness. Excellent resource.

Another faith community member gave the following answer to the financial impact question.

The financial impact community nursing has had on me (us) concerns savings rather than earning. For example, we switched our health insurance based on the information provided by a team of guest speakers who are experts in insurance. We

also share food shopping tips and health tips and suggestions which hopefully save on medical expenses.

Responses from two other individuals related to money saved with nutritional expenses. One female member wrote, “Her emphasis on exercise and eating nutritionally well-balanced meals keeps us healthier and as a result saves us money.” Another woman replied, “Members are aware of labels on cans and know that buying foods in season are more economical. Also ‘Meatless Wednesdays’ represent saving on meats--using beans which are cheaper & in most cases, just as nutritious.”

Budgeting principles was a theme for answers from four participants. An Asian-American woman wrote, “Spend less than what we earn. Always live below our mean.” An elderly woman replied that the faith community nurse had “helped some people with household management and financial direction.” Another woman referred to better budget practices in this response.

I have learned how to budget better and to use my income very wisely or pay the consequences. I am more aware of what I really need and what I would just like to get. I am in much better financial shape than when I started the program.

An African-American man who addressed other financial issues with a reference to his budget wrote the fourth example.

If we are not in good health we cannot provide for ourselves and our families. The more we have to spend on unnecessary health issues the less [sic] we have for our families. The cost of medical bills is a tremendous burden on families in today’s economy. I am personally realizing this for myself. I had no idea how expensive high blood pressure can be even with insurance this is an added expense that I can work on that I can possibly get off of until then this puts an added expense to my budget.

Answers from other participants had an assortment of topics. One man replied that he was “unable to sustain without assistance.” A woman simply wrote, “Very helpful.” One participant responded that faith community nurses are (a) most important, (b) greatly needed, and (c) very essential if nursing services are not a benefit of health insurance policies. Another man indicated the nurse “advises me to get my moneys worth from medication and the hospital and doctors offices.” One woman mentioned, “Currently, we are in a crisis--not only in providing health care, but financially, and in so many other ways.” The response of another woman included how her personal faith community pays operating expenses, supplies, and other items for the faith community nurse. A seventh participant provided the following answer.

No financial impact on me personally but I recognize that the parish nurse program plays a major role in identifying those members of our church who are in need of financial assistance and to bring that need to the attention of the church.

Five additional individuals indicated no financial impact from the faith community nursing program.

**The financial impact according to clergy representatives.** The fifth area of financial impact also had a variety of answers from the clergy participants. One clergy representative described this subject as very important. Some answers addressed money saved through (a) fewer physician office visits, (b) decreased number or doses of medications, (c) reduced driving to obtain medical care, (d) prevented hospitalizations, and (e) improved personal budget practices. One clergy representative wrote about less time being lost from work due to illness and another mentioned how the faith community

nurse brings one-on-one health care assistance for those who are economically disadvantaged. Two of these participants responded about individuals or families who had become financially self-supportive and productive. Another man mentioned the costs to the faith community in terms of salary, supplies, and equipment but wrote, “The benefits of this role/trained individual outweigh the costs.”

**The financial impact according to faith community nurses.** Faith community nurses described several types of financial impact. The first type involved access to health care. The answer of one nurse was that a major portion of her ministry was involved with helping people find access to health care. Another nurse declared, “We have made some impact in ER costs by encouraging individuals to prevent problems and to seek care from clinics instead of the ER.” A third nurse wrote that “Probably the biggest impact has been averting ED visits, by assessing issues and triaging to more appropriate care.” The response of a fourth nurse was “There are folks that without the CN contact and making calls to get them in the door they would have went without care or ended up in the ER.” In a final example, the nurse mentioned the financial benefits of issues that could be handled without a physician’s office visit. This nurse provided the following response.

The services of FCN is free so for the many of seniors on limited budget helps them have someone to run things by before running to the doctor. At times FCN can talk to dr and save a trip to the office.

One response that summarized the second category was “Another financial impact the parish nurse makes is the identification of medical problems before they become serious

and/or expensive.” Two nurses wrote about averting potential strokes or heart attacks and the related cost savings. A third nurse described how she monitored and supported a congregant with depressive symptoms and prevented hospitalization of that individual.

The effects of healthier lifestyles provided some financial impact. One nurse described the following scenario:

One individual who was on BP medication lost weight and was exercising came to me complaining of dizziness. His BP had dropped below 100 systolic and I suggested he talk with his doctor about decreasing his medication. They tried several adjustments and finally found that ¼ tab held his BP at a good level.

She continued her response about other people that experienced monetary savings and wrote, “This new lifestyle lowered their BP enough that I referred them to their doctor to see if their BP medication could be reduced. Less medication means lower cost for the medication.”

The topic of the fourth type of financial impact was resources. One nurse reported that a large part of her ministry was “finding resources to help with finances and even actually going with them to get the resources.” Other responses involved finding resources for (a) healthcare, (b) dental care, (c) medication, (d) food, (e) clothing, (f) shelter, (g) furniture, and (h) substances abuse treatment. Another nurse concluded her answer to the financial impact question with “Finding available resources has definitely had an impact on the faith community.”

Nurses provided some miscellaneous statements that addressed the financial impact. One nurse wrote about budgeting and spending practices of some clients. Another mentioned that financial benefits would be realized as individuals were “promoting

healthy living and medical care to others in the community.” In a third response, the nurse answered that without the nurse’s involvement, some people would not be able to remain at home but would require skilled nursing home placement. The final example was “She evaluates programs/screenings to determine cost efficiency and will partner with other congregational nurses to get the most beneficial result.”

The response of one nurse included three examples of the financial impact that individuals and families would experience from ongoing education. She documented the first situation as, “The poverty cycle is a difficult thing to break. I’m trying to help the parents see that helping their children to stay in school may enable their children to be the ones to really break the cycle.” She then described how she wrote a letter of support, “to enable this young lady to qualify for her scholarship and return to school. Getting her education is her only way to get up and out of her poverty situation.” Her response to the financial impact question ended with “Helping the adults in the families get their GED gives them a greater chance for a better job and a better future.”

Nurses at some faith communities associated with this program are not financially compensated for their work. Instead, they willingly and freely provided their services to individuals, families, and groups, and in doing so, contributed to the financial impact of the program. The answer of one nurse that addressed this contribution was “We are voluntary--we do not get paid. We practice as a faith gift of our talents.”

**The financial impact according to the annual reports.** Based on review of the ten annual reports, the faith community nursing program has had a significant financial impact on the community. The first illustration of a financial impact was described in the



first annual report. Because of some economic issues, a woman with hypertension had not been examined by a physician in over 40 years. The faith community nurse served as an advocate for her and helped her to obtain affordable medical care (Hamilton & Moore, 1999).

Other examples of the financial impact were presented in the second annual report. Two men who participated in an osteoporosis screening were referred to physicians due to abnormal results, and started on appropriate treatments. This illustration emphasized community health screenings as effective methods that contribute to the prevention, early detection, and early treatment for osteoporosis. These are key elements in preventing costly complications and decreasing health care costs for this disease (Hamilton & Moore, 2000). That same year, program activities featured (a) financial assistance for housing, shelter, food, and medical care needed by parishioners and community residents faced with emergency or crisis issues; (b) assistance with locating less expensive prescription medications; and (c) assistance for medically underserved persons to access available resources (Hamilton & Moore, 2000).

During the third year of the program, several nurses worked on various community and state groups that focused on poverty, health promotion, and tobacco cessation. These areas have wide-ranging financial implications. One faith community was able to offer immunizations to a previously underserved group. Another faith community offered free skin cancer screenings and free bone density scans (Hamilton & Moore, 2001).

Several examples of financial impact were described in the fourth annual report. The faith community nursing program provided toilet articles and baby needs to over 20

sheltered families. One faith community gave free food, clothes, and games for neighborhood children. Four faith communities sponsored free osteoporosis screenings and 943 individuals participated in this money-saving health activity. A different faith community provided free dental examinations and free spinal examinations. An additional faith community organized a medical team to staff a health care clinic for the indigent. Another faith community provided free full lunches for 25 individuals during an 11-month period. Three specific illustrations were described. The first case was a woman with a back injury who was staying at a homeless shelter after she lost her job and was displaced from her rental home. The nurse was able to help the woman find employment within her physical limitations. Another situation involved a single disabled mother who gave birth to twins. The nurse sought help from the congregation and the family was given multiple baby products, and a washer and dryer for their home. A third illustration described how the faith community nurse discovered that a man and his wife were entitled to medical care through the Tri-Care program. Because the nurse intervened and helped this family, the final hospital bills were completely covered and the widow avoided a financial hardship after her husband died (Hamilton & Moore, 2002).

A financial impact story described a similar situation in the fifth year annual report. The faith community nurse found out that that a woman qualified for Tri-Care, an insurance program that pays all medical expenses for veterans and their families. This woman had struggled for years to make ends meet as she lived on a farm and supported a disabled son. She was relieved of financial burdens that she had borne for many years (Hamilton & Moore, 2003).

A variety of financial impact situations were described in the sixth year annual report. Faith community nurses connected individuals and families in crisis circumstances to community and state resources. Ministries to disadvantaged people continued. One nurse helped a mother with a brain damaged son secure a financial trust that will cover his future needs while another nurse assisted a single mother to pay her electric bill and find new employment. Free influenza vaccinations were given to 400 individuals and free cholesterol screenings were performed for 71 Montagnards. People received assistance with medication expenses. Money raised from the sale of Mother's Day and Father's Day Remembrance Cards at one faith community was donated to Habitat for Humanity and The Clare House for battered women. Toothbrushes and toothpaste were given to neighborhood children at health fair sponsored by another faith community. An additional faith community donated fresh-grown produce to organizations that provide meals for needy individuals. A different faith community collected clothing and supplies, and supported American Red Cross efforts for monetary donations to assist with needs created by hurricanes in North Carolina and Florida. Finally, references were made to the financial savings realized through early interventions that prevented possible myocardial infarctions or cerebral vascular accidents (Hamilton & Moore, 2004).

The faith community nursing program continued to make a financial impact for underserved or disadvantaged persons in the next two years. Collaborative relationships were maintained between the program, the community, and several state resources. Many people were assisted with a variety of needs (Hamilton & Moore, 2005). Five hundred free influenza vaccinations were given to homeless individuals, immigrant populations,

and elderly people on fixed incomes. Free eye examinations and free glasses were provided for members of the Hispanic population. Ten needy individuals received free glucometers. A single mother with two children received financial assistance with medical needs. One volunteer health team gave over 400 bags of groceries to families with financial difficulties. A potential financial scam that would have cost an elderly woman several hundred dollars was averted through an appropriate and rapid intervention by the faith community nurse. Another nurse advised a client with dental needs to get a referral for dental care from her primary care provider. This recommendation was worth more than the limited financial support that she might have received from the faith community. Participants at a cholesterol screening were given information concerning financial resources. Increased knowledge of childhood diseases helped parents recognize symptoms earlier so that children were treated at home and expensive medical treatment was prevented (Hamilton & Moore, 2006).

The ninth annual report mentioned an assortment of circumstances that yielded a financial impact. References were made to the potential financial benefits through appropriate management of chronic conditions and prevention of long-term complications. Through involvement with the faith community nurse, a diabetic man has lowered his capillary blood glucose levels and decreased his insulin requirements. This created financial savings for that individual. The increased number of individuals that have stopped smoking have caused other financial savings. One faith community provided a nutrition and cooking class that emphasized economic food preparation. Several faith communities supplied assistance with purchasing medications for at-risk

members. Nurses coordinated home health agency and community services that allowed clients to be cared for at home instead of placement at a long-term care facility. They have assisted individuals without insurance gain access to health care. Interventions by faith community nurses (a) located a primary care provider for a member who was using the emergency room for non-emergent health issues, (b) helped homeless substance abusers receive care at appropriate and available facilities instead of going to the emergency room, and (c) averted emergency room visits and prevented hospital admissions (Hamilton & Moore, 2007).

The final annual report described a variety of circumstances that produced positive financial outcomes for faith community members. Faith community nurses connected members with community resources that (a) stopped frequent emergency room visits, (b) provided free transportation to physician offices, (c) made free eye examinations available for individuals without health insurance, (d) gave mammogram scholarships to members, and (e) supplied individuals with prescription medications. After participating in exercise classes, a diabetic woman lost enough weight that she no longer needs medications for her diabetes. Her medication costs have greatly decreased. Because of information provided by the faith community nurse, a clergy member also lost weight and was able to have his blood pressure medication lowered. This generated financial savings for him. The faith community nurse intervened for a member without heat and water and located resources that provided these basic needs. A previous substance abuser has been drug free for a year and is not spending money on illicit or illegal drugs. Faith community nurses participated in the Women's Only 5K. This program benefits women who cannot

afford mammograms. Finally, the report mentioned that immunizations, early detection of acute and chronic illnesses, and early treatment of health conditions decrease the amount of time lost at work and decrease the expenses associated with treatments (Hamilton & Moore, 2008).

Educational programs that focused on the financial aspect also contributed to the financial impact of the faith community nursing program. Several offerings that focused on government sponsored health care initiatives were (a) Medicaid Updates and Guidelines, (b) Medicaid, Medicare, and In Home Care, (c) Medicare, Medicaid, and Alternative Living Options; (d) Long Term Care and Medicare, and (e) Medicare Part D. Other programs that concentrated on financial savings were (a) Saving Money on Health Care, (b) Financial Aid for Medications, (c) Generic Versus Trade Drugs, (d) Scams Targeting Seniors, (e) Avoiding Illness on Vacation, and (f) Do You Need to Go to the Emergency Room? Additional topics with financial impact were (a) End of Life Issues: Long-term Care Insurance, (b) End of Life Issues: Estate Planning, (c) Do You Have the Right Amount or Too Much Medical Insurance and What to Look For, and (d) Welfare Reform.

### **The Spiritual Impact**

**Definitions and coding decisions.** The description of the spiritual impact of the faith community nursing program was derived from responses to the sixth and final item on the impact questionnaire. This item included specific definitions of spiritual based on the conceptual definition of spiritual. The conceptual definition of spiritual was that aspect which includes the value system, belief system, and self-evaluation system so that one

can exist with a sense of unity, continuity, integrity, meaning, purpose, satisfaction, and fulfillment in society and in the universe. The specific definition was “the value, belief, and self-evaluation systems so that you can exist with unity, meaning, purpose, and fulfillment in society and in the universe” for faith community members. The specific definition was “the value, belief, and self-evaluation systems so that one can exist with a sense of unity, meaning, purpose, and fulfillment in society and in the universe” for clergy representatives and faith community nurses. A fundamental example pertained to belief systems and content that addressed belief in God or relationship with God was considered spiritual impact even when this subject matter was located in another area of the impact questionnaire. Additional information concerning the spiritual impact was based on deductive codes that were established prior to data analysis and inductive codes that emerged during data analysis. Examples of deductive codes for this area of impact were (a) spiritual impact, (b) spiritual intervention, and (c) the faith community nursing role of integrator of faith and health. Biblical principle was an example of an inductive code that applied to this area of impact. Finally, the description of the spiritual impact was based on synonyms of terms in the conceptual definitions, the specific definitions, and related deductive and inductive codes. The Microsoft Office Online English Thesaurus (Microsoft Corporation, 2003) was used to list synonyms for various terms and the word documents were examined for related content. An example for this area of impact was the term “purpose” and synonyms included (a) reason, (b) motivation, (c) cause, and (d) goal.

**Spiritual impact related to the conceptual model.** The spiritual impact of the faith community nursing program was related to the self-concept/group identity mode, the role function mode, and the interdependence mode of the RAM. From a broad perspective, study participants described the spiritual impact in a holistic manner with multiple references to their beliefs, purposes, values, and relationships with God. Many spiritual activities contributed to the process of becoming more integrated as a human being with evidence of spiritual growth, spiritual support, and the integration of faith and health. On an individual level and in the self-concept mode, spiritual integrity is a basic need concerned with knowing oneself and existing with unity, meaning, and purposefulness. One component of the personal self is the moral-ethical-spiritual self. This component includes the belief systems and evaluation processes that determine who one is in the greater universe. Examples from study participants included the value of family, the importance of caring and presence, the offering of hope and compassion, the balance between physical and spiritual health, and the connection between the body, mind, and spirit. The spiritual impact was also related to the role function mode. Tertiary roles are freely chosen by an individual, and study participants mentioned being individuals who (a) participated in the religious activities of the faith community, (b) served as a volunteer at activities organized by the faith community nurse, and (c) received prayer and other types of spiritual support from the nurse. Faith community nurses also reported being listeners and being present with individuals and families. Finally, the spiritual impact was associated with the interdependence mode. The context is one subarea of the interdependence mode and it includes internal and external stimuli that influence the



relationships between people. External variables include religious and spiritual factors while internal variable include values, beliefs, principles, and evaluation methods that contribute to meaning, purposefulness, satisfaction, and fulfillment in the universe. The effective adaptation and integration of these variables into relationships promote hope, comfort, acceptance, and unity and these were specific benefits related to the spiritual impact. Ineffective responses suppress integrity and adaptation, and cause loneliness, despair, anxiety, division, and pain. Part of the spiritual impact reported by participants referred to the reduction or elimination of these ineffective behaviors. These examples indicate how the spiritual impact corresponded to the RAM. The RAM effectively allowed the assessment of the spiritual impact in this study. Results suggest a high level of compatibility between the RAM and the spiritual impact as reported by the study participants.

**Brief summary of spiritual impact.** Study participants described the spiritual impact a variety of themes. Individuals in each of the participant groups addressed the connection between spiritual and physical health or between the body, mind, and spirit. The concepts of (a) hope, (b) compassion, (c) comfort, (d) value, and (e) care or caring were recurrent themes in responses from the three participant groups. Additional topics mentioned by all participant groups were spiritual support and specific spiritual benefits, and these benefits were described with many different adjectives. Faith community members, clergy representatives, and faith community nurses included God, prayer, and religious activities in their answers. Faith community members mentioned laughter, fun, helping others, and blessing. Clergy representatives wrote about intangible touch of the

nurses. Faith community nurses included (a) the intentional inclusion of the spiritual component, (b) meeting the needs of others, and (c) the importance of listening, accepting, and being present.

**The spiritual impact according to faith community members.** Faith community members described the spiritual impact of the nursing program with a variety of responses. Many participants included the concept of care. In eight situations, individuals referred to themselves as recipients of the nurse's care. One man wrote that the nurse "cares about your health and you can tell personally that she is concern [*sic*] about you." The answer of a woman was "things help when you have someone giving you the right health information and someone who cares about you and our nurse does." One individual mentioned that by taking care of personal needs, people can reach out to others and care for them. Three other answers pertained to caring for other people and one response is provided.

I find the parish nurse program very rewarding spiritually as mentioned in my answers to previous questions. The program helps the church and members stay connected by assisting, showing love, and caring for members in need. All of these activities help me in my spiritual growth.

Four people used the concept of blessing in their responses. One woman gave the following example.

Faith community nursing is a blessing and wonderful ministry. We have several older adults in our congregation who have been regular participants in this program. What a blessing and I hope it continues. It is such a blessing for so many people.

Responses from four participants indicated that laughter was part of the spiritual impact. Four individuals also reported that having fun contributed to the spiritual effects of the faith community nursing program. One person included both of these concepts and wrote that during an exercise class, “we laugh a lot and have fun together.”

Twelve individuals combined the spiritual and the health aspects in their responses. One person wrote, “The FCN is the resource for the town/community working with all age groups, to improve mind, body, and spirit.” A second example was, “Spiritually the impact is strong in that it is an aide in helping to get and stay healthy and to be more spiritually involved in my faith community and in life in general.” Other answers included (a) confronting the spiritual and physical things, (b) addressing the spiritual side of health care in written materials, (c) having spiritual faith to cope with emotional events, (d) putting faith to work for different health results, and (e) remembering that physical bodies are a gift from God.

Several people answered the spiritual impact question with references to God. A man wrote, “My health is the most important thing that I can do for myself (**after accepting Christ**) that will have a great impact on me now and in my future.” One response was that remaining healthy and protecting natural resources was necessary for service to God’s people. Another answer indicated that staying healthy and serving others was a method of praising God. A homebound individual wrote the nursing program was a God-given gift. Another participant replied that programs led by the nurse help people grow in their faith in God. The response of an African-American man mentioned that a principle of God’s Word is that people be in good health and have prosperity. An Asian-American

woman wrote, “I have to stand firm in my belief & use the ability & talent that God has given me to be a good wife, mother & a partner that my husband can counted [sic] on.”

One person characterized the nurse as God-Christ-like people loving. Another participant described the faith community nurse as a child of God in the following example.

The ministry is very unique in that the nurses provide their services with God’s Holy Spirit showing through them. It is so obvious, reassuring, and inspiring. It affirms the Holy Spirit in you and knowing that this child of God is here to minister to us through her gifts and knowledge of medicine and medical resources.

In another example, the participant referred to herself as a child of God with spiritual benefits.

I am so much more aware that I am a child of God and needed in the world and in society. I read the Bible more often and study and meditate on spiritual things and that effects [sic] all areas of my life. I laugh more often!

Individuals reported they benefitted spiritually by (a) volunteering to help with programs, (b) observing the value of programs, and (c) reaching out to help others. Other participants described the spiritual impact as (a) beneficial, (b) positive, (c) inspiring, (d) very important, (e) reassuring, (f) rewarding, (g) invaluable, and (h) priceless. Two more answers reveal more about the spiritual impact of the faith community nursing program. One participant replied, “The spiritual impact of FCN on me has been great. It made me a more compassionate person and helps me better understand why people think like they do under certain circumstances.” The other individual gave this response.

The spiritual impact of FCN program is unmeasurable [*sic*]. To know that someone is there to back you, support you, educate you, and believe in you is fabulous. To know that someone will pray with you & for you without judgment is fantastic.

**The spiritual impact according to clergy representatives.** The responses of all clergy representatives mentioned the spiritual impact. Benefits that faith community members experienced through interactions with the nurse were (a) hope, (b) comfort, (c) inspiration, (d) nurtured and uplifted spirits, (e) balance between physical health and spiritual health, and (f) awareness of and attention to the connection between body, mind, and spirit. One male clergy representative addressed the intangible spiritual impact and wrote, “She touches people in many ways but through prayers and empathy, she touches their very souls.”

**The spiritual impact according faith community nurses.** The faith community nurses in this study gave a variety of responses to the spiritual impact question. Two nurses mentioned the deliberate inclusion of the spiritual aspect of their practice. One nurse answered “I bring an intentional spiritual component to my work.” The other nurse gave the following response.

As this is an area that we all as nurses incorporate into our practice, being in a setting where that is an “intentional” incorporation, speaks volumes for this program. In almost every encounter, I am aware that the spiritual aspect is addressed. It comes naturally and still sometimes surprises me that this impacts ever interaction.

Three nurses included the importance of listening as part of the spiritual impact. The first example indicated a willingness to listen. Another response was about becoming a

better listener. The third statement was, “I listen to them more than I ever could in hospital setting.”

Prayer was another basic feature of spiritual impact. Two nurses wrote that all clients and their family members are offered prayer. The nurses reported that prayer gave hope and instilled courage. Prayer was perceived as meaningful, essential, and welcomed. Members asked for special prayers for their family and friends. One nurse reported a spiritual outcome of a community health fair was that “a lady who had just placed her mother in a nursing home was given a prayer shawl by the ladies from our prayer shawl ministry to give to her mother.” Another nurse wrote, “Of particular impact is when I pray with parishioners.”

Nurses described the spiritual impact with the concepts of (a) hope, (b) comfort, (c) care, (d) meeting needs, (e) acceptance, and (f) presence. A nurse described two individuals in her faith community with chronic debilitating health conditions. Both persons felt they had lost their spirituality. She wrote, “In both instances my willingness to come to their home, listen and exchange points of view and pray with them has given them hope.”

Four nurses included the concept of comfort in their responses. One mentioned how “being kind and helpful to the underserved clients places those clients in a comfort zone.” Another nurse wrote about offering comfort to people experiencing complicated health issues or making end of life decisions. According to a third nurse, faith community members had a greater comfort level seeking help from the nurse because of confidentiality. The final answer with comfort as spiritual impact was, “By being

accessible to the congregation, I feel my presence gives comfort even when I have no formal role in the event I attend at the church.”

Care was another part of the spiritual impact of the faith community nursing program. One nurse simply wrote “holistic care” as her answer. The response of a second nurse was that care provided by the nurse was an extension of the pastor and pastoral care. Another nurse mentioned the requirement of a genuine caring attitude. A fourth answer to the spiritual impact question was “Love and caring are demonstrated.” The last nurse wrote that she provided spiritual support, “often just a presence, communicating I care.”

Meeting the needs of faith community members was an additional area of spiritual impact. One nurse provided this response.

The congregational nurse is sensitive to the spiritual needs of the members served. She meets clients where they are i.e. in the home, hospital, etc. A simple thinking of you card to lift the spirits of an home bound member at times when one really needs a boost. She prays with the family, works with the pastor to meet the needs of the members.

Much of the ministry of the faith community nurses is with the underserved populations of homeless individuals, elderly persons, and members of racial, ethnic, or cultural minorities. One nurse referred to these underserved clients and wrote, “I want them to feel it’s all about them and their needs and not about me or the church. That is what Christ’s healing ministry should be about.”

Three responses from faith community nurses mentioned the fundamental principle of acceptance. One nurse reported how she accepts “people right where they are and who they are.” Another nurse echoed this thought and wrote how “Acceptance of each person

whatever their circumstance” had contributed to the spiritual impact. A third nurse provided the following answer.

I think there has been a real spiritual impact in the area of valuing the body we have been given and caring for it. Also, demonstrating that you value each individual because they are created by God, and loving them for who they are and accepting them without trying to impose your values on them.

The concept of presence appeared in four answers. Two responses indicated that presence gave comfort and communicated care. One nurse reported, “Presence and attention are provided to all who come to the nurse.” Another nurse replied to the spiritual impact question with “It always amazes me about the power of presence. I may think that I have done very little during a visit, but then have the parishioner tell me I was exactly what was needed.”

Some of the spiritual impact described by the nurses focused on religious activities. Two nurses included home communion for the members in their answers. One nurse mentioned that a homebound woman was reading her Bible again and that God had re-entered this person’s life. Another nurse reported that she updated homebound members on activities at the church. She continued her response with “I have a tape ministry which allows me to bring a tape recording of the worship service to them so they can be a part of the worship too.” She concluded her answer to the spiritual impact question with “I also suggest when it would be appropriate to anoint with oil for healing. I have occasionally transported clients to church who can’t get there any other way.”

The nurses provided a variety of other responses. Three answers included spiritual growth or improvement. Five individual nurses mentioned compassion, empowerment,



insight, confidentiality, and support. Other aspects were (a) appreciating time spent with clients and family members, (b) discussing spiritual interpretations, (c) understanding belief systems, and (d) opening doors to new thought patterns.

**The spiritual impact according to the annual reports.** The spiritual component was frequently mentioned throughout the ten annual reports. Many statements described and supported the spiritual impact of the faith community nursing program. Six separate categories identified in these documents are (a) descriptions of general impact, (b) accounts of specific impact, (c) educational items that focused on the spiritual aspect, (d) ongoing activities, (e) program goals pertaining to the spiritual component, and (f) lessons learned that involved spiritual principles.

The annual report included some descriptions of general spiritual impact. The faith community nursing program began strongly and never wavered. The strong support of the faith communities and their witness in the broader community contributed to program's early success and spiritual impact. Clergy personnel appreciated the holistic gifts and professional skills that the nurses brought to the care-giving ministries of the faith communities. The Christian beliefs of the nurses helped sustain the program. General descriptions included growth in personal relationships with God and with other people. Individuals demonstrated more active participation in faith community events. Members developed increased appreciation for the physiological manifestations of grief and loss. Many families were assisted with end-of-life issues. Times of spiritual reflection at monthly meetings and retreats were reported as enriching experiences for faith community nurses. The connection between spirituality and health was a recurring

spiritual impact theme. Awareness of the body-mind-spirit integration was another topic that appeared frequently (Hamilton & Moore, 2000, 2001, 2002, 2007, 2008). One nurse wrote that “it is such a joy to have the freedom to minister to the whole person-mentally, physically, spiritually, and emotionally” (Hamilton & Moore, 2002).

The annual reports also contained several accounts of specific spiritual impact. Through the interventions, advice, and care-giving of a faith community nurse, a woman that was in an abusive relationship relocated her living situation. She experienced happiness and improved self-esteem, and expressed gratitude for a new life (Hamilton & Moore, 2000). One nurse reported that spiritual impact occurred “in meeting with the person exactly where they are and then walking with that person on their personal journey” (Hamilton & Moore, 2001). Another nurse described the impact of having a women’s book study to beat the winter blues. Participants were delightfully honest and quickly formed a bond. The nurse enjoyed watching the manner the way the women cared for each other and wrote, “The feminine became even more beautiful as their stories bumped into one another and their hearts connected”. Another faith community nurse reported how she and her family shared some garden space with an immigrant family. The garden became a place of friendship, a method of exchanging ideas, and a time for sharing both ways. In the garden, the immigrant mother came out of her sadness and was able to laugh. This ministry to body, mind, and soul was a true example of the spiritual impact. An additional nurse shared letters as a testimony of the spiritual impact of her work families in her faith community. In one letter, the family member expressed thankfulness for the service of the nurse and then wrote, “You made it possible for her to

leave this world at peace and with the dignity she deserved.” Another person also expressed gratitude for the nurse’s help and wrote, “It is a great consolation for me to know you are there with her, helping her, doing the things I wish I could do. But I am not a nurse....You are an angel for my mother and a gift to me too” (Hamilton & Moore, 2004). One faith community nurse wrote that for a woman facing cancer “being able to pray with her, touch her, and counsel her was so rewarding for me and it appeared to give her comfort” (Hamilton & Moore, 2006). In the report for 2007, a faith community nurse was perceived as a resource that is able to deal with multiple and complex concerns with physical, emotional, mental, spiritual, financial, and social aspects (Hamilton & Moore, 2007). The reports included accounts of (a) members who were able to return to church services occasionally, (b) senior citizens who experienced increased hope, (c) individuals who obtained improved self-image, (d) persons who developed a more positive approach to life in general, and (e) a nurse who received great joy and blessing in being able to work with and comfort others (Hamilton & Moore, 2001, 2002, 2006, 2007).

Many educational programs and activities focused on the spiritual dimension of the person and contributed to the spiritual impact of the program. Some programs with a spiritual focus were for specific age groups. Programs designed for children included (a) Self-Esteem - Child of God; (b) Let the Bible Be Your Compass; and (c) Sharing God’s Gifts. Educational offerings prepared for middle and high school students were (a) We Are the Clay, and (b) Native American Spirituality, Religion, and Food. Multiple educational offerings dealt with spiritual growth and development, creation, prayer, balance, death, and grief. Other educational topics were forgiveness, thankfulness, peace,

and healing. Topics with specific purposes were (a) The Bible as a Source of Strength in the 9-11 Tragedy, (b) Grandparents as Spiritual Guides for Grandchildren, and (c) Spirituality and Depression (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2004, 2006, 2007, 2008).

Several ongoing activities contributed to the spiritual impact of the faith community nursing program. Monthly nurse meetings were established in 1999 and the meeting formats included a spiritual enrichment focus. The “Blessing of Hands” is an annual activity to honor health care workers and the daily work of providing care for others. Retreats for the nurses allowed time for spiritual reflection and promoted spiritual well-being. Examples of the featured topics at these retreats were (a) Here We Are, Lord, (b) The Role of Prayer in Healing, and (c) Spirituality Within - Tapping Into Your Intuitive Gifts. Program representatives participated in planning, developing, implementing, and evaluating Health Ministries Association events. The topic of a featured speaker at one of these events was “The Practice of Forgiveness as a Healing Ministry” (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2004, 2006, 2007, 2008).

Program goals consistently addressed the spiritual component. The intentional integration of body, mind, and spirit in all endeavors to achieve optimal wellness was a recurring goal. A similar themed goal was to facilitate the relationship between faith and health. Concepts that were frequently mention in goal statements were the use of prayer and patience. Several goals addressed the development of bereavement and grief support groups or counseling programs. One nurse indicated that a goal for her faith community was to develop and implement prayer shawl ministry where the prayer shawl serves as a

reminder that the love of God and the prayers of others are with the individual. Two goals for nurses were that the nurse (a) participate in worship services by reading scripture, and (b) become a minister of the Eucharist and take communion to those who are ill (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2004, 2006, 2007, 2008).

The annual reports documented multiple lessons learned by the faith community nurses that involved spiritual principles. The first lesson encountered was that faith community nursing must be a continual journey of professional enrichment and spiritual growth. Two recurring concepts in the lessons learned were the importance of prayer and patience with all activities. Some lesson statements addressed attributes of the nurse and included the importance of (a) love for others, (b) honesty, (c) trustworthiness, (d) kindness, (e) respectfulness, (f) cheerfulness, and (g) faithfulness in the faith community nursing ministry. Additional examples that referred to the nurse's work included (a) using the ministry of presence; (b) exhibiting faith through personal example; (c) keeping spiritual healing as a high priority; (d) offering gifts, time, talents, and skills allows God to bless the events and the program; and (e) nurturing the body, mind, and spirit to more effectively minister to others. One nurse wrote that a personal lesson was remembering to listen to those who "talk the talk and walk the walk." A second nurse reported "an individual's needs to retain independence and self-determination can be stronger than the need for hygiene and safety." An example from 2002 was that the "congregation is deeply spiritual and is not afraid of tackling the tough issues, i.e. terrorism and sexuality on intellectual, emotional, and spiritual levels." In 2004, a nurse documented that if nurses seek God's direction for all endeavors, God will bless all efforts to help others in

His time and in His way. The final lesson was that nurses should never underestimate the spiritual impact they have on the people they serve (Hamilton & Moore, 1999, 2000, 2001, 2002, 2003, 2004, 2004, 2006, 2007, 2008).

### **Other Categories and Codes Contributing to Program Impact**

In addition to the report of the health, social, educational, cultural, financial, and spiritual impact, study participants described several other themes in their responses. These themes contributed to the impact of the faith community nursing program. These topics were (a) health disparity characteristics, (b) seriousness of health issues, (c) program continuation, (d) collaboration, (e) communication, (f) community, (g) connection, (h) balance, (i) family, (j) individualized care and where the person is, (k) others, (l) specific Biblical references, (m) faith community nurse roles, (n) faith community nurse attributes, and (o) nursing interventions.

**Health disparity characteristics.** The theme of health disparity characteristics included the three concepts of access to health care, health literacy, and vulnerable populations. Faith community members included each of these in their responses. A statement associated with access to care was, “Everyone should have basic health care, which would allow them to enjoy life to a greater degree as well as continue to work themselves.” “She has been willing to cut through the ‘doctor-speak’ and give helpful lay terminology” was an example of the health literacy topic. The faith community nurses’ ministry to vulnerable, disadvantaged, minority, underserved, or at-risk populations is an essential feature of their practice. One response from a member that pertained to

vulnerable populations was, “Most people, no matter how well-meaning, forget about the homebound, the shut-ins and few realize how lonely and forgotten they can be.”

Clergy participants also addressed the three health disparity characteristics. For access to health care, one clergy representative wrote that individuals do not seek health care because they are fearful of the diagnosis they may hear. Another mentioned that elderly members “are reluctant to seek health care until they are at a crisis point.” Other responses were that access to health care was hindered because individuals do not know the options they have for health care or they are deceived by ever-present myths surrounding symptoms, diseases, and treatments. Four responses pertained to health care costs and how that issue interferes with health care access. One statement related to this matter was “The FCN is able to bring one on one medical assistance to those who cannot afford multiple trips to doctors.” Three other statements referred to health care received from the faith community nurse who served as an advocate for individuals to obtain needed or necessary care from a physician. One clergy representative summarized this thought and wrote, “The faith community nurse program brings a personal, faith-based, medical advocate to those who need it most.” Concerning health literacy, the clergy representatives mentioned that without a faith community nurse, individuals (a) are unsure of what questions to ask physicians, (b) are fearful of hearing the diagnosis, (c) are confused by what they hear, (d) do not know what health care options they have, and (e) have difficulty in making health choices. Through their roles as health educators, personal health counselors, and health advocates, faith community nurses have (a) educated individuals so they know what questions to ask, (b) interpreted medical

information or instructions, and (c) helped and supported decision-making processes. Vulnerable populations were evident in responses from clergy representatives and included (a) individuals who cannot afford medical care, (b) members of cultural and ethnic minority groups, (c) elderly persons, (d) homebound or shut-in members, (e) nursing home residents, and (f) persons with chronic or on-going health problems. A statement from one clergy representative was “One of the biggest impacts is the direct contact the faith community nurse has with our shut-ins and nursing home members.”

The faith community nurses addressed health disparity characteristics in their responses. Nurses wrote over 30 statements referring to health care access. One response for this concept was, “without the CN contact and making calls to get them in the door they would have went without care or ended up in the ER.” A second sentence was “A large part of my ministry involves helping them to find access to care.” A third example was “There are beliefs that interfere with seeking health care. One of those is a suspicion of health care providers.” Statements associated with health literacy indicated members “are provided with needed information to understand and deal with their condition” and have “improved compliance with treatment regimen because they have someone they can ask questions.” Vulnerable populations that nurses identified were (a) older adults, (b) homebound persons, (c) residents in skilled nursing facilities, (d) individuals that do not speak or understand English, (e) people with chronic debilitating conditions, (f) single parents, (g) members of racial or ethnic minority groups, and (h) those with limited financial resources. One nurse wrote that she works “in an area that is steeped in poverty. Many of the clients are elderly” as an example of this concept.



**Seriousness of health issues.** The seriousness of health issues is a second category that was evident in responses to the six impact questions. A response of one member featured “currently, we are in a crisis--not only in providing health care, but financially, and in so many other ways.” Health conditions perceived as serious by participants included (a) hypertension, (b) cardiac disease, (c) diabetes, (d) osteoporosis, (e) chronic obstructive pulmonary disease, (f) influenza, (g) depression, (h) sexually transmitted diseases, (i) substance abuse, (j) obesity, (k) hypercholesterolemia, (l) cerebral vascular accidents, (m) dementia and memory loss, and (n) recent surgical procedures. Many statements referred to a combination of these and other conditions. A statement from a clergy representative simply asserted, “We are overweight!” The prevention, early detection, control, and slower progression of serious illness were reported in several categories of impact. One member reported he was thinking more about “how we can slow down diseases and their effects by knowing our history and condition” and another member wrote “our health is the backbone of our life we have to take it more seriously.” Additional items that were reported as serious were (a) the costs of health care, (b) lack of preventative measures, (c) inability to receive health care, (d) noncompliance with treatment regimens, (e) proper use of medications, (f) unwillingness to change health habits, (g) difficulty in making health choices, and (h) lack of trust in health care providers. An example from a nurse was “the congregants were not seeing the doctor for regular visits. The recommended screening tests were not being done (i.e. mammograms, bp pressure checks, pap smears, etc.). Most were not getting regular physicals.”

**Program continuation.** Several faith community members included statements in their responses that strongly support continuation of the nursing program. Two sentences in one section of the questionnaire from a female participant were, “Hers is a very unique job description. It is very depressing to think of her not being in my life because her job had been discontinued.” A second individual wrote, “She reaches out to me and others in a highly unique way thus providing a service truly above price.” The statement from a third member was “Faith community nursing is a blessing and wonderful ministry.” The example of a fourth person was, “It has been a great asset for the faith community nursing service to come into all our lives.” An additional topic for this category was the availability of the nurse for help, advice, direction, support, care, and reassurance in physical, mental, and spiritual matters. A response from one member included “My congressional nurse at my site not only does a great job with giving information but she cares about your health and you can tell personally that she is concern [*sic*] about you.” Two final statements in support of this program’s continuation came from one man. He wrote his daily prayer was that this program will (a) “grow and continue to have a great impact in our communities,” and (b) “continue it is making a diffrents [*sic*] in health awareness and physical improvements in health of individuals like me.”

The clergy representatives wrote many statements in their responses to the six impact questions that provided strong support for the continuation of the faith community nursing program. According to these participants, the program has provided (a) positive impacts on health and well-being, (b) medical and spiritual resources, (c) education for all age groups in the entire community, and (d) medical advocacy for parishioners from a

personal, caring, and faith-based professional. One clergy representative addressed several benefits of the nurses' service that support program continuation as he wrote, "The work of the congregational nurse obviously increases the understanding of our parishioners relative to a variety of health issues, wellness programs, prevention, good budget practices, good resources in the community, the proper use of medications." A second clergy participant wrote that services of the nurse benefitted "the recipients in helping them to feel better, regain their health, live more comfortably and take pride in being self-supportive and productive."

Several statements in responses from the nurses to the different impact questions specifically pertained to this faith community nursing program and supported its continuation. One nurse wrote that people in her faith community "are proud to have the program and want it to be successful. The congregation always wants to help out any way they can with the program." A second nurse wrote that the program "provides an outreach of the church to the congregation and the community that would not otherwise happen." Another example was, "This community's willingness to cooperate and work together on health issues is one reason for our program's great success." One nurse indicated that faith community nursing care is necessary "with folks on a long term basis if we really want to make an impact on their lives." Three nurses stressed how the practice of this specialty involves not just the client but the family, and not just individual needs but also group and congregational needs. Four statements mentioned that for some individuals, (a) having health screenings, (b) seeking medical care, and (c) getting early and prompt intervention would not occur without this program. Several nurses included

specific features of their job as support for the program's continuation. These aspects included (a) work with the underserved, (b) assistance with resources and financial needs, (c) use of a multifaceted approach, and (d) provision of holistic care. Through her ministry in this program, one nurse asserted, "I can see why congregational nursing is considered the most rapidly growing specialty in nursing!" The growth of this unique nursing practice adds extra support to continuing the local program. According to one nurse, the intentional incorporation of spiritual care "speaks volumes for this program." Finally, another nurse concluded that "There have been more outcomes than there is ability to remember or space to write."

**Collaboration.** Collaboration with other individuals or agencies was a factor in the impact of the faith community nursing program. Participants wrote about collaboration between the nurse and (a) clergy personnel, (b) guest speakers and other professionals or experts at various programs and activities, (c) community agencies, (d) health care providers, (e) specific organizations like Hospice or the Alzheimer's Association, (f) local schools or institutions of higher education, (g) pharmaceutical companies, and (h) other faith community nurses. Concerning collaboration between faith communities and health care providers, one member wrote, "By teaming of churches (who are suffering) and health providers it shows how both together can better provide services." Two members addressed how people within the faith community work together on various projects. One example of this collaboration was "I get to know members of my church and get to work with and to establish relationships with other volunteers." An example of collaboration from a clergy representative was that the nurse had "weekly conferences

with minister to compare notes on parishioners facing health issues.” A nurse described collaborative efforts with “the congregational nurse uses materials available by numerous community resources....and will partner with other congregational nurses to get the most beneficial result.”

**Communication.** Communication was an essential feature of the faith community nursing program impact. Participants provided multiple illustrations of communication in general and communication with the health care team. Besides forms of talk, speak, say, tell, listen and hear, a variety of terms was used. Verbal terms were (a) share, (b) spread the word, (c) interact or contact with, (d) establish a relationship with, (e) pass on or pass down, (f) reach out, (g) discuss, (h) suggest, (i) express, (j) report on or about, (k) keep up with, (l) interpret or reinterpret, (m) call, (n) pay attention to, (o) have a conference or meeting with, (p) compare notes, (q) answer or respond, (r) communicate, (s) ask or request, (t) inform, (u) encourage, (v) comment on, (w) give information to, (x) remind, (y) advise or counsel, and (z) have a conversation with. A phrase in the response of a member was “discussing medical situations with her and she can advise me what to do or ask my doctor about.” Study respondents reported communication occurred with (a) family, group, class, or congregation members; (b) children, teenagers, or elderly; (c) friends; (d) nurses, doctors, or health care professionals; (e) volunteers; (f) ministers or parishioners; (g) clients or patients; (h) Christians; (i) the homebound; (j) the community; (k) a newly diagnosed diabetic, and (l) individuals, others, people, or folks. One faith community nurse wrote, “I feel folks are more likely to open up and discuss difficult issues with me.” Topics of communication included (a) good health, healthy living, or

preventative health care; (b) health situations, information, or choices; (c) family members or parishioners and their health issues; (d) the right questions to ask doctors; (e) cooking practices, meal planning, or healthy eating; (f) exercise or weight loss; (g) spiritual care; (h) traditions, values, or beliefs; (i) current events, finances, or multiculturalism; (j) habits, accomplishments, or ideas; (k) religious practices, prayer, faith in God, or the Bible; and (l) the faith community nursing program or the presence and availability of the nurse. A quote from a clergy representative used the term “counsel” and the topics of “diet, exercise, behaviors (sexual, familial relationships, occupational)--stress & how to manage decisions/consequences.”

Some participants included principles of effective communication in their answers to the impact questions. Items that enhance communication were (a) good people skills (b) knowledge, (c) comfort, (d) courage, (e) assertiveness, (f) time, (g) established relationships, and (h) listeners or listening skills. A quote from a member for enhanced communication was “I believe that I have good people skills and that I have a natural ability gift to make people around me fill [*sic*] relax and open to talk to.” An example written by a clergy representative was “they are always well informed and uses translator to insure all attendees understand and are able to get answers to questions and concerns.” One of the nurses wrote, “The most important aspect is to have some person who will listen.” Things that impede communication were (a) generational differences, (b) stressful events, (c) accents, (d) lack of translation or interpretation, and (e) lack of awareness. Other principles in the responses were that people (a) appreciate having someone to talk with, (b) learn to listen and to ask questions, (c) take advantage of communication

opportunities, (d) do not believe everything they hear, (e) are able to improve their listening skills, and (f) need answers to their questions. Three additional principles were (a) unexpected or serious incidents occur with language or other communication barriers, (b) the “gospel truth from experts” may not be true and may not be the only truth, and (c) communication gives reassurance, relief, and results, but sometimes requires repetition.

Respondents made references to written communication as well as verbal communication. A member mentioned the benefits of written or published literature. A clergy representative reported how “our nurse writes articles for our church newsletters reminding us how to do preventative health care.” An example from a nurse indicated a class participant would share written information on an assistive device for stroke victims with her friend. Another nurse described how her clients with hypertension have “a personal record card they take with them to their doctor’s visit. Most doctors appreciate seeing that information.” Finally, written communication contributed to the spiritual impact according to a nurse who wrote, “A simple thinking of you card to lift the spirits of an home bound member at times when one really needs a boost.”

**Community.** Another feature of the program impact was the concept of community. Participants reported that community outreach was both desired and necessary. The nursing program is providing that essential contact with, having a ministry to, and serving as a resource for the community. Eighteen separate references substantiated this assertion. A statement from one member was “this ministry has been very beneficial to members of the congregation and the community at large.” Another member wrote that his prayer was “this program will grow and continue to have a great impact in our

communities.” One clergy representative wrote that education offerings were “topics that continue to impact and empower the community as a whole” while another reported that community relationships were strengthened through the nursing program. An example from a nurse documented that she was making “information on programs and health related issues available to the community at large.” The program outreach extended to people in (a) childcare centers, (b) schools, (c) individual homes, (d) hospitals, (e) senior centers, and (f) retirement or nursing homes. References with specific names were (a) low income or poverty community, (b) African-American community, (c) old community, (d) culturally diverse community, (e) very integrated community, and (f) affluent community. Fifteen statements pertained to resources in the community that benefitted individuals or the program. One participant wrote that the congregational members were connected to “many of the activities and services available in the community.”

Respondents also addressed the concept of community health. Community health was influenced by (a) health fairs, health screenings, and educational activities sponsored by the nursing program; (b) use of personal, God-given abilities and talents; and (c) lack of medical and nutrition education. A clergy representative answered the social impact question with “preventing STDs and pregnancies are a priority for community health.” An additional reference to community from a member was “people from different cultures can live together in the community.” A final statement that pertained to the concept of community was from a nurse who answered, “This community’s willingness



to cooperate and work together on health issues is one reason for our program's great success.”

**Connection.** The next broad category that contributed to the impact of the faith community nursing program centered on the theme of connection. Terms associated with connection were (a) link, (b) bond, (c) together, (d) merge, (e) in touch with, and (f) not separated. Faith community members wrote about connections between themselves and (a) family members, (b) the faith community, (c) faith community nurses, (d) health care providers, (e) friends, (f) group members, (g) others in general, (h) others with similar health issues, (i) their employment, (j) the community, (k) society, and (l) God. A recurring topic was the connection between physical, mental, and spiritual health or well-being. These participants also documented relationships between personal health and (a) providing for family members, (b) serving others, and (c) being involved in activities. Members identified additional associations between helping others and (a) spiritual benefits, (b) nursing program involvement, and (c) praising God. Four other connections were between (a) spiritual things and life satisfaction, (b) pastoral care and nursing care, (c) personal health history and the progression of diseases, and (d) needs and wants. One member's example for this category was “The program helps the church and members stay connected by assisting, showing love, and caring for members in need.”

Clergy representatives wrote about the connection between faith community members and (a) the nurse, (b) their families, (c) community agencies, or (d) the Lord Jesus Christ. Other associations were between (a) physical health and spiritual health, (b) health or physical education and positive health benefits, (c) learning information and applying

knowledge, (d) health risks and certain ethnic or cultural groups, (e) awareness of and respect for cultural differences, (f) cultural differences and similar personal circumstances, and (g) the nursing program and overall physical, emotional, spiritual, and mental well-being. An example for the theme of connection was, “She is able to share her faith in God and help people see the connection between their mind and spirit.”

Faith community nurses also addressed the theme of connection in their responses. A recurring topic was the connection between the client, family, or congregation and community people, activities, services, or information. Nurses wrote about the connection between themselves and (a) individuals, couples, families, groups, or the congregation; (b) the minister, and (c) other faith community nurses. Other associations were between (a) family members, (b) children and older people, and (c) nursing care and pastoral care. These participants documented a relationship between education and (a) fellowship, and (b) ability to escape the poverty culture. An example described how participation in exercise activities was connected to post-operative outcomes. One nurse wrote about the links between socialization or challenges to brain activity and improved memory retention. Another nurse summarized the importance of connection with “But relationship care is the link.”

**Balance.** The principle of balance was another factor in the program impact. In their responses, faith community members addressed balance in (a) all areas of their general daily lives; (b) physical, mental, and spiritual health, care, and well-being; (c) educational offerings and learning situations; and (d) faith community nurse’s practice or ministry.

One member listed several aspects of the nurse's work as an example of balance in the nursing ministry. This individual wrote

Comfort - care - spiritual - certain of availability, medical knowledge information - follow up on health problems - advise - council - home visits - access to clinics - hospital visits - medicine checks - a confident - a dietician.

Other statements referred to balance between (a) needs and wants, (b) caring for self and reaching out to care for others, (c) older and younger ideas and values (d) health and involvement in activities, (e) earning and spending, and (f) personal abilities, talents, or efforts and God's blessings. An example of that final category was "I believe that I have to do my part and God will do his part."

Clergy representatives wrote about the balance in physical, emotional, spiritual, or mental health and well-being. One participant mentioned the balance between the congregation and himself. Another individual stressed balance with the following response.

We were created to live a life honoring to God. This can not be done to the fullest extent when one area of our lives is out of balance. The nursing program has strived to help us achieve this balance.

The concept of balance was also evident in the nurses' answers. Statements alluded to having balance in (a) educational methods and learning situations, (b) different populations served by the nurse, and (c) different features of practice or ministry. An example of educational approaches was "programs, personal counseling, bulletin board displays, health hints in the Sunday Bulletin and the monthly newsletter, 'The Wellness

Link,' have made up to date information on health issues more accessible.” Another nurse summarized the balance in the practice and ministry of faith community nursing as “an intertwining of all the various parts that it is difficult to separate clients’ encounters into the social, the cultural, and the spiritual or educational aspect.” Additional responses indicated balance between (a) professional knowledge, caring skills, and faith; and (b) God’s help or healing, help from others, and helping ourselves. One nurse wrote, “God can heal, but that he sends other to point us in the direction of health and that we are to ‘help ourselves’ to be healthier.”

**Family.** Another recurrent theme that contributed to program impact was family. Family relationships were included on nine occasions. Sharing information with family members was mentioned seven times. An example from a member was “The information I have received is life changing and I’ve been able to share with my children and extended family.” A nurse wrote, “Praying with the family is an essential part of this ministry,” and five other participants echoed this thought. Other nursing interactions with or interventions for family members were noted 23 times and included giving support, providing counsel, offering comfort, assisting with medications, interpreting information, listening, and visiting in homes and health care facilities. A statement from a member was “the nurse visiting and counseling with me and several family members during a time of crisis made me feel less anxious and desperate, and more hopeful.” Five statements pertained to being the caregiver of another family member. Three respondents used the concept “church family” in their answers and three other answers pertained to the family of God. Four statements referred to the nurse with maternal terms and another

statement indicated the nurse was perceived as a mother figure. Two other terms pertaining to family were genealogy and hereditary and both concepts occurred three times. Other topics were (a) no local family, (b) working together as family, (c) family income, (d) family issues, and (e) multiple roles as a family member. One member answered the educational impact question with “several members have gotten CPR/First Aid Certification & are aware that it is a member of one’s own family who is most likely to be the benefactor of one’s CPR skills.” An additional reference to family from a member was “One example is my high blood pressure I knew I was at risk do [*sic*] to the fact of family history.” Another response from a member was “I evaluate myself daily to make sure I give it my all to my family as well as to the society.” Two final statements that pertained to the concept of family was “The more we have to spend on unnecessary health issues the less [*sic*] we have for our families” and “If we are not in good health we cannot provide for ourselves and our families.”

**Individualized care and where the person is.** Attention to individualized care and where the person is was a tenth theme of program impact. Members documented how the nurse was with them during times of (a) growth, (b) maintenance, (c) change, (d) need, (e) pain, (f) personal or family illness, and (g) death of family members. Concerning the thought of sustainment, one member reported, “Her concern/care enables me to remain centered and focused on the things that I can still do.” A statement from one member that addressed individualized care was “She is willing to take one on one time with each individual to help them with their needs.” An additional example came from a member who wrote, “She has truly kept that vow and stayed with me to where I am now.”

Individualized care reported by clergy representatives included (a) seeing the person holistically, (b) knowing the situational dynamics, (c) visiting people where they live, and (d) being aware of individual differences. Responses of nurses that pertained to this category mentioned the acceptance and value of the individual, whoever or wherever they are, and whatever their circumstances. Examples included (a) members of the working class, (b) individuals with spiritual issues, and (c) people in homes, hospitals, or nursing facilities. A sentence from one nurse included “loving them for who they are and accepting them without trying to impose your values on them.”

**Others.** Another topic that made a contribution to the program impact was others. The three concepts in this category were helping others, outreach to others, and relationship with others. Faith community members mentioned helping others multiple times in their responses. General terms members used were (a) assisting church members, (b) being of service to God’s people, (c) caring for people in need, (d) using talents and skills for others, and (e) working together on projects. A statement from one member was “I can make a difference in others lives by helping them to understand the importance of taking care of their health.” Specific examples of helping others were (a) donating blood, (b) volunteering in influenza immunizations clinics, (c) helping with meals, (d) caring for family members, and (e) working during the health fairs. Statements of outreach to others that did not specifically refer to helping others were (a) the nursing program being an extension of the pastoral care, (b) members remaining in touch with extended family, and (c) participants in a chair yoga class being welcomed as members. Terms that pertained to relationships included (a) members enjoying each and everyone, (b) nursing program

benefitting the congregation and the community, (c) nurse ministering to faith community or group members, (d) teenagers having feelings for opposite gender, (e) people living together as friends, and (f) class participants having fun together. One member wrote, “I get to know members of my church and get to work with and to establish relationships with other volunteers.”

Answers from clergy representatives had references to others. These respondents mentioned helping (a) faith community members, (b) needy families adopted by the congregation, and (c) neighborhoods throughout the urban area. According to this group of participants, outreach extended to local schools, childhood centers, the surrounding community, and “those who need it most.” Phrases applying to relationships with others were (a) touching people in many ways, (b) having contact with shut-ins and nursing home members, (c) becoming aware of individual differences, and (d) showing concern and care for people.

Many statements in the responses from faith community nurses concerned others. The topic of helping others included (a) sharing information, (b) promoting healthy living, (c) working together, and (d) getting various groups involved in projects. Outreach to others came from the nurse, the congregation, members, patients, and the pastor. Recipients of outreach were members, clients, the congregation, the community, large numbers of people, and individuals in hospitals and nursing care facilities. One nurse responded to an impact question with “I am helpful to the pastor and extend his reach to the congregation by making visits to the home and the hospital. This provides an outreach of the church to the congregation and the community that would not otherwise happen.” Responses from

the nurses contained multiple references to relationships with others and used terms of (a) working with, (b) meeting with, (c) being involved in, (d) having fellowship with, (e) spending time with, (f) interacting with, and (g) meeting the needs of. One nurse stressed the importance of this topic with “relationship care is the link.”

**Biblical references.** Another topic that was evident in responses and contributed to program impact was specific Biblical references. Some topics that faith community members included were (a) being a child of God, (b) being of service to and showing love to God’s people, (c) doing the will of God, (d) praising and thanking God, (e) having faith in God, (f) using God-given abilities and talents, and (g) knowing God’s plans for physical living. One member wrote, “The word of God clearly states that he wants and desires for us as his people to prosper and be in good health.” Clergy representatives mentioned (a) thanking God for the nurse, (b) living a life that honors God, (c) keeping our physical bodies as a temple to God, and (d) sharing personal faith in God. One statement was “Bringing Christ to lonely, ailing, and mostly elderly people is the very essence of Christianity.” Faith community nurses wrote about (a) loving others, (b) cherishing other individuals because they are created by God, (c) valuing the physical body, (d) putting faith into action, and (e) realizing God’s healing ministry. An example from a nurse was

Being kind and helpful to the underserved clients places those clients in a comfort zone. I want them to feel it’s all about them and their needs and not about me or the church. That is what Christ’s healing ministry should be about.



**Roles of the faith community nurse.** Faith community nurses function in seven distinct and interrelated roles. Responses of the faith community members had examples that pertained to each role. For the role as health advocate, the answer of one participant was, “The nurse was the one to step forward and say I see your need and I want to help. She has truly kept that vow and stayed with me to where I am now.” A statement that concerned the role as health counselor was, “I have been able to go to her for question and advice regarding any health issue.” An example of the role as health educator was “She keeps us up on latest news about such things as flu and how to protect ourselves from contracting it. She can educate on such matters as nutrition, exercise and weight control.” A woman wrote, “She is one who provides both faith, spiritual care as well as physical and medical care” referring to the role as integrator of faith and health. For the role as referral agent, a woman mentioned she depended on the nurse for “the knowledge that she has with different services that are out there.” A sentence that related to the role as developer/organizer of support groups was, “She just did not visit, she organized food to be brought to my house.” The final role as trainer of volunteers was described by a woman who responded “As often as I can, I volunteer to help at the flu clinics, blood drives, bone density checks, etc that she sponsors. Through this participation as a volunteer, I have met many members of the congregation.”

Responses from clergy representatives had references to six of the seven roles. The role as health advocate was included in a response that mentioned the comfort that faith community members have through the nurse’s expertise and advocacy. The role as personal health counselor was evident as one clergy representative included the one-on-

one time that a nurse can spend with individuals in the faith community setting. One clergy member referred to the role as health educator as he wrote, "At least once a month a program is introduced to the church body which acts to teach and provide positive impact from topics that are important to all members." An example of a response that referred to the role as integrator of faith and health was, "Hope is central to faith in God, therefore the spiritual impact of faith community nursing is evident in our setting because of the hope people find in the nurse's participation in their care." A statement related to the role as referral agent was, "Our nurse has put several church members in contact w/ agencies that have helped in different areas." Another clergy representative addressed the nurses' role as a developer or facilitator of support groups. He mentioned stronger community relationships "through support groups offered by/facilitated by the nurse." The role as trainer of volunteers was not found in clergy representative responses.

Faith community nurses referred to all seven roles in their answers. For the role of health advocate, one nurse gave a general description as she wrote, "There is an extra set of eyes that's coming to the home/hospital or nsg home that will check on them and speak up for them." Another nurse provided a classic example in the following scenario.

The mother of a family from India was in the hospital. The mother understood some English but could not speak English. Because of the language barrier, an incident occurred which upset the patient. The patient felt threaten by a particular nurse. The family asked for my assistance when I came to visit. I called the case manager and asked her to investigate and then speak to the family. The situation was resolved and things improved but the patient never had complete trust again.

The role of personal health counselor was evident in the nurses' responses. Counseling was combined with education in five of the answers. One nurse wrote, "When a

multifaceted approach is used, interaction can include teaching about health, personal health counseling, therapeutic intervention and guidance and counseling.” Another nurse provided the following scenario.

During osteoporosis counseling a great number of individuals did not know the recommended dose for Calcium. They were also unaware that they should divide the dose and take vitamin D to allow for better absorption. I feel they will have better results because of the counseling.

Another role of the faith community nurse is health educator. One nurse declared that health education was a major portion of her practice and she provided education to individuals, on bulletin boards, and through health fairs. The response of a second nurse included, “The congregational nurse is an excellent resource in providing educational resources.” Techniques to share information mentioned by this nurse were (a) presentations, (b) newsletters, (c) bulletin boards, (d) pamphlets, (e) individual interactions, and (f) designated speakers for specific topics. Another nurse referred to this role with, “We offer different educational programs and health fairs that are family oriented. But we offer teachings in current health problems, i.e. swine flu, fireworks, cookouts, etc.” The role of integrator of faith and health was apparent in the nurses’ answers. Terms related to this role were (a) meeting spiritual needs, (b) bringing an intentional spiritual component to nursing practice, (c) demonstrating love and compassion, and (d) providing spiritual support through presence. One nurse wrote, “The FCN is the resource for the town/community working with all age groups, to improve mind, body, and spirit.” Another statement that described this function of a faith community nurse was, “Through this role, I am able to present all aspects of me, my

training, passion for caring, and my faith through this role!” Nurses made several references to their role as a referral agent. One answer pertaining to this topic was, “She serves as an excellent resource and referral center connecting the congregation to many of the activities and services available in the community.” Another example was, “Church members know that there is someone they can contact that has clinical knowledge as well as knowledge regarding agencies, insurances and can make referrals that may be needed.” For the role concerning developer or facilitator of support groups, the example of one nurse was “We can put care teams in place to allow caregivers some time off or help with meals or child care.” A quote that pertained to the role as trainer of volunteers was “The practical skills such as how to approach someone with Dementia, hand over hand method of feeding or shaving someone, etc. were very valuable.”

**Attributes of the faith community nurse.** Faith community members identified multiple attributes of the nurse that contributed to the impact of the nursing program. One participant indicated the nurse was knowledgeable, well-liked, and that she exhibited a lot of effort. Another individual commented on her willingness and availability. The characteristic of accountability was derived from the statement “She reports to us on every activity she sponsors.” The phrase “knowing I can depend on her” addressed her dependability. People described the nurse as (a) understanding, (b) special, (c) unique, (d) very important, (e) very compassionate, (f) supportive, and (g) God-Christ-like people loving.

Clergy representatives mentioned several qualities of the nurse that contributed to the impact of the nursing program. Responses from clergy representatives contained four

references to the nurse as a caring, concerned, or encouraging person. Three statements described her as a person of faith and two other sentences mentioned her helpfulness. One participant wrote that she displays “the very essence of Christianity.” Other individuals commented on her expertise, skillfulness, and being well-informed. One clergy representative wrote that the nurse “doesn’t want to get involved in congregants’ finances” while another referred to her as cost-conscious. Additional attributes were (a) understanding, (b) attentive, (c) friendly, (d) comforting, and (e) positive.

Responses from the nurses also included many personal characteristics. Nurses wrote about being helpful nine times. Six statements addressed the attributes of (a) showing love or compassion, (b) caring, (c) listening, and (d) being cost conscious. Being supportive, willing, accepting, available, and sensitive to the spiritual aspect were each mentioned four times while having faith, being prayerful, and offering comfort were documented three times. Attributes with an alliterative theme were faithful, flexible, friendly, frugal, and firm. Other attributes addressed principles of confidentiality, leadership, creativity, holism, and equality. An example with two characteristics was “acceptance of each person whatever their circumstance, and a genuine caring attitude has made it possible to make interventions that impact health.”

**Nursing interventions.** Faith community members gave several examples of nursing interventions that pertained to the six areas of impact. Health interventions were (a) blood pressure checks, (c) exercise programs, (c) health screening, (d) health counseling, (e) medication monitoring, and (f) influenza vaccination clinics. One example of the thirteen mentions of exercise was “help me maintain a healthy state by encouraging weekly

exercise in a positive, interactive group.” Social interventions included (a) visitation, (b) support, (c) referral for community resources, and (d) organized social activities.

Concerning visitation, an elderly woman wrote, “I am aware of others in our church community whom she has visited daily in the hospital or nursing home.” Different types of educational interventions were (a) classes or programs, (b) invited speakers, (c) verbal reinforcement, and (d) written information in newsletters, pamphlets, or bulletin inserts.

An example from one member was “The speakers that my congressional nurse sets up are very educational and fun to be a part of.” For the category of cultural interventions, one member described how nurse-organized activities provide “the exposure to people who speak another language who, at times share some cultural or historical aspects.” Financial interventions were location of resources, making referrals, and personal counseling. One member wrote, “The parish nurse program plays a major role in identifying those members of our church who are in need of financial assistance and to bring that need to the attention of the church.” The assortment of spiritual interventions identified by the members were (a) giving spiritual care or counseling, (b) facilitating spiritual growth, (c) being present, (d) listening, (e) praying, (f) leading devotionals, and (g) facilitating participation in religious services or activities. One member included spiritual interventions by writing “Receiving advice and care from someone who is willing to pray with and for me is very reassuring.” An additional example was “assisting, showing love, and caring for members in need. All of these activities help me in my spiritual growth.”

In their responses, the clergy representatives provided examples of nursing interventions that pertained to the six areas of impact. Several health interventions listed

by one clergy representative were (a) setting up systems for taking medications, (b) monitoring medication usage, (c) conducting weekly exercise programs, (d) assessing persons with chronic health problems, (e) encouraging healthy nutritional intake, and (f) checking blood pressures. Social interventions included (a) visiting with parishioners, (b) making referrals to community agencies, (c) developing and facilitating support groups, and (d) overseeing and maintaining food and clothing resources. One example of a social intervention was, “She also is able to see the person more whollistically [*sic*]--visiting them where they live and knowing the family system dynamics.” The variety of methods for educational interventions included (a) classes, seminars, or workshops; (b) individual interactions; (c) published literature; and (d) information written by the faith community nurse. One clergy representative wrote, “The faith community nurse puts on educational classes, seminars and health fairs for the entire community.” An additional example of an educational intervention was, “Our nurse writes articles for our church newsletters reminding us how to do preventative health care.” Different features represented by cultural interventions included the culture of (a) different ethnic groups, (b) adolescents, (c) living in America, (d) familial relationships, and (e) occupational situations. An example of a cultural intervention for different ethnic groups described how the nurse “uses translator to insure all attendees understand and are able to get answers to questions and concerns.” For the category of financial interventions, one clergy participant indicated the nurse “encourages them to apply for financial aid that she believes they are entitled to receive.” A second example was, “She always does homework with regards to

what it will cost the person.” Two spiritual interventions were praying with individuals and sharing personal faith in God with others.

The health interventions that faith community nurses identified were duplications of those documented by the faith community members and clergy representatives. An example indicating some of those interventions was “people come for weekly blood pressure checks and diabetic follow up and other chronic or acute problems.” The only exception was the intervention of transporting an individual threatening suicide to a health care facility. The response of the nurse mentioned, “Fortunately, we had developed a good relationship and she allowed me to take her to the Emergency Mental Health Clinic.”

Nurses also reported visitation, provision of social and emotional support, facilitation of support groups, referral procedures, and organized social or educational activities as social interventions. One example from a nurse indicated she would “meet with a group of Sr. adults monthly for a social gathering. We play BINGO, eat and catch up.” Additional interventions contributing to program impact were (a) listening, (b) assessment of living situations, (c) telephone calls, and (d) assistance with food, shelter, and furniture needs.

Responses from faith community nurses matched the educational interventions identified by the other two participant groups. Coordinating health fairs and conducting health screenings for the congregation and the community were mentioned many more times by the nurses. Nurses made several more references to individual health counseling. Most nurses listed a variety of methods used to relay health information. One nurse wrote



that she was available to research health topics and this was an intervention that was not identified by the members or clergy representatives.

Nurses provided examples of some different cultural interventions. First, materials, help, and advice were provided to members based on cultural beliefs, customs, and values. The next intervention was acceptance of people regardless of any situation. Involvement as an advocate for an ethnic minority family was a third cultural intervention. The final example was writing a letter to help a young woman retain her scholarship.

Finding resources, making referrals, and individual counseling were financial interventions that the nurses documented. Other interventions included (a) facilitating access to health care, (b) determining cost efficiency, (c) using finances wisely, (d) addressing financial principles in educational activities, (e) administering emergency funds of the faith community, and (f) collaborating with other nurses. An example for the final area was “two or more Congregational Nurses, along with their congregations, will join together to pool their resources and sponsor an event.”

As with other categories, nurses documented many of the same spiritual interventions. Spiritual care or support involved comfort, care, compassion, value, and kindness. Nurses documented the interventions of presence, listening, acceptance of individuals, and facilitation of religious activities more than other participants. Making telephone calls and sending notes or cards of encouragement were additional interventions. One nurse mentioned collaboration with clergy personnel as an intervention and how she is “helpful to the pastor and extend his reach to the

congregation.” The intentional focus on the spiritual component was a crucial element of spiritual interventions. Nursing interventions and their definitions are based on the Nursing Intervention Classification (Bulechek, Butcher, & Dochterman, 2008), and used with permission of the publisher. The interventions, definitions, and descriptions by participants are presented in Table 7.

Table 7

*Nursing Interventions*

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Active Listening</b> Attending closely to and attaching significance to a patient's verbal and nonverbal messages	<p>She has listened to my concerns about my mother's health (m)</p> <p>A congregational nurse has more time to spend one on one in the church setting than in a clinic/office (c)</p> <p>I listen to them more than I ever could in hospital setting. I can spend all the time I think is needed (n)</p> <p>One nurse wrote that a personal lesson was remembering to listen to those who “talk the talk and walk the walk” (a)</p>
<b>Anxiety Reduction</b> Minimizing apprehension, dread, foreboding, or uneasiness related to an unidentified source of anticipated danger	<p>The nurse visiting and counseling with me and several family members during a time of crisis made me feel less anxious and desperate (m)</p> <p>Education has often prompted congregants to seek further evaluation--also has relieved anxiety (n)</p> <p>The educational offering of “Anxiety and Panic Disorders” targeted a mental health condition (a)</p>
<b>Art Therapy</b> Facilitation of communication through drawings or other art forms	<p>Conversely, my “Art and Health Fair” was one segment of the month-long “Create and Celebrate” event (n)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Behavior Modification</b> Promotion of a behavior change	<p>This information often modifies behavior which, in turn, improves healthier living (m)</p> <p>It helps parishioners to pursue better preventative behavior (c)</p> <p>Provide education and counseling to assist members in making or modifying health behaviors (n)</p> <p>Members also reported increased knowledge, understanding, and awareness of preventative health behaviors (a)</p>
<b>Behavior Modification: Social Skills</b> Assisting the patient to develop or improve interpersonal social skills	Offers an opportunity to use my talents and skills to help others as well as to broaden these talents and skills by participating in numerous educational and training programs (m)
<b>Bibliotherapy</b> Therapeutic use of literature to enhance the expression of feelings, active problem solving, coping or insight	<p>I have led a book study “The Cup of Our Life..A guide for spiritual growth” by Joyce Rupp which suggest we look at ourselves and our lives as we relate to a cup (a full cup, broken cup, cracked cup etc.) The daily study and weekly discussion lead individuals to great insight for themselves and in turn spiritual growth (n)</p> <p>A nurse started a women’s book club to provide diversion from winter blues for individuals prone to seasonal affective disorder. This intervention created social bonds and connections between participants (a)</p>
<b>Calming Technique</b> Reducing anxiety in patient experiencing acute distress	The nurse visiting and counseling with me and several family members during a time of crisis made me feel less anxious and desperate, and more hopeful that changes could be made (m)

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Capillary Blood Sample</b> Obtaining an arteriovenous sample from a peripheral body site, such as the heel, finger or other transcutaneous site	Both groups participated in blood glucose and cholesterol screenings (a)  Through involvement with the faith community nurse, a diabetic man has lowered his capillary blood glucose results (a)
<b>Caregiver Support</b> Provision of the necessary information, advocacy, and support to facilitate primary patient care by someone other than a health care professional	We can put care teams in place to allow caregivers some time off or help with meals or child care (n)  One goal for 2008 was to increase the number of support groups to meet needs of caregivers (a)
<b>Complex Relationship Building</b> Establishing a therapeutic relationship with a patient to promote insight and behavioral change	People come for weekly blood pressure checks and diabetic follow up and other chronic or acute problems. But relationship care is the link (n)  Another nurse helped to reestablish the relationship between elderly woman diagnosed with Alzheimer's disease and her previously estranged daughter (a)
<b>Conflict Mediation</b> Facilitation of constructive dialogue between opposing parties with a goal of resolving disputes in a mutually acceptable manner	The patient felt threaten by a particular nurse. The family asked for my assistance when I came to visit. I called the case manager and asked her to investigate and then speak to the family. The situation was resolved and things improved (n)  An example of a program was "Anger Management and Conflict Resolution" (a)
<b>Consultation</b> Using expert knowledge to work with those who seek help in problem solving to enable individuals, families, groups, or agencies to achieve identified goals	The willingness and availability of a health care professional to consult and receive hands on advice (m)

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Coping Enhancement</b> Assisting a patient to adapt to perceived stressors, changes, or threats which interfere with meeting life demands and roles	<p>Helped me understand the whys and hows of physical conditions and how to overcome or to cope (m)</p> <p>An example of a program was “Coping with the Holidays” (a)</p> <p>One nurse provided practical information, electronic resources, and nursing knowledge about a specific disease, its treatment, and methods of coping with this chronic disease that allowed a female member to manage her condition more effectively (a)</p>
<b>Cost Containment</b> Management and facilitation of efficient and effective use of resources	<p>We also share food shopping tips and health tips and suggestions which hopefully save on medical expenses (m)</p> <p>She always does homework with regards to what it will cost the person and is it affordable (c)</p> <p>She evaluates programs/screenings to determine cost efficiency and will partner with other congregational nurses to get the most beneficial result (n)</p> <p>The report mentioned that immunizations, early detection of acute and chronic illnesses, and early treatment of health conditions decrease the expenses associated with treatments (a)</p> <p>The prevention, early detection, and early treatment for osteoporosis are key elements in preventing costly complications and decreasing health care costs for this disease (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Counseling</b> Use of an interactive helping process focusing on the needs, problems, or feelings of the patient and significant others to enhance or support coping, problem solving, and interpersonal relationships	<p>She (CN) is a member of my congregation and so provides invaluable spiritual counseling (m)</p> <p>Counseling about diet, exercise, behaviors (sexual, familial relationships, occupational)--stress &amp; how to manage decisions/consequences (c)</p> <p>Making resources such as screenings, counseling, published literature, etc. available in areas where it's otherwise unavailable (c)</p> <p>Available to research health topics, counsel individuals, offer preventive health education and exercise sessions (n)</p> <p>Another goal was to provide personal counseling and advocacy for homeless populations and clients with limited income (a)</p>
<b>Crisis Intervention</b> Use of short-term counseling to help the patient cope with a crisis and resume a state of functioning comparable to or better than the pre-crisis state	<p>The nurse visiting and counseling with me and several family members during a time of crisis made me feel less anxious and desperate, and more hopeful that changes could be made (m)</p> <p>I have had several recent crises in my life, and she has been the one person who has helped me through these difficult times (m)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Culture Brokerage</b> The deliberate use of culturally competent strategies to bridge or mediate between the patient's culture and the biomedical health care system	<p>The cultural impact is probably the sharing of medical advice among friends &amp; family (m)</p> <p>The cultural impact of faith community nursing on me is the exposure to people who speak another language who, at times share some cultural or historical aspects (m)</p> <p>The information that has been provided has included health risk for all different cultures/ethnic groups. This makes us more aware of the differences that bring us together, a respect for different ways of doing things (c)</p> <p>We live in a very culturally diverse community and the FCN works with each group to help them understand nutrition and the importance of good decisions (c)</p> <p>They are always well informed and uses translator to insure all attendees understand and are able to get answers to questions and concerns (c)</p> <p>Materials are provided to members based on the cultural values, customs (n)</p>
<b>Decision-Making Support</b> Providing information and support for a patient who is making a decision regarding health care	<p>Understanding of personal problems with past experience giving sound advice so best decisions are made by all parties involved (m)</p> <p>The FCN works with each group to help them understand nutrition and the importance of good decisions (c)</p> <p>Sometimes we help the out of town family to stay connected, to know how to make long distance decisions (n)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Developmental Enhancement: Adolescent</b> Facilitating optimal physical, cognitive, social, and emotional growth of individuals during the transition from childhood to adulthood	<p data-bbox="646 369 1404 478">Teenagers in our congregation appear to feel very comfortable talking with the congregational nurse on a variety of topics (m)</p> <p data-bbox="646 516 1404 625">Most members--including children &amp; youth-- can verbalize a “heart healthy” diet &amp; the benefits of regular physical activity (m)</p> <p data-bbox="646 663 1404 699">Our nurse may be offering a class on sexuality for teens (c)</p> <p data-bbox="646 737 1404 846">Our youth participated in the GO FAR 5K Run. During the 10 week program they gradually increased their endurance (n)</p> <p data-bbox="646 884 1404 953">Addressing self-esteem issues in adolescents was a program goal (a)</p> <p data-bbox="646 991 1404 1136">Educational activities that targeted the culture of this specific age group included “Food Pyramid and Portion Sizes for Adolescents” and “Family Life and Changing Bodies in Adolescence” (a)</p> <p data-bbox="646 1173 1404 1243">One goal was to plan intergenerational events to involve more youth (a)</p>



Nursing Intervention Definition	Description by Participant
<b>Developmental Enhancement: Child</b> Facilitating or teaching parents/caregivers to facilitate the optimal gross motor, fine motor, language, cognitive, social and emotional growth of preschool and school-aged children	<p>Most members--including children &amp; youth-- can verbalize a “heart healthy” diet &amp; the benefits of regular physical activity (m)</p> <p>Working mothers appear more aware of “bad” eating habits--fast foods--and more aware of benefits of fruits &amp; veggies for snacking and of taking time to prepare a nutritious meal in the evenings after work with assistance from dads &amp; the children (m)</p> <p>I strongly believe that activities such as our Intergenerational Tea and Grandparents Camp have help build stronger bonds between me, my children, and grandchildren and provide an opportunity to pass on traditions and values to them (m)</p> <p>Our nurse also participates in worship services by doing children’s messages related to the sermon by the minister (c)</p> <p>FCN works with Latinos and African-Americans, and helps them make their traditional foods healthier by limiting sodium and fat. The healthier choices help the younger children still have traditional foods/customs but healthier (n)</p> <p>I did a series on “The Temple of God”--focusing on nutrition, exercise, sleep, &amp; self-esteem. It was exciting as the children would share what they had learned in school about the food pyramid with the older people (n)</p> <p>I conduct vision screenings for children at Vacation Bible School. Vision deficits found before school starts should help the children have a better school year (n)</p> <p>One faith community nurse sponsored “Girls on the Run.” This activity was for girls in third, fourth, and fifth grades and topics included nutrition, peer pressure, and developing a spiritual life (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Dying Care</b> Promotion of physical comfort and psychological peace in the final phase of life	<p>He died two days later, and our nurse had stayed with me during those last hours and was there with my family in the hospital when he died (m)</p> <p>One of the special gifts that I have had the privilege to provide is that of sitting with the family of a dying client (n)</p> <p>We offer comfort to members and their families who are experiencing end-of-life decision making (n)</p> <p>Many families were assisted with end-of-life issues (a)</p> <p>An imprisoned son was able to visit his dying mother and attend her funeral through the faith community nurse's involvement with the family (a)</p>
<b>Emotional Support</b> Provision of reassurance, acceptance, and encouragement during times of stress	<p>Her visits improve my mental and emotional wellbeing (m)</p> <p>Her explanation was that I had given her more emotional support than anyone had (n)</p> <p>It is such a joy to have the freedom to minister to the whole person-mentally, physically, spiritually, and emotionally (a)</p>
<b>Environmental Management</b> Manipulation of the patient's surroundings for therapeutic benefit, sensory appeal, and psychological well-being	<p>Our nurse has provided a variety of services for our church members including finding and providing furniture for a needy parishioner (c)</p> <p>If they are trying to get an apartment or house for their family and do not have furniture, I try to arrange to meet that need through various agencies (n)</p> <p>When I visited her, she had a plastic chair, a wicker yard chair and an air mattress to sleep on. I obtained furniture for her from a local agency (n)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Environmental Management: Comfort</b> Manipulation of the patient's surroundings for promotion of optimal comfort	All the services the nurse renders helps them to feel better and live more comfortably (c)
<b>Environmental Management: Home Preparation</b> Preparing the home for safe and effective delivery of care	<p>She helped me choose my surgeon and was very attentive to my needs including lining up home nursing care when I was allowed to come home. She helped my daughter line up the medications that were prescribed (m)</p> <p>A nurse identified an unsafe home environment and collaborated with several people to resolve the situation while allowing the member to maintain control and retain personal dignity (a)</p>
<b>Environmental Management: Safety</b> Monitoring and manipulation of the physical environment to promote safety	<p>Not only has she routinely called to check on me, she has visited me and helped me do a little house re-arranging for my safety. Removing those “throw rugs”, putting “things” where they are more convenient for me, even getting into my bath tub to double check my new shower stool = all stand out as such important helpful things she has done for me (m)</p> <p>Frequently assess elderly r/t living situation &amp; general home safety (n)</p> <p>Other nurses worked with multiple elderly individuals to get them out of unsafe home environments and into more appropriate or optimal living situations (a)</p>

<b>Nursing Intervention Definition</b>	Description by Participant
<b>Exercise Promotion</b> Facilitation of regular physical activity to maintain or advance to a higher level of fitness and health	<p>Faith community nursing helps me maintain a healthy state by encouraging weekly exercise in a positive, interactive group (m)</p> <p>Our nurse has provided a variety of services for our church members including conducting weekly exercise programs (c)</p> <p>Exercise programs are provided (n)</p> <p>One nurse sponsored "Turn Off the TV" week. This initiative promoted interactions and building relationships with others and encouraged physical activity (a)</p>
<b>Exercise Promotion: Strength Training</b> Facilitating regular resistive muscle training to maintain or increase muscle strength	<p>The chair exercise program is the longest running and has had a number of outcomes: "I can get up from the commode more easily." "I don't have as much trouble getting out of low chairs." A member of the chair exercise group had breast surgery and she felt her recovery was hastened by the exercise prior to surgery (n)</p> <p>Many individuals began regular exercise programs arranged by the nurse with increased muscular strength as a documented health benefit (a)</p>
<b>Exercise Therapy: Ambulation</b> Promotion and assistance with walking to maintain or restore autonomic and voluntary body functions during treatment and recovery from illness or injury	<p>She has brought a lot of information to us about different things. Maintain what you have and put it work for you by walking (m)</p> <p>We have had several programs, for all ages that challenge people to get in the habit of walking. We had about 40 people in our simulated walk across the USA (n)</p> <p>Recently we started a walking program and 30 people participated. 75% of those have been walking and report benefits in the form of lowered blood sugar, decreased cholesterol, more energy, and weight loss (n)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Exercise Therapy:</b> <b>Joint Mobility</b> Use of active or passive body movement to maintain or restore joint flexibility	<p>Two men, each had strokes involving their left side of the body, joined the chair exercise program. One gained about 12 inches of elevation with his left arm (n)</p> <p>The Dancing for exercise program was done per request of a member of the congregation. One man, a chiropractor who recently had knee surgery, felt that the dancing was good rehabilitation (n)</p> <p>Nurses organized regular exercise programs and physical health outcomes realized through these measures were improved flexibility and mobility (a)</p>
<b>Exercise Therapy:</b> <b>Muscle Control</b> Use of specific activity or exercise protocols to enhance or restore controlled body movement	<p>Two men, each had strokes involving their left side of the body, joined the chair exercise program. One gentleman hadn't been able to use his left arm for 30 plus years. He now is able to open door with it (n)</p>
<b>Family Integrity</b> <b>Promotion</b> Promotion of family cohesion and unity	<p>Our CN's visits and interest enable me to remain in touch with my extended family and to dabble in genealogy (m)</p> <p>I strongly believe that activities such as our Intergenerational Tea and Grandparents Camp have help build stronger bonds between me, my children, and grandchildren and provide an opportunity to pass on traditions and values to them (m)</p> <p>In 2002, one faith community nurse promoted a "Turn off the TV Week" so individuals and families could establish connections, increase interactions, and build relationships with others (a)</p> <p>Another nurse helped to reestablish the relationship between elderly woman diagnosed with Alzheimer's disease and her previously estranged daughter (a)</p> <p>Increased contact between family members was the result of another nurse's service to individuals in her faith community (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Family Involvement Promotion</b> Facilitating participation of family members in the emotional and physical care of the patient	<p>She has helped me through the worse times of my blind mother-in-law who has PAD, COPD, and many more things (m)</p> <p>Sometimes we help the out of town family to stay connected, to know how to make long distance decisions (n)</p> <p>The classes gave one family the self confidence to grant their mother's wish to come back home for a visit (n)</p> <p>I also talked to his wife about meal planning and gave her information about the glycemic index (n)</p> <p>An imprisoned son was able to visit his dying mother and attend her funeral through the faith community nurse's involvement with the family (a)</p>
<b>Family Mobilization</b> Utilization of family strengths to influence patient's health in a positive direction	<p>She helped my daughter line up the medications that were prescribed. I would never have recovered so fast and so fully without her help (m)</p> <p>One lady recently told me that something I had said in my prayer on my visit the day before had given her the courage to make a request of her brother for some financial assistance. He has considerable funds and she lost her money in the stock market. He agreed to help her. My client could then focus on the important business of rehabilitation (n)</p> <p>A third example described the situation where a female member voluntarily shared her knowledge of the proper technique for breast self-examination with family and friends (a)</p> <p>Through one nurse's advice, intervention, and caring, a woman was able to leave an abusive relationship and to establish a new life and new opportunities for herself and her children (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Family Support</b> Promotion of family values, interests and goals	<p>Our nurse has provided a variety of services for our church members including working with two needy families adopted by our congregation in helping them achieve self-support for themselves (c)</p> <p>The family is appreciative of the support and the time you spend with them (n)</p> <p>The FCN offers support, a listening ear &amp; prayers to all, both client and family members (n)</p> <p>I'm trying to help the parents see that helping their children to stay in school may enable their children to be the ones to really break the cycle (n)</p>
<b>Financial Resource Assistance</b> Assisting an individual/family to secure and manage finances to meet health care needs	<p>I found the community nurse <u>very</u> helpful to me when I was seriously ill last year. She helped me find resources to help me (m)</p> <p>It helped me save money through health fairs, regular blood pressure checks, and screenings and therefore detecting problems early and having lower dosage of medicines and being able to work (m)</p> <p>Offers other avenues to make such care free, less cost, or affordable (c)</p> <p>A large part of my ministry involves helping them to find access to care, finding resources to help with finances and even actually going with them to get the resources (n)</p> <p>Because of some economic issues, a woman with hypertension had not been examined by a physician in over 40 years. The faith community nurse served as an advocate for her and helped her to obtain affordable medical care (a)</p> <p>Program activities featured financial assistance for medical care and prescription medications needed by parishioners (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Fiscal Resource Management</b> Procuring and directing the use of financial resources to ensure the development and continuation of programs and services	Our FCN is working through a grant & some money from the community organization of churches. It has been a slow process getting the community to add some money to the dwindling grant (m)  A goal for 2008 was to apply for grants to increase working capital (a)
<b>Forgiveness Facilitation</b> Assisting an individual's willingness to replace feeling of anger and resentment toward another, self, or higher power, with beneficence, empathy, and humility	Other educational topics were forgiveness, peace, and healing (a)  The topic of a speaker at a retreat for nurses was "The Practice of Forgiveness as a Healing Ministry" (a)
<b>Grief Work Facilitation</b> Assistance with the resolution of a significant loss	When my husband became very ill suddenly, and I took him to the ER, she is the one I called. He died two days later, and our nurse had stayed with me during those last hours and was there with my family in the hospital when he died. She remembers the important anniversaries of his death, and we always have lunch together on that day (m)  Encouragement from support group members was available for persons experiencing grief or depression (a)
<b>Health Care Information Exchange</b> Providing patient care information to other health professionals	Each individual has a personal record card they take with them to their doctor's visit. Most doctors appreciate seeing that information (n)



<b>Nursing Intervention</b> Definition	Description by Participant
<b>Health Education</b> Developing and providing instruction and learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities	<p data-bbox="646 369 1406 478">Learning about nutrition, disease prevention coupled with the spiritual adds a dimension to our congregation where many members have benefitted (m)</p> <p data-bbox="646 516 1406 585">She has offered many programs in the health field to our whole congregation (m)</p> <p data-bbox="646 623 1406 732">The programs--health topics--are usually well attended. The nurses have an opportunity to provide health information and to dispel myths and misinformation (m)</p> <p data-bbox="646 770 1406 879">She demonstrated self-breast examinations and let us feel a silicone display breasts with lumps so we can identify them in ourselves (m, p)</p> <p data-bbox="646 917 1406 987">The faith community nurse puts on educational classes, seminars and health fairs for the entire community (c)</p> <p data-bbox="646 1024 1406 1176">Programs provided and conducted by the faith community delivers relevant topics to improved daily living and health conditions not only for myself by the church and congregation as a whole (c)</p> <p data-bbox="646 1213 1406 1323">This is a major component of what I do--education is provided through health fairs--bulletin boards--and individually (n)</p> <p data-bbox="646 1360 1406 1501">Educational programs, personal counseling, bulletin board displays, health hints in the Sunday Bulletin and the monthly newsletter, "The Wellness Link," have made up to date information on health issues more accessible (n)</p> <p data-bbox="646 1539 1406 1715">Many people attended a variety of health education activities related to the social aspect. Some examples of these programs were "Effects and Hazards of Smoking," "Sexually Transmitted Diseases," and "Avoiding Illness on Vacation" (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Health Literacy Enhancement</b> Assisting individuals with limited ability to obtain, process, and understand information related to health and illness	<p>She has been willing to cut through the “doctor-speak” and give helpful lay terminology (m)</p> <p>Sometimes I am over-whelmed by doctor’s information, and I forget or miss the opportunity to ask a question. My faith nurse is there to assist (m)</p> <p>The faith community nurse has given me information on Alzheimer, has helped me with talking with the doctor (m)</p> <p>Nurses can reinterpret medical information that’s been given. Oftentimes persons are confused by what they hear. They still don’t know the options they have (c)</p> <p>She also educates before they visit a doctor so they will know what questions to ask (c)</p> <p>Improved compliance with treatment regimen because they have someone they can ask questions (n)</p> <p>Clients are referred to their personal physician and are provided with needed information to understand and deal with their condition (n)</p> <p>Nurses were described and commended as valuable resources for converting medical terms, conditions, and instructions into less technical, practical, and understandable terms for congregational members (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Health Screening</b> Detecting health risks or problems by means of history, examination, and other procedures	<p data-bbox="646 369 1333 441">She also has had B/P screenings on Sunday mornings, which again was helpful to me (m, p)</p> <p data-bbox="646 478 1365 585">I benefit physically and mentally by taking advantage of the programs and screenings the parish nurse offers our congregation (m)</p> <p data-bbox="646 623 1130 659">Health screenings bring awareness (c)</p> <p data-bbox="646 697 1403 804">Preventative care--screenings that have impacted care by assessing ↑ B/P, low pulse rates through early intervention--on two occasions have averted a possible stroke (n)</p> <p data-bbox="646 842 1349 913">Our community wide osteoporosis screening picked up osteoporosis and osteopenia (n)</p> <p data-bbox="646 951 1382 1022">I conduct vision screenings for children at Vacation Bible School (n)</p> <p data-bbox="646 1060 1370 1131">We also had mental health screenings for depression and dementia (n)</p> <p data-bbox="646 1169 1390 1318">Another nurse reported that a school-aged boy enjoyed more frequent participation, greater fun, and better performance in social sports activities after she intervened during a vision screening and he acquired glasses (a)</p> <p data-bbox="646 1356 1360 1461">Two men who participated in an osteoporosis screening were referred to physicians due to abnormal results, and started on appropriate treatments (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Health System Guidance</b> Facilitating a patient's location and use of appropriate health services	<p>Helps navigate the health system &amp; other resources in the community (m)</p> <p>My congregation may see a nurse long before they see a doctor. They often have difficulty in making health choices and our nurse guides them (c)</p> <p>A large part of my ministry involves helping them to find access to care (n)</p> <p>The nurse located affordable medical care for a woman with dangerously high blood pressure and the member received appropriate and ongoing treatment (a)</p> <p>A nurse located a primary care provider for a member who was using the emergency room for non-emergent health issues (a)</p>
<b>Hope Inspiration</b> Enhancing the belief in one's capacity to initiate and sustain actions	<p>The nurse visiting and counseling with me and several family members during a time of crisis made me feel less anxious and desperate, and more hopeful that changes could be made (m)</p> <p>A nurse can &amp; does bring hope &amp; informed understanding through counseling &amp; education (c)</p> <p>The spiritual impact of faith community nursing is evident in our setting because of the hope people find in the nurse's participation in their care (c)</p> <p>My willingness to come to their home, listen and exchange points of view and pray with them has given them hope (n)</p> <p>The reports included accounts of senior citizens who experienced increased hope (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Humor</b> Facilitating the patient to perceive, appreciate, and express what is funny, amusing, or ludicrous in order to establish relationships, relieve tension, release anger, facilitate learning, or cope with painful feelings	<p>She has seen the cancer and has helped me laugh at it (m)</p> <p>Another faith community nurse reported how she and her family shared some garden space with an immigrant family. The garden became a place of friendship, a method of exchanging ideas, and a time for sharing both ways. In the garden, the immigrant mother came out of her sadness and was able to laugh (a)</p>
<b>Immunization/Vaccination Management</b> Monitoring immunization status, facilitating access to immunizations, and providing immunizations to prevent communicable disease	<p>Our parish nurse has coordinated flu shot clinics during Sunday mornings (m, p)</p> <p>As often as I can, I volunteer to help at the flu clinics that she sponsors (m)</p> <p>Five hundred free influenza vaccinations were given to homeless individuals, immigrant populations, and elderly people on fixed incomes (a)</p>
<b>Learning Facilitation</b> Promoting the ability to process and comprehend information	<p>The visits by our CN keep me on fairly stable ground emotionally. Because of this, I am free to continue to learn and grow in new areas, such as cooking, computer knowledge, sewing, and needlework, and current events (m)</p>
<b>Learning Readiness Enhancement</b> Improving the ability and willingness to receive information	<p>It has taught me to rethink what I think I know and relearn my things I need to know such as nutrition, eating habits, exercise and meditation (m)</p> <p>The part in this question where it states <b>change what you know</b> is very interesting because as a society we do not change from our habits and rutens easily. When it comes to our thinking and knowledge it is sometimes stubbornness as well. I never want to think that I know it all but always ready to learn and grow from other people (m)</p> <p>Information given by parish nurse may be the first opportunity some have of learning the importance of wellness (c, p)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Medication Management</b> Facilitation of safe and effective use of prescription and over-the-counter drugs	<p>She helped my daughter line up the medications that were prescribed (m)</p> <p>It allows the faith community nurse to check their health and medications (c)</p> <p>The work of the congregational nurse obviously increases the understanding of our parishioners relative to a variety of health issues and the proper use of medications (c)</p> <p>Our nurse has provided a variety of services for our church members including setting up systems for taking various drugs when this would otherwise be confusing to members (c)</p> <p>Many in my congregation are integrating the information I have given them into their own life styles and are taking their meds more consistently (n)</p> <p>Faith community members were more compliant with continuous monitoring of selected health conditions and with taking prescribed medications (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Nutritional Counseling</b> Use of an interactive helping process focusing on the need for diet modification	<p>The nurse helps me with information about diet, cholesterol information (m)</p> <p>I have had a number of conversation with the parish nurses about keeping a low sodium diet (m)</p> <p>The FCN works with each group to help them understand nutrition and the importance of good decisions (c)</p> <p>Many widowers are poor at taking care of their dietary needs. Our nurse encourages them to eat more healthily (c)</p> <p>We have discussed the above issues and most everyone has acknowledged that the “traditional style” of eating is not healthy, and they try to eat more fruits and veggies and less red meat, pork and fried foods (n)</p> <p>One faith community provided a nutrition and cooking class that emphasized economic food preparation (a)</p> <p>Documented changes in dietary practices that people implemented were eating more vegetables and fresh fruits, drinking more water, reducing the amount of fried foods, choosing healthier snacks, and selecting foods with lower sodium, lower fat, and higher fiber content (a)</p>
<b>Oral Health Promotion</b> Promotion of oral hygiene and dental care for a patient with normal oral and dental health	Toothbrushes and toothpaste were given to neighborhood children at health fair sponsored by another faith community (a)
<b>Pain Management</b> Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient	The core exercises we did helped one woman relieve her back aches (n)

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Parent Education:</b> <b>Childrearing Family</b> Assisting parents to understand and promote the physical, psychological, and social growth and development of their toddler, preschool, or school-aged child/children	She also works with our local school, and childhood center. She educates senior citizens, pre-k students and everyone in between (c)  FCN works closely with pre-k students and parents on nutrition--healthy eating and with a parent group at the early childhood center (n)
<b>Parent Education:</b> <b>Infant</b> Instruction on nurturing and physical care needed during the first year of life	One nurse developed a “new baby” visitation program to help families in that special situation (a)
<b>Physician Support</b> Collaborating with physicians to provide quality patient care	She came as soon as I called her and took me to my doctor’s office. From there she took me to the hospital as ordered (m)  This new lifestyle lowered their BP enough that I referred them to their doctor to see if their BP medication could be reduced (n)  Clients are referred to their personal physician and are provided with needed information to understand and deal with their condition (n)
<b>Preceptor: Student</b> Assisting and supporting learning experiences for a student	The start of the Congregational Social Work Education Initiative has been a great help to both the students and the congregational nurses (n)



<b>Nursing Intervention</b> Definition	Description by Participant
<b>Presence</b> Being with another, both physically and psychologically, during times of need	<p>Presence and attention are provided to all who come to the nurse (n)</p> <p>By being accessible to the congregation, I feel my presence gives comfort (n)</p> <p>Provide spiritual support--often just a presence--communicating I care (n)</p> <p>Additional examples that referred to the nurse's work included using the ministry of presence (a)</p>
<b>Program Development</b> Planning, implementing, and evaluating a coordinated set of activities designed to enhance wellness, or to prevent, reduce, or eliminate one or more health problems for a group or community	<p>She has offered many programs in the health field to our whole congregation (m)</p> <p>Attending the Saturday wellness program that the nurse from the congregational nurse program has sponsored, I learn a variety of useful information about wellness (m)</p> <p>Programs provided and conducted by the faith community delivers relevant topics to improved daily living and health conditions not only for myself by the church and congregation as a whole (c)</p> <p>We offer different educational programs and health fairs that are family oriented. But we offer teachings in current health problems, i.e. swine flu, fireworks, cookouts, etc (n)</p> <p>Our "Stomp Out Stroke" program was a monthly program for a group of people wishing to learn how to lessen their risk for stroke and heart disease (n)</p> <p>A nurse presented a program on emergency preparedness to identify people who lack support system for managing environmental situations such as a severe thunderstorm or ice storm (a)</p> <p>Other programs that concentrated on financial savings were "Saving Money on Health Care," "Generic Versus Trade Drugs," "Scams Targeting Seniors," and "Avoiding Illness on Vacation" (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Referral</b> Arrangement for services by another care provider or agency	<p>Helps navigate the health system &amp; other resources in the community such as VIC (m)</p> <p>Our nurse has put several church members in contact w/ agencies that have helped in different areas (c)</p> <p>She serves as an excellent resource and referral center connecting the congregation to many of the activities and services available in the community (n)</p> <p>Counseling services and referral to community resources helped several families in crises situations (a)</p>
<b>Religious Ritual Enhancement</b> Facilitating participation in religious practices	<p>When I needed a ride to a church meeting one evening, she drove out of her way to drive me there and back home (m)</p> <p>The shut-ins and nursing home of our church now receive home communion during Advent and Lent (n)</p> <p>I often inform the minister when homebound communion might be needed. I also suggest when it would be appropriate to anoint with oil for healing. I have occasionally transported clients to church who can't get there any other way (n)</p> <p>Other interventions with a social impact have allowed individuals to begin or resume participation in faith community activities including worship services, fellowship opportunities, group meetings, and day camp events (a)</p> <p>One goal was that the nurse become a minister of the Eucharist and take communion to those who are ill (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Relocation Stress Reduction</b> Assisting the individual to prepare for and cope with movement from one environment to another	<p>She was very attentive to my needs including lining up home nursing care when I was allowed to come home (m)</p> <p>Some had to move to less expensive living quarters. This created an emotional trauma that many had never dealt with before. The support that the Parish Nurse brings to that situation has been invaluable and well received (n)</p> <p>Other nurses worked with multiple elderly individuals to get them out of unsafe home environments and into more appropriate or optimal living situations (a)</p>
<b>Research Data Collection</b> Collecting research data	<p>With our yoga program we tried to study the impact of yoga on Blood Pressure. While our data didn't give any real conclusion (n)</p>
<b>Risk Identification</b> Analysis of potential risk factors, determination of health risks, and prioritization of risk reduction strategies for an individual or group	<p>One example is my high blood pressure I knew I was at risk do to the fact of family history; however through the nursing program I have someone in the medical field that can keep me up dated and encourage me to take my medicine daily (m)</p> <p>The information that has been provided has included health risk for all different cultures/ethnic groups. This makes us more aware of the differences that bring us together, a respect for different ways of doing things (c)</p> <p>During a church sponsored community cholesterol screening, participants were invited to join a new program, "Stomp Out Stroke", specifically aimed at lowering the risk of stroke and heart disease (n)</p> <p>In 2006, one goal with a physical health focus was to identify individuals with increased risks for common diseases and provide strategies to reduce those risks (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Security Enhancement</b> Intensifying a patient's sense of physical and psychological safety	<p>She helped me do a little house re-arranging for my safety. Removing those “throw rugs”, putting “things” where they are more convenient for me, even getting into my bath tub to double check my new shower stool (m)</p> <p>Frequently assess elderly r/t living situation &amp; general home safety (n)</p> <p>A nurse identified an unsafe home environment and collaborated with several people to resolve the situation while allowing the member to maintain control and retain personal dignity (a)</p>
<b>Self-Awareness Enhancement</b> Assisting a patient to explore and understand his/her thoughts, feelings, motivations, and behaviors	<p>It has made me more aware of both physical health and mental health and what my body and mind needs to be healthier (m)</p>
<b>Self-Efficacy Enhancement</b> Strengthening an individual's confidence in his/her ability to perform a health behavior	<p>Having someone available to you as a resource has been very reassuring and makes you feel more confident and inspired to improve yourself in all aspects of your life (m)</p> <p>The classes gave one family the self confidence to grant their mother's wish to come back home for a visit (n)</p>
<b>Self-Esteem Enhancement</b> Assisting a patient to increase his/her personal judgment of self-worth	<p>The boy was amazed that he actually made it for the whole race. It really helped his self-esteem (n)</p>
<b>Smoking Cessation Assistance</b> Helping another to stop smoking	<p>One goal was to host smoking cessation networks and facilitate support groups (a)</p> <p>Other positive health outcomes were included decreased alcohol, tobacco, and drug use (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Socialization Enhancement</b> Facilitation of another person's ability to interact with others	<p>I always considered myself an outgoing person and friendly but the nursing program has developed those characteristics in me a little more (m)</p> <p>I am able to interact with others without feeling superior or inferior (m)</p> <p>We meet twice a month to play games that stimulate our minds and provide additional socialization (n)</p> <p>One nurse sponsored "Turn Off the TV" week. This initiative promoted interactions and building relationships with others (a)</p>
<b>Spiritual Growth Facilitation</b> Facilitation of growth in patient's capacity to identify, connect with, and call upon the source of meaning, purpose, comfort, strength, and hope in their lives	<p>The program helps the church and members stay connected by assisting, showing love, and caring for members in need. All of these activities help me in my spiritual growth (m)</p> <p>The daily study and weekly discussion lead individuals to great insight for themselves and in turn spiritual growth (n)</p> <p>Multiple educational offerings dealt with spiritual growth and development, creation, prayer, balance, death, and grief (a)</p> <p>An early lesson documented in an annual report was that faith community nursing must be a continual journey of professional enrichment and spiritual growth (a)</p>
<b>Spiritual Support</b> Assisting the patient to feel balance and connection with a greater power	<p>Help us achieve this balance between physical, emotional, spiritual, and mental well being (c)</p> <p>Her visits provide them with an uplifting spiritual touch (c)</p> <p>Our nurse nurtures the spirituality of the congregation in her visits to hospital parishioners as well as person in their homes and in the totality of her ministry (c)</p>
<b>Substance Use Prevention</b> Prevention of an alcoholic or drug use lifestyle	<p>Through a nurse's intervention, a previous substance abuser has been drug free for a year and is not spending money on illicit or illegal drugs (a)</p> <p>Nurses sponsored a substance abuse symposium (a)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Substance Use Treatment</b> Supportive care of patient/family members with physical and psychosocial problems associated with the use of alcohol or drugs	I have helped find resources for medication, healthcare, food shelter, and even substances abuse treatment (n)  Another positive health outcome was decreased alcohol, tobacco, and drug use (a)  Group encouragement was available for persons experiencing substance abuse treatment (a)
<b>Suicide Prevention</b> Reducing risk of self-inflicted harm with intent to end life	She felt trapped and was so depressed that she wanted to commit suicide. Fortunately we had developed a good relationship and she allowed me to take her to the Emergency Mental Health Clinic (n)
<b>Support Group</b> Use of a group environment to provide emotional support and health-related information for members	Strengthening community relationships through support groups offered by/facilitated by the nurse (c)  Educational components of support groups are beneficial to the faith community (c)  One initial program goal was to develop support groups to address multiple physical and mental health issues (a)  Support groups organized and facilitated by the faith community nurses included those for individuals with breast or prostate cancer, Alzheimer's Disease, anxiety or panic disorders, and grief (a)
<b>Support System Enhancement</b> Facilitation of support to patient by family, friends, and community	She helped me utilize & grow my support system. I have no family in (specific location omitted) or this area--& I live alone (m)

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Surveillance</b> Purposeful and ongoing acquisition, interpretation, and synthesis of patient data for clinical decision-making	<p>Our CN keeps check on my depression--the old kind that I've struggled with for years, as well as the kind that seems to go with be shut-in and fairly isolated (m)</p> <p>The Faith Community Nursing allows me to keep a close check on my blood pressure (m)</p> <p>They look forward to her prayers, health checks and friendly visits. It allows the faith community nurse to check their health and medications (c)</p> <p>There is an extra set of eyes that's coming to the home/hospital or nsg home that will check on them and speak up for them (n)</p>
<b>Sustenance Support</b> Helping an individual/family in need to locate food, clothing, or shelter	<p>Our nurse has provided a variety of services for our church members including finding and providing furniture for a needy parishioner, and setting up and maintaining clothes and food closets for the needy (c)</p> <p>I have helped find resources for medication, healthcare, food shelter, and even substances abuse treatment (n)</p> <p>I tell them about Angel Food Ministry where they can use their food stamps to get quality meats, frozen and fresh fruit and vegetable etc. for less money (n)</p> <p>Collections of clothing and health care supplies contributed to hurricane relief (a)</p> <p>Program activities provide financial assistance for housing, shelter, food, and medical care needed by parishioners and community residents faced with emergency or crisis issues (a)</p>

<b>Nursing Intervention Definition</b>	Description by Participant
<b>Teaching: Disease Process</b> Assisting the patient to understand information related to a specific disease process	<p>She has brought a lot of information to us about different things we didn't know about diabetes (m)</p> <p>The nurse has provided valuable information that has helped me better understand my current medical condition (m)</p> <p>The work of the congregational nurse obviously increases the understanding of our parishioners relative to a variety of health issues, wellness programs, prevention, and the proper use of medications (c)</p> <p>Our "Stomp Out Stroke" program was a monthly program for a group of people wishing to learn how to lessen their risk for stroke and heart disease. We covered nutrition, signs and symptoms of a heart attack and stroke, small vessel heart disease, diabetes and heart disease, and many other topics (n)</p> <p>Educational offerings that addressed women's health included programs on heart disease, breast cancer, menopause, and hormone replacement therapy (a)</p> <p>A male patient had decreased fears about open-heart surgery after the faith community nurse educated him on the pros and cons of the surgery (a)</p>



Nursing Intervention Definition	Description by Participant
<b>Teaching: Group</b> Development, implementation, and evaluation of a patient teaching program for a group of individuals experiencing the same health condition	<p>She demonstrated self-breast examinations and let us feel a silicone display breasts with lumps so we can identify them in ourselves (m, p)</p> <p>As president of our women's group, the nurse has done presentations for our qtrly [<i>sic</i>] meetings--a health fair and talk on heart health for women (m, p)</p> <p>At least once a month a program is introduced to the church body which acts to teach and provide positive impact from topics that are important to all members (c)</p> <p>I can teach large groups then for weeks afterwards people come up to me asking questions or bringing me new ideas to me (n)</p> <p>One educational goal relevant to a specific social circumstance was to offer drug abuse education for youth groups (a)</p>
<b>Teaching: Individual</b> Planning, implementation, and evaluation of a teaching program designed to address a patient's particular needs	<p>It has taught me to rethink what I think I know and relearn my things I need to know such as nutrition, eating habits, exercise and meditation. I am learning a better way to live in all areas of my life (m)</p> <p>Through education by the parish nurse, I have a better understanding of the <u>whole person</u>, i.e. -my physical, mental, and spiritual well-being (m)</p> <p>Information given by parish nurse may be the first opportunity some have of learning the importance of wellness (c, p)</p> <p>Recently a newly diagnosed diabetic requested help with his diabetes. The client and I reviewed the basics of diet, exercise, medication and need for weight loss (n)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Teaching: Prescribed Diet</b> Preparing a patient to correctly follow a prescribed diet	<p>I have had a number of conversation with the parish nurses about keeping a low sodium diet because I have some swelling of my hip and lower extremities (m)</p> <p>FCN works closely with pre-k students and parents on nutrition--healthy eating (n)</p> <p>FCN works with Latinos and African-Americans, and helps them make their traditional foods healthier by limiting sodium and fat (n)</p> <p>We had an eight week nutrition and exercise series. A couple of diabetics learned more about eating strategies to control their blood sugar (n)</p>
<b>Teaching: Prescribed Medication</b> Preparing a patient to safely take prescribed medications and monitor for their effects	<p>During osteoporosis counseling a great number of individuals did not know the recommended dose for Calcium. They were also unaware that they should divide the dose and take vitamin D to allow for better absorption. I feel they will have better results because of the counseling (n)</p>
<b>Teaching: Sexuality</b> Assisting individuals to understand physical and psychosocial dimensions of sexual growth and development	<p>Our nurse may be offering a class on sexuality for teens. Preventing STDs and pregnancies are a priority for community health (c)</p>
<b>Telephone Consultation</b> Eliciting patient's concerns, listening, and providing support, information, or teaching in response to patient's stated concerns, over the telephone	<p>She gave my husband some much needed advice via phone call (m, p)</p> <p>Not only has she routinely called to check on me, she has visited me (m)</p> <p>Having an additional person who is going to call combats loneliness (n)</p>

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Touch</b> Providing comfort and communication through purposeful tactile contact	<p>Clearly there are other avenues of medical advice (i.e. internet), but a human touch is usually better (m)</p> <p>Sometimes I am able to answer their questions or just sit quietly holding their hand (n)</p> <p>One faith community nurse wrote that for a woman facing cancer “being able to pray with her, touch her, and counsel her was so rewarding for me and it appeared to give her comfort” (a)</p>
<b>Truth Telling</b> Use of whole truth, partial truth, or decision delay to promote the patient's self-determination and well-being	<p>When family members can't handle the truth our FCN is there breaking it down for the family (m)</p> <p>Our FCN was there to help my mother-in-law to see the truth of her illnesses (m)</p>
<b>Vehicle Safety Promotion</b> Assisting individuals, families and communities to increase awareness of measures to reduce unintentional injuries in motorized and non-motorized vehicle	One accomplishment was that problems with infant and car safety seats were identified and corrected (a)
<b>Visitation Facilitation</b> Promoting beneficial visits by family and friends	<p>The classes gave one family the self confidence to grant their mother's wish to come back home for a visit (n)</p> <p>An imprisoned son was able to visit his dying mother and attend her funeral through the faith community nurse's involvement with the family (a)</p>
<b>Vital Signs Monitoring</b> Collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications	A group of adults seek out the nurse to keep track of their blood pressure readings (m)

<b>Nursing Intervention</b> Definition	Description by Participant
<b>Weight Management</b> Facilitating maintenance of optimal body weight and percent body fat	She can educate on such matters as nutrition, exercise and weight control (m)  Many individuals began regular exercise or weight control programs (a)
<b>Weight Reduction Assistance</b> Facilitating loss of weight and/or body fat	The nurse helps me with information about diet, cholesterol information, and talks with me about different exercise to help with losing weight (m)  Our nurse is bringing a scale to the church and encouraging folks to participate in a weight loss program (c)  We had an eight week nutrition and exercise series. We did weekly weights and blood pressures and some of the folks were applying what they learned as indicated by their weight loss (n)  After participating in exercise classes, a diabetic women lost enough weight that she no longer needs medications for her diabetes (a)

(p: pilot study participant; m: faith community member; c: clergy representative; n: faith community nurse; a: annual report information)

Interventions and definitions were adapted and used with permission from Bulechek, G., Butcher, H. & Dochterman, J. (Eds.) (2008). Nursing Interventions Classification (NIC) (5th ed.) St. Louis: Mosby/Elsevier.

## CHAPTER V

### DISCUSSION

This research project was comprised of a pilot study and a main study. Participants in the pilot study (a) evaluated a newly developed demographic instrument and impact questionnaire that were used in the main study, and (b) provided initial and limited information concerning the impact of faith community nursing and interventions that faith community nurses use in their practice. The first purpose of the main study was to examine the impact of the faith community nursing program on a culturally diverse urban community in the southeastern United States from the perspectives of faith community members, clergy representatives, and faith community nurses. The second purpose was to identify nursing interventions that faith community nurses use in their practice with individuals, families, groups, communities, or society. The following two research questions were generated for the main study.

1. How do faith community members, clergy representatives, and nurses describe the impact of the faith community nurse program in their communities related to health, social, educational, cultural, financial and spiritual effects?
2. What interventions do faith community nurses provide in culturally diverse faith communities?

Results of this study provide evidence that faith community nursing in general, and the local faith community nursing program in particular, (a) extensively impact the lives

of individuals, families, groups, and communities; and (b) obviously have describable, scientific value. The unique care provided by this dedicated and specialized group of nurses has (a) positively contributed to improved outcomes with health, social, educational, cultural, financial, and spiritual effects; and (b) effectively used a variety of nursing interventions to accomplish these purposes. The exceptional nursing services have improved health care access for vulnerable, minority, disadvantaged, underserved, or at-risk populations. Health care spending has been reduced for members of this culturally diverse region through the earlier, accurate assessments and the appropriate, timely interventions of the faith community nurses.

### **Brief Summary of Major Findings Related to Research Question One**

Study participants described the health impact with an assortment of themes. All participant groups reported healthier lifestyles, specific physical and mental health benefits, avoidance of health care in other settings, and connections between physical, mental, and spiritual health. Additional topics pertaining to the health impact that were identified by faith community members, clergy representatives, or faith community nurses included (a) advantages relating to participation in activities, (b) averted potential heart attacks or strokes, (c) lifesaving interventions, (d) personal health counseling, (e) health system navigation, (f) improved management of chronic diseases, and (g) care for the body.

Individuals who returned questionnaires described the social impact with a variety of themes. All participant groups reported (a) social support, (b) social interactions, (c)

helping others or meeting needs of others, (d) improved communication, (e) stronger relationships, and (f) visits to homes, hospitals, and long-term health care facilities. Specific benefits identified by one or two of the three participant groups included (a) assistance from community agencies, (b) decreased loneliness, (c) ability to assist with events and activities at the faith community, and (d) improved self-esteem, self-confidence, or self-support. Study participants indicated that the social impact was positive and facilitated connections between varieties of phenomena.

Study participants described the educational impact with several different themes. All participant groups addressed (a) increased knowledge, awareness, or understanding concerning health issues; (b) positive changes in health of individuals or families as a result of education; (c) shared knowledge; and (d) integration of information into personal lifestyles. Individuals in one or two of the three participant groups mentioned the subjects of (a) empowerment, (b) personal health counseling, (c) health literacy, (d) seriousness of health issues, (e) availability of published literature, (f) future benefits of education, (g) the variety of techniques to make information available, and (h) the combination of educational features with spiritual aspects.

The cultural impact was described with a variety of terms. Individuals in each of the participant groups addressed (a) cultural traditions, values, beliefs, customs, behaviors, standards, norms, myths, communication, or information; (b) families, hereditary issues, or generational topics; (c) cultural similarities or differences; and (d) health risks, health practices, or health care. Responses of participants included society and living in a culturally diverse community. Additional topics addressed learning needs of different

groups and nutritional practices of ethnic or cultural groups. Individuals also mentioned the concepts of togetherness and lifestyles.

The financial impact was also described with several different themes. In their responses, all three participant groups reported (a) the concept of free, (b) saving money, (c) budgeting principles, (d) ability to work, (e) economically disadvantaged individuals, and (f) costs versus benefits. Faith community members and clergy representatives included the costs of having the nursing program while the faith community nurses included lack of payment for their services. Additional topics were the financial crisis of society, lack of health insurance benefits, and the importance of being self-supportive and productive. Responses from nurses focused on access to health care, locating resources for financial assistance, health care costs avoided through their interventions, and future financial benefits of education. Only faith community members indicated no financial impact from the nursing program.

Study participants described the spiritual impact a variety of themes. Individuals in each of the participant groups addressed the connection between spiritual and physical health or between the body, mind, and spirit. The concepts of (a) hope, (b) compassion, (c) comfort, (d) value, (e) care or caring, (f) spiritual support, and (g) spiritual benefits were recurrent themes in responses from all participant groups. All three participant groups mentioned God, prayer, and religious activities in their responses. Faith community members mentioned laughter, fun, helping others, and blessing. Clergy representatives wrote about intangible touch of the nurses. Faith community nurses



included (a) the intentional inclusion of the spiritual component, (b) meeting the needs of others, and (c) the importance of listening, accepting, and being present.

### **Brief Summary of Major Findings Related to Research Question Two**

Data analysis identified over 90 different nursing interventions that faith community nurses provided in their service to individuals, families, groups, the faith community, and the greater culturally diverse community. Many of the interventions were both mentioned by individuals in all three participant groups and located in the ten annual reports. The interventions pertained to a variety of topics and contributed to the health, social, educational, cultural, financial, and spiritual effects of the faith community nursing program. Some of the interventions with a health focus were (a) different types of exercise promotion and exercise therapy, (b) health screening, (c) immunization/vaccination management, (d) medication management, (e) pain management, (f) smoking cessation assistance, (g) substance use treatment, (h) vital signs monitoring, and (i) weight reduction assistance. Interventions that pertained to the social impact were (a) art therapy, (b) behavior modification: social skills, (c) complex relationship building, (d) family involvement promotion, (e) socialization enhancement, (f) support system enhancement, and (g) visitation facilitation. Educational interventions included (a) health education, (b) health literacy enhancement, (c) learning facilitation, (d) learning readiness enhancement, (e) parent education, and (f) teaching individual, groups, disease process, prescribed medications, prescribed diet, and sexuality. Culture brokerage, developmental enhancement, and family integrity promotion were examples

of interventions associated with the cultural impact. Examples of financial interventions were (a) cost containment, (b) financial resource assistance, (c) fiscal resource management, (d) referral, and (e) sustenance support. Interventions with a spiritual emphasis were (a) coping enhancement, (b) forgiveness facilitation, (c) grief work facilitation, (d) hope inspiration, (e) humor, (f) presence, (g) spiritual growth facilitation, (h) spiritual support, and (i) touch. Nursing interventions were based on the Nursing Intervention Classification (Bulechek, Butcher, & Dochterman, 2008), and used with permission of the publisher.

### **Meaning of the Findings in View of the Theory**

The Roy Adaptation Model (RAM) (Roy & Andrews, 1999) effectively and consistently provided for the assessment of the health impact in this study. According to the RAM, health is generally defined as the complete well-being and integrity of a person. From a broad perspective, study participants described the health impact in a holistic manner with multiple references to overall well-being and not the absence of illness, injury, disease, or disability. Numerous health-related activities and several interventions that specifically pertained to health contributed to individuals, families, and groups becoming more integrated as human beings with greater purposefulness in their human existence. Results indicated the RAM was an appropriate and compatible framework that allowed a holistic representation of the health impact based on questionnaire responses and identified health interventions.

Next, the RAM (Roy & Andrews, 1999) was a reasonable and useful tool for the examination of the social impact of the faith community nursing program. From a broad perspective, study participants described the social impact in a holistic manner with multiple references to their individual selves and to others. Many social activities and interventions particularly associated with the social aspect contributed to the process of individuals, families, and groups becoming more integrated as human beings with evidence of growth, understanding, involvement, and unity. Data analysis revealed that the RAM efficiently and systematically permitted a comprehensive description of the social impact based on questionnaire responses and identified social interventions.

Third, the RAM (Roy & Andrews, 1999) appropriately allowed for the investigation of the educational impact in this project. From a general perspective, study participants described the educational impact with multiple references to personal learning, educational activities, availability of information, and the application of learned material to lifestyle behaviors. Many educational activities and educational interventions contributed to individuals, families, groups, and communities becoming more integrated as human beings with evidence of increased awareness, knowledge, and understanding. Research findings demonstrated that the RAM was an effective and appropriate framework that contributed to an extensive description of the educational impact on the basis of questionnaire answers and identified educational interventions.

Additionally, the RAM (Roy & Andrews, 1999) consistently and efficiently provided for the assessment of the cultural impact in this study. From a broad perspective, study participants described the cultural impact with references to cultural similarities and

differences, cultural traditions and values, and cultural sensitivity and diversity. Cultural behaviors, beliefs, and belonging to groups in combination with numerous interventions that were specifically related to the cultural impact contributed to the integration processes for individuals, families, groups, and communities. Results indicated the RAM was an appropriate and compatible framework that allowed a holistic representation of the cultural impact based on questionnaire responses and identified cultural interventions.

Fifth, the RAM (Roy & Andrews, 1999) was a reasonable and useful tool for the examination of the financial impact of the faith community nursing program. From a general perspective, study participants described the financial impact with multiple references to resources, costs, savings, and the concept of free. Several financial-related factors supported and maintained the effective adaptation and integrity of the persons in this project. Many statements in the data referred to financial interventions concerned with the obtaining, using, and sharing of material and monetary resources. Data analysis revealed that the RAM efficiently and systematically permitted a broad description of the financial impact based on questionnaire responses and identified financial interventions.

Finally, the RAM (Roy & Andrews, 1999) appropriately allowed for the investigation of the spiritual impact in this project. From a broad perspective, study participants described the spiritual impact in a holistic manner with multiple references to their beliefs, purposes, values, and relationships with God. Many spiritual activities and spiritual interventions contributed to the process of individuals, families, groups, and communities becoming more integrated with evidence of spiritual growth, spiritual support, and the integration of faith and health. Research findings demonstrated that the

RAM was an effective and appropriate framework that contributed to an extensive description of the spiritual impact on the basis of questionnaire answers and identified spiritual interventions.

## **Nursing Interventions in View of the Literature Research**

### **Health Interventions**

The variety of nursing interventions identified by this research is similar to those described in earlier studies. Interventions with a health focus included health counseling, health education, health screening, and an assortment of health promotion activities related to behavior modification strategies, dietary measures, exercise, and weight management. These interventions are consistent with findings by other researchers (Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Bokinskie & Kloster, 2008; Brown, Coppola, Glacona, Petriches, & Stockwell, 2009; Burkhart & Androwich, 2004; Chase-Ziolek & Iris, 2002; Chase-Ziolek & Striepe, 1999; Coenen et al., 1999; King & Tessaro, 2009; McCabe & Somers, 2009; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Miskelly, 1995; Mosack et al., 2006; Quenstedt-Moe, 2003; Rydholm, 2006; Tuck & Wallace, 2000; Tuck, Pullen, & Wallace, 2001; van Loon, 1998; Wallace et al., 2002; Weis et al., 1997). Additional health related interventions derived from the data and mentioned by previous researchers include (a) vital signs monitoring (Bitner & Woodward, 2004; Burkhart & Androwich, 2004; Burkhart et al., 2005); (b) health system guidance (Bard, 2006; Bokinskie & Evanson, 2009; Bokinskie & Kloster, 2008; Brendtro & Leuning, 2000; Burkhart et al., 2005; Chase-Ziolek & Iris, 2002; Patterson, 2007); (c)

medication management (Bitner & Woodward, 2004; Burkhart & Androwich, 2004; Burkhart et al., 2005; Chase-Ziolek & Striepe, 1999; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Weis et al., 1997); and (d) immunization/vaccination management (Chase-Ziolek & Iris, 2002; Chase-Ziolek & Striepe, 1999).

Many additional health interventions were identified in this study and will complement the work of other investigators. First, health care information exchange provides patient information discovered, gathered, or monitored in the faith community setting to other pertinent health care professionals. Second, health literacy enhancement assists individuals to acquire, process, and comprehend information related to health and illness. Third, pain management strategies contribute to an alleviation of or reduction in pain so that an acceptable level of comfort for the individual is achieved. Next, the analysis of potential health risk factors, the determination of health risks, and the prioritization of risk reduction strategies for individual, families, or groups form the intervention of risk identification. Smoking cessation assistance to help individuals stop smoking is a fifth health intervention that also has disease prevention implications. Substance use prevention is an intervention for the prevention of alcoholic or drug use lifestyles while substance use treatment provides supportive care to individuals and family members with physical and psychosocial problems associated with the use of alcohol or drugs. Finally, reducing the risk of self-inflicted harm with intent to end life forms the intervention of suicide prevention.

## **Social Interventions**

Multiple interventions identified in this study pertained to the social aspect. Social interventions that were documented by other investigators included making referrals, providing emotional or social support, and facilitating support groups (Bard, 2006; Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Bokinskie & Kloster, 2008; Burkhart & Androwich, 2004; Burkhart et al., 2005; Chase-Ziolek & Iris, 2002; Chase-Ziolek & Striepe, 1999; Coenen et al., 1999; Hinton, 2009; Koenig, 2008; McCabe & Somers, 2009; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Mendelson, McNeese-Smith, Koniak-Griffin, Nyamathi, & Lu, 2008; Miskelly, 1995; Mosack et al., 2006; Quenstedt-Moe, 2003; Rydholm, 2006; Tuck & Wallace, 2000; Tuck, Pullen, & Wallace, 2001; van Loon, 1998; Wallace et al. 2002; Weis et al., 1997). Additional interventions that were frequently documented were interactions involving listening or visiting people in homes, hospitals, and care facilities (Bard, 2006; Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Bokinskie & Kloster, 2008; Burkhart & Androwich, 2004; Burkhart et al, 2005; Chase-Ziolek & Striepe, 1999; Coenen et al., 1999; Hinton, 2009; Koenig, 2008; McCabe & Somers, 2009; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Mosack et al. 2006; Quenstedt-Moe, 2003; Rydholm, 2006; Tuck & Wallace, 2000; Tuck, Pullen, & Wallace, 2001; Wallace et al., 2002). Other social interventions reported by a small number of researchers included (a) coordinating volunteer activities (McDermott & Burke, 1993; McGinnis & Zoske, 2008; Rydholm, 2006); (b) establishing or strengthening relationships (Bard, 2006; Van Dover & Pfeiffer, 2007; van Loon, 1998); (c) providing violence or abuse protection support (Burkhart et

al., 2005; McGinnis & Zoske, 2008; Miskelly, 1995; Rydholm, 2006); (d) enhancing socialization processes (Coenen et al., 1999); (e) counseling people concerning family issues (King & Tessaro, 2009); (f) helping with home maintenance or home safety items (Burkhart et al., 2005; McDermott & Burke, 1993); (g) assisting in the selection of nursing care facilities (Bard, 2006); and (h) transporting individuals to community organizations or activities (Burkhart & Androwich, 2004).

Several social interventions identified in this study will add to the existing knowledge of faith community nursing. First, art therapy facilitates communication through a variety of artistic expressions. Next, behavior modification contributes to the development or improvement of interpersonal social skills. Third, bibliotherapy involves the therapeutic use of literature to enhance coping, insight, problem solving, and expressing personal feelings. Developmental enhancement of children and adolescents are two separate interventions that facilitate the social and emotional growth of preschool and school-aged children, and individuals making the transition from childhood to adulthood. Sixth, self-awareness enhancement assists individuals to explore and understand their personal thoughts, feelings, motivations, and behaviors. Finally, self-efficacy enhancement strengthens the person's confidence to perform specific health behaviors.

### **Educational Interventions**

Many interventions identified in this study pertained to the educational aspect. Interventions with an educational focus included (a) teaching individuals, families, and groups on a variety of health topics, (b) program development, implementation, and evaluation, and (c) health education. These interventions are consistent with findings by



many other researchers (Bard, 2006; Bitner & Woodward, 2004; Burkhart & Androwich, 2004; Burkhart et al., 2005; Chase-Ziolek & Iris, 2002; Chase-Ziolek & Striepe, 1999; Coenen et al., 1999; Hinton, 2009; King & Tessaro, 2009; Koenig, 2008; Kuhn, 1997; Mayhugh & Martens, 2001; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Miles, 1997; Mosack, Medvene, & Wescott, 2006; Tuck & Wallace, 2000; Tuck, Pullen, & Wallace, 2001; van Loon, 1998; Wallace et al., 2002; Weis et al., 1997). Other educational interventions that have been previously reported were (a) serving as preceptors for students (Brendtro & Leuning, 2000; Otterness, Gekrke, & Sener, 2007); (b) helping clients process information from physicians or other health care providers (Chase-Ziolek & Iris, 2002); and (c) offering health system guidance (Burkhart et al., 2005).

Several educational interventions derived from the data analysis of this study will add to the existing knowledge of faith community nursing. Developmental enhancement of children and adolescents are two separate interventions that facilitate the cognitive and language growth of preschool and school-aged children, and individuals making the transition from childhood to adulthood. The intervention of learning facilitation promotes the ability to process and comprehend information while the intervention of learning readiness enhancement improves the ability and willingness to receive information. Parent education for the infant provides instruction on the nurturing and physical care needed during the first year of life. Parent education for the childrearing family assists parents to understand and promote the physical, psychological, and social growth and development of toddlers, preschool children, or school-aged children. A final educational

intervention is vehicle safety promotion which assists individuals, families, and communities to increase awareness of measures to reduce vehicle related injuries.

### **Cultural Interventions**

Some interventions identified in this study pertained to the cultural aspect. One key cultural intervention documented by other investigators was cultural brokerage. This intervention addresses the careful and purposeful use of culturally competent strategies and activities to bridge or mediate between health care and the culture of the individual, family, group, or community (Bard, 2006; Bokinskie & Evanson, 2009; Burkhart et al., 2005; McGinnis & Zoske, 2008; Tuck, Pullen, & Wallace, 2001; Weis et al., 1997).

Some additional cultural interventions were identified in this study and will complement the work of other investigators. Three interventions pertain specifically to the cultural aspect of families. First, family integrity promotion addresses the unity and cohesiveness between family members. Second, family involvement promotion facilitates the participation of family members in the provision of physical, psychosocial, and spiritual care of the patient. Third, family mobilization influences the patient's health in a positive direction through utilization of family strengths. The intervention of risk identification analyses potential risk factors, determines actual risks, and prioritizes risk reduction strategies for cultural groups.

### **Financial Interventions**

A number of interventions identified in this study pertained to the financial aspect. Interventions with a financial focus included referral, financial resource assistance, and

sustenance support. As a financial nursing intervention, referral means the arrangement for services by another agency. Financial resource assistance helps individuals or families to secure and manage finances so that health care needs may be met. Sustenance support assists individuals or families to locate and obtain food, clothing, and shelter. These interventions are consistent with findings by many other researchers (Bard, 2006; Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Burkhart & Androwich, 2004; Burkhart et al., 2005; Coenen et al., 1999; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Miskelly, 1995; Rydholm, 2006; Tuck & Wallace, 2000; Tuck, Pullen, & Wallace, 2001; van Loon, 1998; Wallace et al., 2002; Weis et al., 1997).

Two additional financial interventions derived from the data analysis of this study will add to the existing knowledge of faith community nursing. First, cost containment is defined as the management of resources and the effective, efficient use of those resources. Second, fiscal resource management is concerned with the procurement and use of financial resources to ensure that programs and services are developed and sustained.

### **Spiritual Interventions**

Multiple interventions identified in this study pertained to the spiritual aspect since faith community nursing incorporates the intentional care of the spirit. The provision of spiritual support, spiritual care, or spiritual growth facilitation has been documented in many previous reports by many scholars and researchers as they investigated and discussed the unique practice of faith community nursing (Bard, 2006; Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Bokinskie & Kloster, 2008; Burkhart &

Androwich, 2004; Burkhart et al., 2005; Chase-Ziolek & Iris, 2002; Coenen et al., 1999; Hinton, 2009; King & Tessaro, 2009; Koenig, 2008; McCabe & Somers, 2009; Mendelson et al., 2008; O'Brien, 2006; Quenstedt-Moe, 2003; Rydholm, 2006; Tuck, Pullen, & Wallace, 2001; Tuck & Wallace, 2000; Tuck, Wallace, & Pullen, 2001; Van Dover & Pfeiffer, 2007; van Loon, 1998; Wallace et al., 2002; Weis et al., 1997). Several other authors documented the interventions of coping enhancement, grief work facilitation, and dying care (Burkhart & Androwich, 2004; Burkhart et al., 2005; Coenen et al., 1999; Koenig, 2008; McDermott & Burke, 1993; McGinnis & Zoske, 2008; Quenstedt-Moe, 2003; Rydholm, 2006; Weis et al., 1997). The interventions of presence, touch, humor, and instilling hope have also been cited in earlier reports (Burkhart et al., 2005; Coenen et al., 1999; Hinton, 2009; O'Brien, 2006; Rydholm, 2006; Tuck, Pullen, & Wallace, 2001; Tuck & Wallace, 2000; Tuck, Wallace, & Pullen, 2001; Van Dover & Pfeiffer, 2007; Weis et al., 1997). Religious ritual enhancement is an additional intervention that has been mentioned by some authors (Bard, 2006; Bitner & Woodward, 2004; Bokinskie & Evanson, 2009; Burkhart et al., 2005; Coenen et al., 1999; Kuhn, 1997; Maddox, 2000; O'Brien, 2006; Rydholm, 2006; Tuck, Pullen, & Wallace, 2001; Tuck, Wallace, & Pullen, 2001).

Two additional spiritual interventions that were identified in this study and that will add to the existing knowledge of faith community nursing are forgiveness facilitation and self-esteem enhancement. Forgiveness facilitation helps individuals develop willingness to replace feelings of anger, bitterness, jealousy, or resentment with feelings of

beneficence, empathy, and humility. Self-esteem enhancement helps people to increase their personal perception of self-worth and value.

### **Study Results Related to Nursing Interventions Classification**

In the fifth edition of *Nursing Interventions Classification*, Bulechek, Butcher, and Dochterman (2008) identified 38 core nursing interventions that define the nature of faith community nursing. These interventions are frequently implemented by and predominately used by faith community nurses, and are considered critical in their role, service, and ministry. Findings from this project indicated that 32 of these core interventions were included as participants documented the impact of the faith community nursing program. Core interventions not identified during data analysis of this project were (a) abuse protection support, (b) anticipatory guidance, (c) guilt work facilitation, (d) religious addiction prevention, (e) self-care assistance, and (f) values clarification.

Data analysis revealed several interventions that could definitely be recommended as additional core interventions for this specialty nursing practice. One role of the faith community nurse is that of personal health counselor and the intervention of counseling is an obvious choice. The nurse also functions as a developer of support groups so the intervention of support group is another logical intervention. Health screening is a third intervention frequently used by faith community nurses as they focus on health promotion. Teaching disease process, teaching prescribed diet, and teaching prescribed medications would certainly augment the interventions of teaching individuals and

teaching groups. With the emphasis on health education and teaching, the interventions of learning facilitation and learning readiness enhancement would clearly complement a group of fundamental specialty interventions. The intervention of program development includes planned activities to enhance wellness for groups and communities and that intervention is an essential aspect of faith community nursing. Much of the work of the faith community nurse is directed toward finding resources for individuals and families so financial resource assistance could reasonably be included in a list of key interventions. An expanded list of core interventions for faith community nursing would most certainly match the expanding practice while simultaneously supporting the advancement of faith community nursing science.

### **Study Results Related to Literature**

Findings from this research project confirm that nurses in this program are adhering to the standards of practice and professional performance for faith community nursing outlined in Faith Community Nursing: Scope and Standards of Practice (American Nurses Association & Health Ministries Association, 2005). Participants reported that assessment activities focused on immediate conditions while incorporating spiritual care principles. The nurses collaborated with patients, and their support systems, community resources, and other healthcare providers to (a) reduce the occurrence of illness, (b) foster health-promoting behaviors, (c) support adaptation to chronic changes in health status, and (d) enhance physical, mental, and spiritual well-being. They facilitated educational activities that addressed healthy lifestyles, developmental needs, and self-care while

considering age-specific, ethnic, cultural, social, economic, safety, spiritual, and individual learning factors. Features that contributed to enhanced quality and effectiveness of the nursing practice were creativity, innovation, flexibility, satisfaction, organization, leadership, and cost consciousness. Research results indicated that the nurses embraced the standard of education through personal learning activities and experiences to acquire and maintain knowledge, skills, and competence in their practice. They interacted with colleagues and multidisciplinary team members to enhance professional practice, role performance, and spiritual development. Ethical considerations that participants documented included confidentiality, respectfulness, advocacy, and individualized care. Nurses integrated research into their practice by serving as study participants and describing the impact of their practice from their personal perspectives. Individuals in each of the three participant groups documented the consideration of costs, benefits, and the effective, efficient use of resources. Leadership principles were evident in the responses and included (a) working as a staff member of the faith community, (b) being willing and available in less than convenient circumstances, (c) serving in the key ministries of the faith community by participating on committees or teams, and (d) valuing people as the most precious asset.

Solari-Twadell and Hackbarth (2010) asserted that the original seven roles or functions of faith community nursing do not adequately address its current and growing practice. They recommended an expanded description that creates a new paradigm for faith community nursing. The new definition of this unique ministry incorporates lifestyle changes, the family unit, and intentional spiritual care. Addition features of the revised

model will facilitate the health of the faith community, the health of the general community, and the effective use of the health system (Solari-Twadell & Hackbarth, 2010). Findings from this research support that recommendation as study participants provided multiple references for each of those variables. The themes of healthier living and modified health behaviors pertain to lifestyle changes. References to the family unit included family relationships, interventions for family members, family caregivers, church family, and family of God. Intentional spiritual care was addressed through the principles of holism, balance between physical and spiritual health, and the connection between the mind, body, and spirit. The health of the faith community and of the general community was addressed through health fairs, immunization clinics, and educational outreaches. Improving health literacy, navigating the healthcare system, and facilitating healthcare access apply to the effective use of the health system.

Findings from this study support conclusions reported by Brown et al (2009). Through their interventions, faith community nurses helped individuals and families access health care more quickly, efficiently, and appropriately. The results of this easier and earlier entry into health care services reduced unnecessary emergency department visits, physician office visits, hospitalizations, and placement in assisted living or long-term care facilities. The costs avoided through services provided by the faith community nurses can only be imagined.

Thompson (2010) indicated that while pastors generally have positive attitudes about faith community nursing, they regard spiritual care as only their area of expertise. However, clergy representatives in this study did not perceive themselves as the only



source of spiritual care within the faith community. They reported frequent and ongoing collaboration with the nurses in serving the congregations and meeting spiritual needs of individuals and families. The clergy representatives also emphasized the balance and the connections between physical, mental, and spiritual health that is a direct result of the nurses' services. The spiritual care and the spiritual impact are equally important and equally necessary as the physical and mental aspects.

### **Other Items of Interest**

#### **The Alpha Coefficients for the Research Instrument Evaluation Tool**

Overall, the alpha coefficients for the research instrument evaluation tool in the pilot study were high. Since this data came from a very small sample ( $n = 4$ ), these results must be interpreted with great caution. These four participants indicated they had obtained at least an undergraduate degree. Results may have been significantly different if the research instruments had been evaluated by (a) a larger sample, (b) individuals with lower educational levels, (c) individuals with high levels of research expertise, or (d) individuals not involved in a faith community nursing program.

#### **The Response Rate in the Main Study**

Survey response rates can vary greatly and this variation can be related to several factors. The response rate in this project was 46% and that value may be considered low by research standards. Low response rates contribute to error, research or methodological bias, and lowered amounts of validity in research. Respondents that self-selected to return

the questionnaires might not be representative of the target population. Factors that may have improved response rates and enhanced results include (a) providing monetary or other types of incentives, (b) sending follow-up reminder notices to return the questionnaires, (c) mailing an additional research packet after a selected period of time, (d) having a greater diversity of participant characteristics, and (e) categorizing results by different populations or variables (e.g. age groups, racial-ethnic categories, educational levels, or number of contacts with faith community nurses). Characteristics that may have contributed to the response rate were (a) motivation of participants, (b) importance of or interest in the faith community nursing program, (c) length of questionnaire and time required for its completion, (d) complexity of the questionnaire items, (e) wording on the letters of introduction, (f) belief that research participation might positively impact program continuation, (g) perception that study benefits were low when compared to the required time and effort, and (h) relationships between faith community members, clergy representatives, and faith community nurses.

### **Inter-rater Reliability and the Intra-class Correlation Coefficient**

The intra-class correlation coefficient (ICC) was the statistic used to report the inter-rater reliability. The ICC can range from zero to one and the corresponding equation includes both systematic variance and the variance that can be attributed to systematic differences, chance, and/or error. Higher values indicate greater amounts of agreement. The analysis yielded a value of 0.421. According to Landis and Koch (1977), this value of agreement can be interpreted as “moderate.” This interpretation must be made with caution because of the arbitrary nature of the values and the corresponding descriptors.

Overall, the number of identically identified coding decisions between at least two of the coders was fairly high. While there were no major disagreements between the individuals concerning the coding decisions, 20% of the codes were not identically identified by all four coders. This lack of total agreement contributed to a lower value for the ICC and may be related to systematic differences, chance, or error. Results may have improved through (a) increased training of the coders, (b) additional practice and trial runs prior to the actual analysis, (c) more explicit instructions, (d) limited number of codes and categories, and (e) use of coders with greater experience (Waltz, Strickland, & Lenz, 2005).

### **The Concept of Culturally Diverse**

The concept of a culturally diverse community may be questioned since (a) the participants in this study had several demographic characteristics in common, (b) the participants were associated with only the 23 faith communities that agreed to take part in this project, and (c) only three racial-ethnic categories were identified by participants. Most of the data in this study pertained to the impact of the program within the faith communities but a small amount of the data did apply to the culturally diverse community. And the greater community is culturally diverse. Almost 60,000 people speaking close to 100 different native languages and representing over 60 countries around the world live in the county of the southeastern state where the faith community nursing program is located (The Center for New North Carolinians, 2011). Much research with a variety of methodologies is necessary to determine the program impact on the more extensive culturally diverse community.

## **The Purposive Sampling Technique**

A purposive sampling technique was used for this project. This technique supported typical case sampling which includes cases that are considered typical of the phenomena being examined. Responses from many participants were considered typical cases. The answers were (a) written on the questionnaire, (b) composed of three to five sentences, and (c) contained in the provided area. Typical cases included answers to the six impact areas and some participants even provided other information not addressed by the questionnaire items.

Purposive sampling also allowed information-rich cases to be examined in greater depth. The data from two faith community members, one clergy representative, and one faith community nurse are just four examples of information-rich cases. The first information-rich case is from the youngest participant in the study. The responses of a 31-year old African-American male who indicated he had graduated from high school showed great insight seemingly above and beyond his educational level. His answer included how health is the backbone of one's life and the need to take it seriously. This man wrote about how family history contributes to the seriousness of health issues and how dangerous health conditions impact the ability to provide for one's family. He also mentioned the importance of health education and the responsibility that individuals have for their own health education. His answers to the different areas of impact included the importance of self-discipline in the areas of dietary intake, exercise participation, and adherence to medication regimens. His statement that as a society we (a) do not change what we know, (b) do not change from our habits, (c) do not change our thinking

processes, and (d) maintain high levels of stubbornness was an attention-grabbing, thought-provoking, and emotionally-arousing insight that demonstrated wisdom extending beyond his formal educational years. His response also indicated that he never wants to think that he knows “it all” but wants to always be ready to learn and grow from other people. However, in the same paragraph, this participant misspelled “rutens” (interpreted in the context of the sentence as “routines”).

A second information-rich case expressed appreciation for the conception and implementation of the faith community nursing program. The responses of a 64-year old, homebound, disabled woman indicated a greatly enhanced quality of life as a result of the faith community nurse’s ministry. She described the nurse as someone who “reaches out to me and others in a highly unique way thus providing a service truly above price.” This woman wrote several statements about maintaining stability and focusing on what she could do while many other sentences referred to new areas of growth, learning, relationships, and service. She perceived herself as a reasonably well-functioning member of society who continually benefits from both the physical and spiritual care provided by the faith community nurse. Finally, she included several sentences about (a) the importance of the faith community nursing program, (b) the personal desire for the program to continue, and (c) the need for the program to be maintained so service and ministry to individuals, families, groups, the faith community, and the greater community could and would continue.

The third example of an information-rich case involved the responses of a 57-year old, Asian American male clergy representative. His answers to the impact questions

included the impact on himself as well as the faith community and the larger general community. He mentioned how educational programs and health promoting activities meet the needs of all members in a culturally appropriate manner. He indicated that many of these programs have been helpful as his faith community, his family, and himself have made adjustments to living in America. Several statements described attributes of the faith community nurse. The concepts of care and concern appeared several times in this clergy representative's responses. Finally, the nurse was portrayed not just as an important part of the faith community but an important part of the health and care of the faith community.

Responses from a 67-year old faith community nurse serve as the fourth example of an information-rich case. This participant provided several specific and detailed examples of how her interventions had impacted the lives of individuals, families, groups, and communities. She described health impacts such as improvements in blood pressure values and lives saved through rapid and accurate assessments. Social impacts that she mentioned included the facilitation of family visits and enhanced socialization achieved through group activities. Her responses addressed educational impacts such as the availability of health literature and the sharing of information with others. Cultural impacts that she wrote about were changing dietary practices of cultural groups and facilitating death rituals for some families from other countries. Her answers to the impact questionnaire described financial impacts such as identifying health conditions before they become more serious and therefore more expensive, and providing resources for basic needs of food, clothing, shelter, and health care. Finally, she included several

spiritual impacts such as greater hope, comfort, peace, and spiritual growth and support. The above examples may well serve as (a) extreme cases with special or unusual features, and (b) critical cases that clarify information and contribute to the interpretation and understanding of the research topic.

Purposive sampling also supported strategies of maximum variation sampling which provides cases with the greatest differences in specific qualities. One quality was the amount of information that participants wrote on the impact questionnaire. An 80-year old female participant only answered the social impact item and her response was the three word sentence “I enjoy it.” At the other end of the amount of information spectrum, a faith community nurse sent eight pages of single-spaced, typed information with over a page of content for each of the impact areas. A second characteristic was related to the understanding of the questionnaire items. One participant, a 73-year old female with an undergraduate degree wrote that she had a hard time understanding the questions. Another participant, a 78-year old female who had attended some graduate school expressed appreciation for the opportunity to complete the survey and mentioned that the information on the questionnaire was true and accurate and should contribute to the continuation of the faith community nursing program. The third feature was the people included in the responses. Some participants only addressed the impact of the faith community nursing program from their personal perspective while others included the impact on their family, social groups, the faith community, and the larger, general community. Next, the writing of some participants was difficult to read while some other participants typed their responses. Fifth, responses ranged from bulleted lists to sentence

fragments to complete paragraphs. Finally, the strategy of maximum variation sampling was supported by the wide range of demographic characteristics reported by the participants. Ages of the participants ranged from 31 to 90. All options for highest educational level were indicated by at least one participant. All choices for employment status, household income level, and length of time involved with the faith community nursing program were selected by at least one participant. Membership in the faith communities ranged from less than 100 people to over 6000 people.

### **Implications of Limitations**

The use of a purposive sample, the use of a convenience sample, and the small sample size in this study limit the ability to draw conclusions about the specific impact of other faith community nursing programs or the general impact of faith community nursing from a broad perspective. While the response rate for the pilot study was very high for mailed surveys (67%), the actual sample size was very low ( $n = 6$ ). In the main study and with an impressive response rate (46%), the sample size was very small compared to the number of individuals who interact with or use the services of faith community nurses in this program. Results may not be representative of the greater population of individuals, families, groups, and communities that use faith community nurses and their interventions for health care. The limited geographical area served by the faith community nursing program and the limited data collection time may also have affected the results. Larger sample sizes using randomized selection of participants in multi-centered studies are needed to support or refute the findings of this study.



The specific study inclusion criteria were another limitation and multiple groups did not contribute to the findings. The impact of the program was not examined from the perspectives of individuals who have occasionally participated in health-related activities sponsored by the faith community but who have not had at least three interventions or services during a specific time. The study did not include people (a) unable to read, write, and understand English; (b) not actively associated with a faith community; (c) under the age of 18; and (d) associated with the other 28 faith communities participating in the program but not in this project. A complete assessment of the faith community nursing program impact should include individuals not restricted by specific inclusion criteria.

Some faith communities and some faith community nurses have been associated with this program since its inception while others have only recently become involved. The newer individual programs and the newer nurses had less input into the annual reports. Individuals at the newer locations may not have had the required number of interactions with or services from the faith community nurse in the designated time frame. The impact of the faith community nursing program is incomplete without the perspectives of newly involved individuals.

The process of allowing the faith community nurses to select and supply names and addresses of potential study participants is another limitation. The nurses may not have totally abided by the inclusion criteria when they sent in lists of potential participants. Contact between faith community members and the faith community nurse may have influenced even being placed on the potential list of participants. The nurses may have intentionally only included those individuals whom they knew would provide positive

feedback or may have intentionally omitted individuals that were currently experiencing a type of crisis in their lives. Alternative recruitment strategies such as placing flyers at the faith community and in the general community may have engaged persons with a completely different perspective of the program impact.

Overall, participants in this study had high educational levels. All pilot study participants and 62% of main study participants indicated educational achievements beyond high school graduation. Forty-nine percent ( $n = 17$ ) of faith community members in the main study also selected completion of an undergraduate degree or more as the highest educational level. Faith community nurses are participants that will automatically have a higher educational level since the process for obtaining licensure as a registered nurse or licensed practical nurse in the southeastern state involved in this study requires completion of a Board of Nursing approved nursing education program. These programs are offered at post-secondary educational institution, hospitals, colleges that award associate and/or applied science degrees, and universities that provide baccalaureate and/or higher degree education. Educational requirements for clergy representatives vary among the individual faith communities but many of them may prefer a certain amount of formal education. These participants with higher levels of education may have been more willing to participate in a research project that involved written responses to questionnaires than individuals with less education.

Questionnaire items may have been written at a level higher than some participants' actual reading abilities. Questionnaire items were checked with the Flesch Reading Ease Test and with the Flesch-Kincaid Grade Level Test. The ratings from these two

procedures are based on the average number of syllables per word and the average number of words per sentence. A higher score on the Flesch Reading Ease Test indicates that the document is easier to read and the desired score is between 60 and 70 on a 100-point scale for most standard files. The Flesch-Kincaid Grade Level Test corresponds to a United States school grade level. This means that a fourth grade student can understand a document with a score of 4.0. Most documents should have a score of approximately 7.0 to 8.0. The Flesch Reading Ease and the Flesch-Kincaid Grade Level values for all research documents were presented earlier in Table 1. All items sent to faith community members were revised in an attempt to reach an approximate seventh grade reading level. However, educational levels of participants do not necessarily correlate with their individual reading abilities. Educational levels may be either lower or higher than actual reading abilities. For example, an individual who graduated from high school may read at an eighth grade level or at a level corresponding to three years of undergraduate education.

The names and denominations of the participating faith communities were included on the letters of support and permission to collect data from individuals, and therefore contributed to the concept of a culturally diverse community. Specific religious affiliations were not requested on the demographic instrument but some participants still included references to their individual religious denomination. Many faith communities in this study adhere to philosophies of Christian faith and this characteristic may have contributed to similarities in the results. Faith communities have a wide range of philosophical, political, educational, economic, religious, spiritual, and cultural values,

beliefs, traditions, customs, and practices. The program impact should be thoroughly examined considering all these viewpoints.

Content analysis is basically a descriptive research method and a useful technique to identify categories, trends, and patterns. However, content analysis does not reveal why content was provided or why the information is in a specific form on the questionnaires. Some individuals wrote or typed their responses on additional sheets of paper instead of writing on the provided questionnaire. Most participants wrote their responses in narrative, sentence form but some participants used bulleted lists for their answers. The information available for content analysis may not have been representative of the total impact of the faith community nursing program.

Finally, both the quality and the quantity of self-reported data may have been affected or restricted by a variety of factors that contributed to the completion and the return of the questionnaires. Some reasons include personal interest in the nursing program, significance of research processes, time involved to complete written questionnaires, and the desire or motivation to share personal experiences. Alternative data collection techniques to include personal interviews and focus groups may have increased both the amount and depth of the data. Other individuals may have been more motivated to participate if data collection had involved the use of electronic technology.

### **Implications for Future Research**

Future research should examine the impact of faith community nursing from the perspectives of persons who neither are members of nor affiliated with specific faith

communities. This population would be individuals in the general community that may attend or participate in the variety of health related activities organized or sponsored by the faith community or faith community nurse. Other investigations should include the viewpoints of people who did not meet the inclusion criteria for this particular research project. Three groups in this category are individuals who (a) are unable to read, write, or understand English; (b) had only one contact with the faith community nurse; or (c) are under the age of 18. Additional studies should focus on the impact of faith community nursing practice after the initial encounter with the nurse. Other investigations could examine the effects or outcomes of faith community nursing interventions that are repeated over time at specific intervals for specific reasons such as the ongoing weekly monitoring of an individual's blood pressure or blood glucose levels. Future research should examine (a) the perceptions of individuals and families who have only sporadic interactions with the nurse, and (b) the perceptions of nursing students following their clinical experiences with faith community nurses. Different research methodologies should be included in future investigations. Case studies, individual interviews, and focus groups are qualitative approaches that can potentially reveal comprehensive data and provide significant insight about the effects of faith community nursing. Longitudinal studies could examine if behaviors are sustained and outcomes are maintained after faith community nursing interventions. Additional research could focus on developing and testing instruments to evaluate the practice and the impact of faith community nursing.

### **Implications for Education**

Findings from this study provide additional support for the ongoing inclusion of faith communities as clinical sites for students pursuing degrees in nursing, social work, or public health. For several years, faith community nurses and the program coordinator have served as preceptors or mentors for local college and university students in these disciplines. The partnership between the department of social work at a local university and the faith community nursing program was described as greatly helpful as faith community nurses assisted and supported learning experiences for social work students. Clinical experiences with faith community nurses will provide nursing students with unique opportunities to (a) deliver holistic care, (b) focus on the spiritual aspect of the person, (c) address the prevention and management of chronic health conditions, and (d) concentrate on education for individuals, families, groups, and the greater community.

### **Implications for Practice**

The practice of faith community nursing remains a young specialty that has grown rapidly in the past 25 years. Faith community nursing is so specialized, so unique, and so complex that it is difficult to separate it into individual components such as health impact, educational impact, or financial impact. The care and the ministry are clearly client-centered and truly holistic, and use collaborative approaches that complement the services of other health care providers.

As faith community nursing practice continues to grow, theories will be generated and tested through a variety of research methods. Additional instruments that focus on the practice, the interventions, and the outcomes of faith community nursing will be developed, evaluated, and used to increase the knowledge for this specialty nursing practice. As research in this unique type of nursing continues, the science of faith community nursing will experience corresponding growth and development. Faith community nurses should be able to contribute to and affect the development of health policies as the population increases, health care reform becomes a reality, and health care costs continue their upward trends. Faith community nurses need to promote their practice among their individual faith communities, in the public sector, within the profession of nursing, and unto the greater arena of health care. These actions will maximize the impact, will potentiate the benefits of health care delivery within the community, and will continue to enhance positive patient outcomes. Certification in this specialty nursing practice is a logical next step that is currently being considered by experts in the field. The expertise of faith community nurses will be combined with the best evidence and integrated within the values and beliefs of the client while they intentionally care for the spiritual component to provide high quality care and meet the multifaceted needs of individuals, families, groups, communities, and society.

## **Conclusion**

Faith community nurses associated with the faith community nursing program in this study facilitate holistic health, and promote health and well-being as they minister to

culturally diverse populations regardless of demographic variables. The unique care provided by this specialty group of nurses help prevent or minimize illnesses, diseases, and disabilities in individuals, families, groups, and communities by integrating the care of the body, mind, and spirit. Faith community members, clergy representatives, and faith community nurses described the impact of the faith community nursing program with a wide variety of positive outcomes related to health, social, educational, cultural, financial, and spiritual effects. Participants reported living healthier, helping others, increasing and sharing knowledge, using culturally appropriate behaviors, saving money, and experiencing hope, comfort, and inspiration, and achieving balance between physical and spiritual health as just some of the multiple outcomes. The description of the program impact was complemented by a large number of nursing interventions that faith community nurses use in their practice, their service, and their ministry. The faith community nurses associated with this nursing program have multiple opportunities to reduce health disparities in vulnerable, underserved, and at-risk populations through innovative, economical strategies while simultaneously and intentionally focusing on spiritual care. The faith community setting provides health care, screenings, counseling, education, and referrals for minority, disadvantaged, and underserved individuals and families who would otherwise go without these services. Results of this study have implications for nursing practice, education, and research since the faith community is remaining and growing as a setting for health care delivery.



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## APPENDIX A

### THE DEMOGRAPHIC INSTRUMENT ALL ABOUT ME

#### All About Me

Thank you for helping with this study. This information is about you. Please select one response for each item and answer to the best of your ability. Please do not include any information that will personally identify you.

To which group do you belong?

- ☐ Member
- ☐ Clergy representative
- ☐ Faith community nurse

What is your gender?

- ☐ Female
- ☐ Male
- ☐ Prefer not to answer

What is your age?

- ☐ Years old
- ☐ Prefer not to answer

What is your marital status?

- ☐ Never married
- ☐ Involved in committed, unmarried relationship
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Other
- ☐ Specify status
- ☐ Prefer not to answer

In what area do you live?

- ☐ City
- ☐ County
- ☐ Prefer not to answer

In what area is your faith community nursing program located?

- ☐ City
- ☐ County
- ☐ Prefer not to answer

What is your racial-ethnic category?

- ☐ African-American
- ☐ Alaskan Native
- ☐ Asian-American
  - ☐ Specify country
- ☐ Native-American
  - ☐ Specify group
- ☐ Pacific-Islander
  - ☐ Specify island
- ☐ Hispanic
  - ☐ Cuban
  - ☐ Mexican
  - ☐ Puerto-Rican
  - ☐ Central American
  - ☐ South American
  - ☐ Spanish
  - ☐ Other
- ☐ Mixed
- ☐ White
- ☐ Prefer not to answer

What is your highest educational level?

- ☐ Completed eight grades or less in school
- ☐ Attended some high school
- ☐ Received GED
- ☐ Graduated from high school
- ☐ Attended some college or university
- ☐ Completed undergraduate degree program
  - ☐ Specify degree
  - ☐ Specify field or discipline
- ☐ Attended some graduate school
- ☐ Completed graduate degree program
  - ☐ Specify degree
  - ☐ Specify field or discipline
- ☐ Prefer not to answer



What is your employment status?

- ☐ Unemployed
- ☐ Disabled
- ☐ Employed part-time by company or organization
- ☐ Employed full-time by company or organization
- ☐ Self-employed part-time
- ☐ Self-employed full-time
- ☐ Retired and not working
- ☐ Retired and working either part-time or full-time
- ☐ Other
- ☐ Specify status
- ☐ Prefer not to answer

What is the annual income of your household?

- ☐ Less than or equal to \$9,999
- ☐ Between \$10,000 and \$24,999
- ☐ Between \$25,000 and \$49,999
- ☐ Between \$50,000 and \$74,999
- ☐ Between \$75,000 and \$99,999
- ☐ Equal to or above \$100,000
- ☐ Prefer not to answer

How many clergy representatives are employed by or serve your faith community?

- ☐ One
- ☐ Two
- ☐ Three
- ☐ Four
- ☐ Five
- ☐ Six or more
- ☐ Prefer not to answer

What is the membership of your faith community?

- ☐ Less than one hundred
- ☐ More than one hundred but less than three hundred
- ☐ More than three hundred but less than five hundred
- ☐ More than five hundred
- ☐ Specify number if known
- ☐ Prefer not to answer

How often do you participate in activities offered by your faith community?

- ☐ Less than monthly (one to ten times per year)
- ☐ Monthly (once per month)
- ☐ More than monthly but less than weekly (two or three times per month)
- ☐ Weekly (once per week)
- ☐ More than weekly but less than daily (two or more times per week)
- ☐ Daily (once per day)
- ☐ Prefer not to answer

How long have you been involved with the faith community nursing program?

- ☐ Less than one year
- ☐ More than one year but less than three years
- ☐ More than three years but less than five years
- ☐ More than five years but less than seven years
- ☐ More than seven years but less than nine years
- ☐ More than nine years
- ☐ Prefer not to answer

If you receive any type of service from the faith community nurse, how often does that occur?

- ☐ Less than monthly (one to ten times per year)
- ☐ Monthly (once per month)
- ☐ More than monthly but less than weekly (two or three times per month)
- ☐ Weekly (once per week)
- ☐ More than weekly but less than daily (two or more times per week)
- ☐ Daily (once per day)
- ☐ More than daily (more than one time per day)
- ☐ Prefer not to answer

If you are the faith community nurse, how many separate faith communities do you serve?

- ☐ Does not apply to me
- ☐ One
- ☐ Two
- ☐ Three
- ☐ Four or more
- ☐ Prefer not to answer

## APPENDIX B

### VERSIONS OF THE IMPACT QUESTIONNAIRE

#### Impact Questionnaire for Faith Community Members

Faith community nursing is a unique type of nursing. Contact with, and service from a faith community nurse affects many areas of a person's life. Please tell me about the impact that faith community nursing has had on your life.

1. What is the impact of faith community nursing on your health?  
Health means physical and mental activities of the human body.

2. What is the social impact of faith community nursing on you?

Social means people or support systems that affect what you have to offer as a person (what you know, what skills you have, what talents you have).

3. What is the educational impact of faith community nursing on you?

Educational means the ability to learn and change what you know.

4. What is the cultural impact of faith community nursing on you?

Cultural means the things shared by a group of people. It includes values, customs, lifestyles, and use of material resources. These things are passed from one generation to the next.

5. What is the financial impact of faith community nursing on you?

Financial means the ability to earn and use money.

6. What is the spiritual impact of faith community nursing on you?

Spiritual means the value, belief, and self-evaluation systems so that you can exist with unity, meaning, purpose, and fulfillment in society and in the universe.

Please feel free to add other information not mentioned in the above questions.

### Impact Questionnaire for Clergy Representatives

Faith community nursing is a unique and specialized area of holistic nursing practice that positively influences several dimensions in the lives of individuals, families, groups, and communities. Please describe the impact that faith community nursing has had on individuals, families, groups, or the complete community at your organization.

1. What is the impact of faith community nursing on health?

Health includes physiological and mental structures, functions, processes, needs, and activities of the human body.

2. What is the social impact of faith community nursing?

Social includes individuals, families, groups, associations, organizations, or support systems and affects all one has to offer as a person (e.g. knowledge, skills, talents, time).

3. What is the educational impact of faith community nursing?

Educational includes the ability to gain, increase, share, master, evaluate, or transform knowledge.



4. What is the cultural impact of faith community nursing?

Cultural includes the learned behaviors (e.g. traditions, philosophies, values, languages, customs, use of material resources) shared by a particular group of people and transmitted from generation to generation.

5. What is the financial impact of faith community nursing?

Financial includes the ability to earn, use, and control money and monetary resources.

6. What is the spiritual impact of faith community nursing?

Spiritual includes the value, belief, and self-evaluation systems so that one can exist with a sense of unity, meaning, purpose, and fulfillment in society and in the universe.

Please feel free to include other information not addressed in the above questions.

### Impact Questionnaire for Faith Community Nurses

Faith community nursing is a unique and specialized area of holistic nursing practice that positively influences several dimensions in the lives of individuals, families, groups, and communities. Please describe the impact that faith community nursing has had on members who regularly or frequently use your services within your specific organization.

1. What is the impact of faith community nursing on health in your current practice? Health includes physiological and mental structures, functions, processes, needs, and activities of the human body.

2. What is the social impact of faith community nursing in your current practice?

Social includes individuals, families, groups, associations, organizations, or support systems and affects all one has to offer as a person (e.g. knowledge, skills, talents, time).

3. What is the educational impact of faith community nursing in your current practice?

Educational includes the ability to gain, increase, share, master, evaluate, or transform knowledge.

4. What is the cultural impact of faith community nursing in your current practice?

Cultural includes the learned behaviors (e.g. traditions, philosophies, values, languages, customs, use of material resources) shared by a particular group of people and transmitted from generation to generation.

5. What is the financial impact of faith community nursing in your current practice?

Financial includes the ability to earn, use, and control money and monetary resources.

6. What is the spiritual impact of faith community nursing in your current practice?  
Spiritual includes the value, belief, and self-evaluation systems so that one can exist with a sense of unity, meaning, purpose, and fulfillment in society and in the universe.

Please feel free to include other information not addressed in the above questions.

## APPENDIX C

### LETTERS OF INTRODUCTION FOR PARTICIPANTS

January 21, 2009

Hello!

My name is Cynthia Shores. I am a student at The University of North Carolina at Greensboro in the School of Nursing. I am working on an important research project. This study will look at the impact of faith community nursing on persons within a community that is made up of many cultures. Parish nursing is another name for faith community nursing.

You have been randomly selected to help with this study. Taking part in this study is voluntary. You may provide as much or as little information as you desire. Helping with this study will not affect any care or services you receive from the nurse.

This packet has some important papers. The first paper is a copy of the consent form. You will keep this form for your records. My name and contact information are on that form.

The next is a four-page form labeled "All About Me." This information will help me describe the people who helped with this study. Please do not put your name, phone number, address, or any other identifying information on that form. This will keep the information confidential and anonymous.

Then, there are six questions for you to answer on separate sheets of paper. If you need more room, please use extra sheets of paper.

The final form will let me know what you think about the first two forms. I want to know if the items are easy to read, easy to understand, and easy to use. I also want to know how long it took to complete the two forms.

Please return the three forms to me in the stamped, addressed envelope. It would be great if you can mail me the forms in the next two weeks. Mailing the information back to me will serve as permission to use the responses. I will not send you any other mail about this study.

Thank you. I appreciate your time, effort, and willingness to help me with this important research project.

Sincerely,

Cynthia Shores, MSN, RN

Graduate Student, The University of North Carolina at Greensboro

August 17, 2009

Hello!

My name is Cynthia Shores. I am a student at The University of North Carolina at Greensboro in the School of Nursing. I am working on an important research project. This study will look at the impact of a faith community nursing program on persons within a community that is made up of many cultures. Parish nursing and congregational nursing are other names for faith community nursing.

You have been randomly selected to help with this study. Taking part in this study is voluntary. You may provide as much or as little information as you desire. Helping with this study will not affect any care or services you receive from the nurse.

This packet has some important papers. The first paper is a copy of the consent form. You will keep this form for your records. My name and contact information are on that form.

The next is a four-page form labeled "All About Me." This information will help me describe the people who helped with this study. Please do not put your name, phone number, address, or any other identifying information on that form. This will keep the information confidential and anonymous.

Then, there are six questions for you to answer on separate sheets of paper. If you need more room, please use extra sheets of paper.

Please return the two forms to me in the stamped, addressed envelope. It would be great if you can mail me the forms in the next two weeks. Mailing the information back to me will serve as permission to use the responses. I will not send you any other mail about this study.

Thank you. I appreciate your time, effort, and willingness to help me with this important research project.

Sincerely,

Cynthia Shores, PhDc, RN  
Graduate Student, The University of North Carolina at Greensboro



February 21, 2009

Hello!

My name is Cynthia Shores. I am a doctoral student in the School of Nursing at The University of North Carolina at Greensboro.

I am conducting a research project that will examine the impact of faith community nursing on persons within a culturally diverse community. This study will include the perspectives of congregational members, clergy representatives, and faith community nurses. Your participation in this project is voluntary.

This packet contains several important documents. The first paper is a copy of the consent form that you will keep for your records. My name and contact information are provided on that form. The four-page form labeled "All About Me" will help me to describe the group of people who participated in this study. To protect your confidentiality and anonymity, please do not include any information that could personally identify you. Then, there are six questions for you to answer on separate sheets of paper. These questions address areas impacted by the unique, specialized, and holistic practice of faith community nursing. You may provide as much or as little information as you desire. If you need more room, please attach additional sheets. The final item is an evaluation tool for the two previous instruments. I would appreciate your feedback concerning the clarity, readability, and user-friendliness of each item. Please return all documents to me in the stamped, addressed envelope. Returning the questionnaires will serve as consent to use the responses.

Thank you. I appreciate your time, effort, and willingness to help with this important research project.

Sincerely,

Cynthia Shores, MSN, RN  
Graduate Student, The University of North Carolina at Greensboro

July 22, 2009

Hello!

My name is Cynthia Shores. I am a doctoral student in the School of Nursing at The University of North Carolina at Greensboro.

I am conducting a research project that will examine the impact of a faith community nursing program on persons within a culturally diverse community. This study will include the perspectives of congregational members, clergy representatives, and faith community nurses. Your participation in this project is voluntary.

This packet contains three important documents. The first paper is a copy of the consent form that you will keep for your records. My name and contact information are provided on that form. The four-page form labeled "All About Me" will help me to describe the group of people who participated in this study. To protect your confidentiality and anonymity, please do not include any information that could personally identify you. Finally, there are six questions for you to answer on separate sheets of paper. These questions address areas impacted by the unique, specialized, and holistic practice of faith community nursing. You may provide as much or as little information as you desire. If you need more room, please attach additional sheets. Please return the last two documents to me in the stamped, addressed envelope. Returning the questionnaires will serve as consent to use the responses.

Thank you. I appreciate your time, effort, and willingness to help with this important research project.

Sincerely,

Cynthia Shores, PhD, RN  
Graduate Student, The University of North Carolina at Greensboro

## APPENDIX D

### CONSENT FORMS

#### **The University of North Carolina at Greensboro**

##### Consent to Act as a Human Participant

Project Title: The Impact of Faith Community Nursing on a Culturally Diverse Community--A Pilot Study

Project Director: Dr. Eileen Kohlenberg, PhD, RN

#### **What is the study about?**

This study involves research using mailed questionnaires. The purpose of this study is to evaluate two newly developed research tools for clarity, readability, and user-friendliness.

#### **Why are you asking me?**

You are asked to participate because you belong to one of three groups of people. The first group is people who have used the services of a faith community nurse at least three times in the past year. The second group is members of the clergy. The third group is faith community nurses. Ten people are being asked to help with this study.

#### **What will you ask me to do if I agree to be in the study?**

You will give written answers on three separate forms. The first form is a demographic data tool. The second form is the impact questionnaire. The third form gives feedback about the first two forms. Completing the three forms may take between 30 minutes and an hour. You will mail the completed forms to Cynthia Shores in the stamped, addressed envelope. Return postage is guaranteed. You will not be mailed any more information about the study. There will not be any follow-up with participants in this study.

#### **What are the dangers to me?**

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses no risk to participants. Participating in this study will *NOT* affect any contact with the nurse or any care or services you receive from the nurse.

If you have any concerns about your rights or how you are being treated, please contact Eric Allen in the Office of Research and Compliance at UNCG at (336) 256-1482.

If you have questions about this project or your benefits or risks associated with being in this study, you may contact Cynthia Shores by emailing *cishores@uncg.edu* or by calling (336) 824-6200. You may also contact Dr. Eileen Kohlenberg by emailing *eileen\_kohlenberg@uncg.edu* or by calling (336) 334-5261.

#### **Are there any benefits to me for taking part in this research study?**

There are no direct benefits to participants in this study.

**Are there any benefits to society if I take part in this research?**

The results of this study may help the researcher make necessary changes to the two forms that will be used in another study after this project is completed. The results may also add to what we know about faith community nursing.

**Will I be paid for being in the study? Will it cost me anything?**

There are no costs to you or payments made for participating in this study.

**How will you keep my information confidential?**

You will not give any information that can personally identify you. You cannot and will not be identified by name. Your address will not be used for any other purpose. It will be destroyed using a crosscut shredder after the questionnaires are mailed. Written data will be stored in a locked file cabinet. Electronic data will be stored on a password-protected computer. All information obtained in this study is strictly confidential unless disclosure is required by law.

**What if I want to leave the study?**

You have the right to refuse to participate or to withdraw at any time, without any penalty. If you withdraw, it will not affect you in any way. If you withdraw, you may request that your answers be destroyed unless they cannot be identified. If you do not want to participate, please destroy all items in this packet.

**What about new information or changes in the study?**

You may contact Eric Allen, Cynthia Shores, or Dr. Eileen Kohlenberg to find out if the study has changed or if there is any new information. Their phone numbers are on the first page of this consent form.

**Voluntary Consent by Participant:**

If you return the completed questionnaires in the stamped, addressed envelope, you are agreeing to the following items:

1. You have read this consent form.
2. You fully understand the contents of this document.
3. You are voluntarily agreeing to participate in this project.
4. You are openly and willingly consenting to take part in this study.
5. You are at least 18 years of age or older.
6. All of your questions about this study have been answered.

## **The University of North Carolina at Greensboro**

### **Consent to Act as a Human Participant**

Project Title: The Impact of a Faith Community Nursing Program on a Culturally Diverse Community

Project Director: Dr. Eileen Kohlenberg, PhD, RN

#### **What is the study about?**

This study involves research using mailed questionnaires. The purpose of this study is to examine the impact of a faith community nursing program.

#### **Why are you asking me?**

You are asked to participate because you belong to one of three groups of people. The first group is people who have used the services of a faith community nurse at least three times in the past year. The second group is members of the clergy. The third group is faith community nurses.

#### **What will you ask me to do if I agree to be in the study?**

You will give written answers on two separate forms. The first form is a demographic data tool. The second form is the impact questionnaire. Completing the two forms may take between 30 minutes and an hour. You will mail the completed forms to Cynthia Shores in the stamped, addressed envelope. Return postage is guaranteed. You will not be mailed any more information about the study. There will not be any follow-up with participants in this study.

#### **What are the dangers to me?**

The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses no risk to participants. Participating in this study will *NOT* affect any contact with the nurse or any care or services you receive from the nurse.

If you have any concerns about your rights or how you are being treated, please contact Eric Allen in the Office of Research and Compliance at UNCG at (336) 256-1482.

If you have questions about this project or your benefits or risks associated with being in this study, you may contact Cynthia Shores by emailing [cishores@uncg.edu](mailto:cishores@uncg.edu) or by calling (336) 824-6200. You may also contact Dr. Eileen Kohlenberg by emailing [eileen\\_kohlenberg@uncg.edu](mailto:eileen_kohlenberg@uncg.edu) or by calling (336) 334-5261.

#### **Are there any benefits to me for taking part in this research study?**

There are no direct benefits to participants in this study.

**Are there any benefits to society if I take part in this research?**

The results of this study may add to what we know about faith community nursing.

**Will I be paid for being in the study? Will it cost me anything?**

There are no costs to you or payments made for participating in this study.

**How will you keep my information confidential?**

You will not give any information that can personally identify you. You cannot and will not be identified by name. Your address will not be used for any other purpose. It will be destroyed using a crosscut shredder after the questionnaires are mailed. Written data will be stored in a locked file cabinet. Electronic data will be stored on a password-protected computer. All information obtained in this study is strictly confidential unless disclosure is required by law.

**What if I want to leave the study?**

You have the right to refuse to participate or to withdraw at any time, without any penalty. If you withdraw, it will not affect you in any way. If you withdraw, you may request that your answers be destroyed unless they cannot be identified. If you do not want to participate, please destroy all items in this packet.

**What about new information or changes in the study?**

You may contact Eric Allen, Cynthia Shores, or Dr. Eileen Kohlenberg to find out if the study has changed or if there is any new information. Their phone numbers are on the first page of this consent form.

**Voluntary Consent by Participant:**

If you return the completed questionnaires in the stamped, addressed envelope, you are agreeing to the following items:

1. You have read this consent form.
2. You fully understand the contents of this document.
3. You are voluntarily agreeing to participate in this project.
4. You are openly and willingly consenting to take part in this study.
5. You are at least 18 years of age or older.
6. All of your questions about this study have been answered.

## APPENDIX E

### RESEARCH INSTRUMENT EVALUATION TOOLS

#### Research Instrument Evaluation Tool for Members

In each of the five statements that follow the item, please circle your opinion about the specific item.

To which group do you belong? ____ Member ____ Clergy representative ____ Faith community nurse
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

What is your gender? ____ Female ____ Male ____ Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

What is your age? <input type="text"/> Years old <input type="text"/> Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

What is your marital status? <input type="text"/> Never married <input type="text"/> Involved in committed, unmarried relationship <input type="text"/> Married <input type="text"/> Separated <input type="text"/> Divorced <input type="text"/> Widowed <input type="text"/> Other <input type="text"/> Specify status <input type="text"/> Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly



<p>In what area do you live?</p> <p>_____City</p> <p>_____County</p> <p>_____Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>In what area is your faith community nursing program located?</p> <p>_____City</p> <p>_____County</p> <p>_____Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is your racial-ethnic category?</p> <p><input type="checkbox"/> African-American</p> <p><input type="checkbox"/> Alaskan Native</p> <p><input type="checkbox"/> Asian-American</p> <p><input type="checkbox"/> <input type="checkbox"/> Specify country</p> <p><input type="checkbox"/> Native-American</p> <p><input type="checkbox"/> <input type="checkbox"/> Specify group</p> <p><input type="checkbox"/> Pacific-Islander</p> <p><input type="checkbox"/> <input type="checkbox"/> Specify island</p> <p><input type="checkbox"/> Hispanic</p> <p><input type="checkbox"/> Cuban</p> <p><input type="checkbox"/> Mexican</p> <p><input type="checkbox"/> Puerto-Rican</p> <p><input type="checkbox"/> Central American</p> <p><input type="checkbox"/> South American</p> <p><input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Mixed</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is your highest educational level?</p> <p><input type="checkbox"/> Completed eight grades or less in school</p> <p><input type="checkbox"/> Attended some high school</p> <p><input type="checkbox"/> Received GED</p> <p><input type="checkbox"/> Graduated from high school</p> <p><input type="checkbox"/> Attended some college or university</p> <p><input type="checkbox"/> Completed undergraduate degree program</p> <p><input type="checkbox"/> Specify degree</p> <p><input type="checkbox"/> Specify field or discipline</p> <p><input type="checkbox"/> Attended some graduate school</p> <p><input type="checkbox"/> Completed graduate degree program</p> <p><input type="checkbox"/> Specify degree</p> <p><input type="checkbox"/> Specify field or discipline</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is your employment status?</p> <p><input type="checkbox"/> Unemployed</p> <p><input type="checkbox"/> Disabled</p> <p><input type="checkbox"/> Employed part-time by company or organization</p> <p><input type="checkbox"/> Employed full-time by company or organization</p> <p><input type="checkbox"/> Self-employed part-time</p> <p><input type="checkbox"/> Self-employed full-time</p> <p><input type="checkbox"/> Retired and not working</p> <p><input type="checkbox"/> Retired and working either part-time or full-time</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Specify status</p> <p><input type="checkbox"/> Prefer not to answer</p>
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

<p>What is the annual income of your household?</p> <p><input type="checkbox"/> Less than or equal to \$9,999</p> <p><input type="checkbox"/> Between \$10,000 and \$24,999</p> <p><input type="checkbox"/> Between \$25,000 and \$49,999</p> <p><input type="checkbox"/> Between \$50,000 and \$74,999</p> <p><input type="checkbox"/> Between \$75,000 and \$99,999</p> <p><input type="checkbox"/> Equal to or above \$100,000</p> <p><input type="checkbox"/> Prefer not to answer</p>
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

How many clergy representatives are employed by or serve your faith community?
<input type="checkbox"/> One
<input type="checkbox"/> Two
<input type="checkbox"/> Three
<input type="checkbox"/> Four
<input type="checkbox"/> Five
<input type="checkbox"/> Six or more
<input type="checkbox"/> Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

What is the membership of your faith community?
<input type="checkbox"/> Less than one hundred
<input type="checkbox"/> More than one hundred but less than three hundred
<input type="checkbox"/> More than three hundred but less than five hundred
<input type="checkbox"/> More than five hundred
<input type="checkbox"/> Specify number if known
<input type="checkbox"/> Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

<p>How often do you participate in activities offered by your faith community?</p> <p><input type="checkbox"/> Less than monthly (one to ten times per year)</p> <p><input type="checkbox"/> Monthly (once per month)</p> <p><input type="checkbox"/> More than monthly but less than weekly (two or three times per month)</p> <p><input type="checkbox"/> Weekly (once per week)</p> <p><input type="checkbox"/> More than weekly but less than daily (two or more times per week)</p> <p><input type="checkbox"/> Daily (once per day)</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>
<p>How long have you been involved with the faith community nursing program?</p> <p><input type="checkbox"/> Less than one year</p> <p><input type="checkbox"/> More than one year but less than three years</p> <p><input type="checkbox"/> More than three years but less than five years</p> <p><input type="checkbox"/> More than five years but less than seven years</p> <p><input type="checkbox"/> More than seven years but less than nine years</p> <p><input type="checkbox"/> More than nine years</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>If you receive any type of service from the faith community nurse, how often does that occur?</p> <p><input type="checkbox"/> Less than monthly (one to ten times per year)</p> <p><input type="checkbox"/> Monthly (once per month)</p> <p><input type="checkbox"/> More than monthly but less than weekly (two or three times per month)</p> <p><input type="checkbox"/> Weekly (once per week)</p> <p><input type="checkbox"/> More than weekly but less than daily (two or more times per week)</p> <p><input type="checkbox"/> Daily (once per day)</p> <p><input type="checkbox"/> More than daily (more than one time per day)</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>If you are the faith community nurse, how many separate faith communities do you serve?</p> <p><input type="checkbox"/> Does not apply to me</p> <p><input type="checkbox"/> One</p> <p><input type="checkbox"/> Two</p> <p><input type="checkbox"/> Three</p> <p><input type="checkbox"/> Four or more</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the impact of faith community nursing on your health? Health means physical and mental activities of the human body.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the social impact of faith community nursing on you? Social means people or support systems that affect what you have to offer as a person (what you know, what skills you have, what talents you have).</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the educational impact of faith community nursing on you? Educational means the ability to learn and change what you know.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>



<p>What is the cultural impact of faith community nursing on you?  Cultural means the things shared by a group of people and passed from one generation to the next. It includes values, customs, lifestyles, and use of material resources.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the financial impact of faith community nursing on you?  Financial means the ability to earn and use money.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the spiritual impact of faith community nursing on you?  Spiritual means the value, belief, and self-evaluation systems so that you can exist with unity, meaning, purpose, and fulfillment in society and in the universe.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

How much time did it take to complete the demographic tool *All About Me*? \_\_\_\_\_  
How much time did it take to complete the impact questionnaire? \_\_\_\_\_

### Research Instrument Evaluation Tool for Clergy Representatives

In each of the five statements that follow the item, please circle your opinion about the specific item.

To which group do you belong? ____ Member ____ Clergy representative ____ Faith community nurse
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

What is your gender? ____ Female ____ Male ____ Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

What is your age? <input type="text"/> Years old <input type="text"/> Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

What is your marital status? <input type="text"/> Never married <input type="text"/> Involved in committed, unmarried relationship <input type="text"/> Married <input type="text"/> Separated <input type="text"/> Divorced <input type="text"/> Widowed <input type="text"/> Other <input type="text"/> Specify status <input type="text"/> Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear
This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant
This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

<p>In what area do you live?</p> <p>_____City</p> <p>_____County</p> <p>_____Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>In what area is your faith community nursing program located?</p> <p>_____City</p> <p>_____County</p> <p>_____Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is your racial-ethnic category?</p> <p><input type="checkbox"/> African-American</p> <p><input type="checkbox"/> Alaskan Native</p> <p><input type="checkbox"/> Asian-American</p> <p><input type="checkbox"/> <input type="checkbox"/> Specify country</p> <p><input type="checkbox"/> Native-American</p> <p><input type="checkbox"/> <input type="checkbox"/> Specify group</p> <p><input type="checkbox"/> Pacific-Islander</p> <p><input type="checkbox"/> <input type="checkbox"/> Specify island</p> <p><input type="checkbox"/> Hispanic</p> <p><input type="checkbox"/> Cuban</p> <p><input type="checkbox"/> Mexican</p> <p><input type="checkbox"/> Puerto-Rican</p> <p><input type="checkbox"/> Central American</p> <p><input type="checkbox"/> South American</p> <p><input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Mixed</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is your highest educational level?</p> <p><input type="checkbox"/> Completed eight grades or less in school</p> <p><input type="checkbox"/> Attended some high school</p> <p><input type="checkbox"/> Received GED</p> <p><input type="checkbox"/> Graduated from high school</p> <p><input type="checkbox"/> Attended some college or university</p> <p><input type="checkbox"/> Completed undergraduate degree program</p> <p><input type="checkbox"/> Specify degree</p> <p><input type="checkbox"/> Specify field or discipline</p> <p><input type="checkbox"/> Attended some graduate school</p> <p><input type="checkbox"/> Completed graduate degree program</p> <p><input type="checkbox"/> Specify degree</p> <p><input type="checkbox"/> Specify field or discipline</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
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<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is your employment status?</p> <p><input type="checkbox"/> Unemployed</p> <p><input type="checkbox"/> Disabled</p> <p><input type="checkbox"/> Employed part-time by company or organization</p> <p><input type="checkbox"/> Employed full-time by company or organization</p> <p><input type="checkbox"/> Self-employed part-time</p> <p><input type="checkbox"/> Self-employed full-time</p> <p><input type="checkbox"/> Retired and not working</p> <p><input type="checkbox"/> Retired and working either part-time or full-time</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Specify status</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the annual income of your household?</p> <p><input type="checkbox"/> Less than or equal to \$9,999</p> <p><input type="checkbox"/> Between \$10,000 and \$24,999</p> <p><input type="checkbox"/> Between \$25,000 and \$49,999</p> <p><input type="checkbox"/> Between \$50,000 and \$74,999</p> <p><input type="checkbox"/> Between \$75,000 and \$99,999</p> <p><input type="checkbox"/> Equal to or above \$100,000</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>How many clergy representatives are employed by or serve your faith community?</p> <p><input type="checkbox"/> One</p> <p><input type="checkbox"/> Two</p> <p><input type="checkbox"/> Three</p> <p><input type="checkbox"/> Four</p> <p><input type="checkbox"/> Five</p> <p><input type="checkbox"/> Six or more</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>What is the membership of your faith community?</p> <p><input type="checkbox"/> Less than one hundred</p> <p><input type="checkbox"/> More than one hundred but less than three hundred</p> <p><input type="checkbox"/> More than three hundred but less than five hundred</p> <p><input type="checkbox"/> More than five hundred</p> <p><input type="checkbox"/> Specify number if known</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>



<p>How often do you participate in activities offered by your faith community?</p> <p><input type="checkbox"/> Less than monthly (one to ten times per year)</p> <p><input type="checkbox"/> Monthly (once per month)</p> <p><input type="checkbox"/> More than monthly but less than weekly (two or three times per month)</p> <p><input type="checkbox"/> Weekly (once per week)</p> <p><input type="checkbox"/> More than weekly but less than daily (two or more times per week)</p> <p><input type="checkbox"/> Daily (once per day)</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>How long have you been involved with the faith community nursing program?</p> <p><input type="checkbox"/> Less than one year</p> <p><input type="checkbox"/> More than one year but less than three years</p> <p><input type="checkbox"/> More than three years but less than five years</p> <p><input type="checkbox"/> More than five years but less than seven years</p> <p><input type="checkbox"/> More than seven years but less than nine years</p> <p><input type="checkbox"/> More than nine years</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>If you receive any type of service from the faith community nurse, how often does that occur?</p> <p><input type="checkbox"/> Less than monthly (one to ten times per year)</p> <p><input type="checkbox"/> Monthly (once per month)</p> <p><input type="checkbox"/> More than monthly but less than weekly (two or three times per month)</p> <p><input type="checkbox"/> Weekly (once per week)</p> <p><input type="checkbox"/> More than weekly but less than daily (two or more times per week)</p> <p><input type="checkbox"/> Daily (once per day)</p> <p><input type="checkbox"/> More than daily (more than one time per day)</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>If you are the faith community nurse, how many separate faith communities do you serve?</p> <p><input type="checkbox"/> Does not apply to me</p> <p><input type="checkbox"/> One</p> <p><input type="checkbox"/> Two</p> <p><input type="checkbox"/> Three</p> <p><input type="checkbox"/> Four or more</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the impact of faith community nursing on health?  Health includes physiological and mental structures, functions, processes, needs, and activities of the human body.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the social impact of faith community nursing?  Social includes individuals, families, groups, associations, organizations, or support systems and affects all one has to offer as a person (e.g. knowledge, skills, talents, time).</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the educational impact of faith community nursing?  Educational includes the ability to gain, increase, share, master, evaluate, or transform knowledge.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the cultural impact of faith community nursing?</p> <p>Cultural includes the learned behaviors (e.g. traditions, philosophies, values, languages, customs, use of material resources) shared by a particular group of people and transmitted from generation to generation.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the financial impact of faith community nursing?</p> <p>Financial includes the ability to earn, use, and control money and monetary resources.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the spiritual impact of faith community nursing?</p> <p>Spiritual includes the value, belief, and self-evaluation systems so that one can exist with a sense of unity, meaning, purpose, and fulfillment in society and in the universe.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
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How much time did it take to complete the demographic tool *All About Me*? \_\_\_\_\_

How much time did it take to complete the impact questionnaire? \_\_\_\_\_

### Research Instrument Evaluation Tool for Faith Community Nurses

In each of the five statements that follow the item, please circle your opinion about the specific item.

To which group do you belong? <input type="checkbox"/> Member <input type="checkbox"/> Clergy representative <input type="checkbox"/> Faith community nurse
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
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This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

What is your gender? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
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This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

What is your age? <input type="text"/> Years old <input type="text"/> Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
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This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

What is your marital status? <input type="text"/> Never married <input type="text"/> Involved in committed, unmarried relationship <input type="text"/> Married <input type="text"/> Separated <input type="text"/> Divorced <input type="text"/> Widowed <input type="text"/> Other <input type="text"/> Specify status <input type="text"/> Prefer not to answer
This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate
This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read
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This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly

<p>In what area do you live?</p> <p>_____City</p> <p>_____County</p> <p>_____Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>In what area is your faith community nursing program located?</p> <p>_____City</p> <p>_____County</p> <p>_____Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is your racial-ethnic category?</p> <p><input type="checkbox"/> African-American</p> <p><input type="checkbox"/> Alaskan Native</p> <p><input type="checkbox"/> Asian-American</p> <p><input type="checkbox"/> <input type="checkbox"/> Specify country</p> <p><input type="checkbox"/> Native-American</p> <p><input type="checkbox"/> <input type="checkbox"/> Specify group</p> <p><input type="checkbox"/> Pacific-Islander</p> <p><input type="checkbox"/> <input type="checkbox"/> Specify island</p> <p><input type="checkbox"/> Hispanic</p> <p><input type="checkbox"/> Cuban</p> <p><input type="checkbox"/> Mexican</p> <p><input type="checkbox"/> Puerto-Rican</p> <p><input type="checkbox"/> Central American</p> <p><input type="checkbox"/> South American</p> <p><input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Mixed</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>



<p>What is your highest educational level?</p> <p><input type="checkbox"/> Completed eight grades or less in school</p> <p><input type="checkbox"/> Attended some high school</p> <p><input type="checkbox"/> Received GED</p> <p><input type="checkbox"/> Graduated from high school</p> <p><input type="checkbox"/> Attended some college or university</p> <p><input type="checkbox"/> Completed undergraduate degree program</p> <p><input type="checkbox"/> Specify degree</p> <p><input type="checkbox"/> Specify field or discipline</p> <p><input type="checkbox"/> Attended some graduate school</p> <p><input type="checkbox"/> Completed graduate degree program</p> <p><input type="checkbox"/> Specify degree</p> <p><input type="checkbox"/> Specify field or discipline</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
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<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is your employment status?</p> <p><input type="checkbox"/> Unemployed</p> <p><input type="checkbox"/> Disabled</p> <p><input type="checkbox"/> Employed part-time by company or organization</p> <p><input type="checkbox"/> Employed full-time by company or organization</p> <p><input type="checkbox"/> Self-employed part-time</p> <p><input type="checkbox"/> Self-employed full-time</p> <p><input type="checkbox"/> Retired and not working</p> <p><input type="checkbox"/> Retired and working either part-time or full-time</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Specify status</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>What is the annual income of your household?</p> <p><input type="checkbox"/> Less than or equal to \$9,999</p> <p><input type="checkbox"/> Between \$10,000 and \$24,999</p> <p><input type="checkbox"/> Between \$25,000 and \$49,999</p> <p><input type="checkbox"/> Between \$50,000 and \$74,999</p> <p><input type="checkbox"/> Between \$75,000 and \$99,999</p> <p><input type="checkbox"/> Equal to or above \$100,000</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>How many clergy representatives are employed by or serve your faith community?</p> <p><input type="checkbox"/> One</p> <p><input type="checkbox"/> Two</p> <p><input type="checkbox"/> Three</p> <p><input type="checkbox"/> Four</p> <p><input type="checkbox"/> Five</p> <p><input type="checkbox"/> Six or more</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>What is the membership of your faith community?</p> <p><input type="checkbox"/> Less than one hundred</p> <p><input type="checkbox"/> More than one hundred but less than three hundred</p> <p><input type="checkbox"/> More than three hundred but less than five hundred</p> <p><input type="checkbox"/> More than five hundred</p> <p><input type="checkbox"/> Specify number if known</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>How often do you participate in activities offered by your faith community?</p> <p><input type="checkbox"/> Less than monthly (one to ten times per year)</p> <p><input type="checkbox"/> Monthly (once per month)</p> <p><input type="checkbox"/> More than monthly but less than weekly (two or three times per month)</p> <p><input type="checkbox"/> Weekly (once per week)</p> <p><input type="checkbox"/> More than weekly but less than daily (two or more times per week)</p> <p><input type="checkbox"/> Daily (once per day)</p> <p><input type="checkbox"/> Prefer not to answer</p>
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<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>How long have you been involved with the faith community nursing program?</p> <p><input type="checkbox"/> Less than one year</p> <p><input type="checkbox"/> More than one year but less than three years</p> <p><input type="checkbox"/> More than three years but less than five years</p> <p><input type="checkbox"/> More than five years but less than seven years</p> <p><input type="checkbox"/> More than seven years but less than nine years</p> <p><input type="checkbox"/> More than nine years</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>If you receive any type of service from the faith community nurse, how often does that occur?</p> <p><input type="checkbox"/> Less than monthly (one to ten times per year)</p> <p><input type="checkbox"/> Monthly (once per month)</p> <p><input type="checkbox"/> More than monthly but less than weekly (two or three times per month)</p> <p><input type="checkbox"/> Weekly (once per week)</p> <p><input type="checkbox"/> More than weekly but less than daily (two or more times per week)</p> <p><input type="checkbox"/> Daily (once per day)</p> <p><input type="checkbox"/> More than daily (more than one time per day)</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>If you are the faith community nurse, how many separate faith communities do you serve?</p> <p><input type="checkbox"/> Does not apply to me</p> <p><input type="checkbox"/> One</p> <p><input type="checkbox"/> Two</p> <p><input type="checkbox"/> Three</p> <p><input type="checkbox"/> Four or more</p> <p><input type="checkbox"/> Prefer not to answer</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the impact of faith community nursing on health in your current practice? Health includes physiological and mental structures, functions, processes, needs, and activities of the human body.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the social impact of faith community nursing in your current practice? Social includes individuals, families, groups, associations, organizations, or support systems and affects all one has to offer as a person (e.g. knowledge, skills, talents, time).</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the educational impact of faith community nursing in your current practice? Educational includes the ability to gain, increase, share, master, evaluate, or transform knowledge.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the cultural impact of faith community nursing in your current practice?  Cultural includes the learned behaviors (e.g. traditions, philosophies, values, languages, customs, use of material resources) shared by a particular group of people and transmitted from generation to generation.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the financial impact of faith community nursing in your current practice?  Financial includes the ability to earn, use, and control money and monetary resources.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

<p>What is the spiritual impact of faith community nursing in your current practice?  Spiritual includes the value, belief, and self-evaluation systems so that one can exist with a sense of unity, meaning, purpose, and fulfillment in society and in the universe.</p>
<p>This item is (a) very appropriate, (b) moderately appropriate, (c) somewhat appropriate, or (d) not appropriate</p>
<p>This item is (a) very easy to read, (b) moderately easy to read, (c) somewhat easy to read, or (d) not easy to read</p>
<p>This item is (a) very clear, (b) moderately clear, (c) somewhat clear, or (d) not clear</p>
<p>This item is (a) very relevant, (b) moderately relevant, (c) somewhat relevant, or (d) not relevant</p>
<p>This item is (a) very user-friendly, (b) moderately user-friendly, (c) somewhat user-friendly, or (d) not user-friendly</p>

How much time did it take to complete the demographic tool *All About Me*? \_\_\_\_\_  
How much time did it take to complete the impact questionnaire? \_\_\_\_\_

APPENDIX F  
INSTITUTIONAL REVIEW BOARD DOCUMENTS



Carolinus Medical Center  
NorthEast

September 15, 2008

Eileen Kohlenberg, PhD, RN  
UNC-G School of Nursing  
Room 213 – Margaret Moore Nursing Building  
Greensboro, NC 27402-6170

*Re: IRB# 200822 – The Impact of Faith Community Nursing on a Culturally Diverse Community*

The Institutional Review Board (IRB) of CMC-NorthEast approved the above referenced study by expedited review in accordance with 45 CFR 46.110 on September 15, 2008 for a period of one year.

Application for renewal will be due on July 1, 2009. The protocol expires on September 1, 2009.

If you make further changes in procedures it will be necessary to submit those changes for approval. Any serious and unexpected events must be reported immediately.

A copy of the protocol is maintained in the IRB Office. All minutes and proceedings pertinent to this protocol are maintained on file. The Institutional Review Board is in compliance with the requirements in Part 56, Subchapter D, Part 312 of 21 Code of Federal Regulations.

If you have any questions or need additional information, please contact, IRB Office at (704) 783-4165.

Sincerely,

  
Robert Kinney, MD; Chair  
Institutional Review Board





Cynthia Shores <cishores@uncg.edu>

---

## Research Study Approval

2 messages

**Ellis, Waqiah <Waqiah.Ellis@mosescone.com>**

Thu, Oct 9, 2008 at 1:47 PM

To: eileen\_kohlenberg@uncg.edu, cishores@uncg.edu

Good Afternoon,

Your study entitled "The Impact of a Faith Community Nursing Program on a Culturally Diverse Community" has received expedited approval through September 24, 2009. We are mailing the approval documents to: Cynthia Shores, 231 Greenhill Road, Ramseur, NC 27316.

Congratulations, and please let us know if we can help with your study in anyway.

Waqiah Ellis, MSN, RN  
Nursing Research Committee (Chair)  
Moses Cone Health System  
1200 N. Elm Street  
Greensboro, NC 27401



The Moses H. Cone  
Memorial Hospital

1200 North Elm Street  
Greensboro, NC 27401-1020  
336.832.7000

Writer's Direct Number:

**OFFICE OF RESEARCH SUPPORT  
THE INSTITUTIONAL REVIEW BOARD (IRB)  
COMMITTEE FOR HUMAN RESEARCH PROTECTIONS**

**DATE:** September 24, 2008

**TO:** Eileen Kohlenberg, PhD, RN, Principal Investigator  
Cynthia Shores, MSN, RN, Associate Investigator

**FROM:** Charles H. Wilson, MD, Chairman, IRB

**RE:** IRB 1223, The Impact of a Faith Community Nursing Program on a Culturally Diverse Community

The Chairman of the Institutional Review Board has reviewed the application for the above study. This study has been granted an expedited approval, as this study poses no risk to human subjects. The approval is for one (1) year beginning September 24, 2008 until September 24, 2009.

**Note:**

- (1) This Committee complies with the requirements found in Part 56 of the 21 Code of Federal Regulations and Part 46 of the 45 Code of Federal Regulations.
- (2) The IRB must review this protocol again if:
  - a. any significant alterations or additions to the protocol are made;
  - b. you wish to continue the study after the approval end date.
- (3) It is required that all consent forms be retained on file

This approval will be announced at the next meeting of the IRB and will be recorded in the minutes accordingly. Thank you for your research protocol submission and best of luck on your project.

---

***For IRB completion and return to Principal Investigator:***

Action taken: Expedited Approval – September 24, 2008 – September 24, 2009

Signature of IRB Chair


*Charles H. Wilson, MD* Date 9/25/08



THE UNIVERSITY of NORTH CAROLINA  
**GREENSBORO**

**OFFICE OF RESEARCH COMPLIANCE**  
2718 Beverly Cooper Moore and Irene Mitchell Moore  
Humanities and Research Administration Bldg.  
PO Box 26170  
Greensboro, NC 27402-6170  
336.256.1482  
Web site: [www.uncg.edu/orc](http://www.uncg.edu/orc)  
Federalwide Assurance (FWA) #216

**To:** Eileen Kohlenberg  
Adult Health  
213 Moore Building  
Univ. of N. C. at Greensboro  
Greensboro, NC 27402-6170

**From:** UNCG IRB IRB 

**Date:** 1/08/2009

**RE:** Notice of IRB Exemption  
**Exemption Category:** 2. Survey, interview, public observation  
**Study #:** 09-0003

**Study Title:** The Impact of Faith Community Nursing on a Culturally Diverse Community

This submission has been reviewed by the above IRB and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

**Study Description:**

The purpose of this study is to evaluate a demographic instrument and an impact questionnaire that will be used in a future study.

**Investigator's Responsibilities**

Please be aware that any changes to your protocol must be reviewed by the IRB prior to being implemented. The IRB will maintain records for this study for five years from the date of the original determination of exempt status.



Date: Friday, May 8, 2009 11:38 AM  
From: IRB <irbcorr@uncg.edu>  
To: Eileen\_Kohlenberg@uncg.edu  
Cc: accshores@tried.rr.com  
Subject: IRB Notice

To: Eileen Kohlenberg  
Adult Health  
213 Moore Building,

From: UNCG IRB

Date: 5/08/2009

RE: Notice of IRB Exemption  
Exemption Category: 2.Survey, interview, public observation  
Study #: 09-0003

Study Title: The Impact of Faith Community Nursing on a Culturally Diverse Community

This submission has been reviewed by the above IRB and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

Study Description:

The purpose of this study is to evaluate a demographic instrument and an impact questionnaire that will be used in a future study.

Study Specific Details:

This amendment, dated 4/28/2009, addresses the following:

Change in procedure; this portion of the project is the Main Study, rather than the pilot, and does not include an instrument evaluation.

Addition of seven more faith community sites that are associated with a large health care system: Oak Ridge United Methodist Church, St. Philip A.M.E. Zion Church, Trinity African Methodist Episcopal Zion Church, Faith Presbyterian, The Salvation Army Center of Hope in Greensboro, St. Matthews United Methodist Church, and Immanuel Baptist Church.

Change in subject enrollment; 35 additional participants will be added, bringing the total expected enrollment to 45.

The consent form and recruitment letters are changed to reflect these modifications.

These modifications do not alter the exempt status of the study.

Investigator's Responsibilities

Please be aware that any changes to your protocol must be reviewed by the IRB prior to being implemented. The IRB will maintain records for this study for five years from the date of the original determination of exempt status.

CC: Cynthia Shores

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<http://webmail.roadrunner.com/do/mail/message/preview?msgId=INBOXDELIM3714&l=...> 6/22/2009



Date: Monday, June 15, 2009 10:50 AM  
From: IRB <irb@uncg.edu>  
To: Eileen\_Kohlenberg@uncg.edu  
Cc: accshores@mac.com  
Subject: IRB Notice

To: Eileen Kohlenberg  
Adult Health  
213 Moore Building

From: UNCG IRB

Date: 6/15/2009

RE: Notice of IRB Exemption  
Exemption Category: 2.Survey, interview, public observation  
Study #: 09-0003

Study Title: The Impact of Faith Community Nursing on a Culturally Diverse Community

This submission has been reviewed by the above IRB and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

**Study Description:**

The purpose of this study is to evaluate a demographic instrument and an impact questionnaire that will be used in a future study.

**Study Specific Details:**

This amendment, dated 6/12/09, addresses the following:

Addition of eleven sites: Grace Community Church, Guilford Park Presbyterian, Jewish Family Services, Oak Ridge UMC, Prince of Peace Lutheran, Proximity UMC, St. Paul the Apostle Catholic Church, Saint Pius X Catholic Church, Shiloh Church of God in Christ, United Montegnard Christian Church.

Increase in enrollment to a total expected of 100, due to addition of sites.

These changes do not alter the exempt status of the study.

**Investigator's Responsibilities**

Please be aware that any changes to your protocol must be reviewed by the IRB prior to being implemented. The IRB will maintain records for this study for five years from the date of the original determination of exempt status.

CC: Cynthia Shores

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Date: Friday, June 19, 2009 8:48 AM  
From: IRB <irbcorre@uncg.edu>  
To: Eileen\_Kohlenberg@uncg.edu  
Cc: accshores@triad.rr.com  
Subject: IRB Notice

This letter, sent 6/19/2009, amends and supersedes the original letter addressing this modification, sent 6/15/2009. First Presbyterian Church, which was inadvertently omitted from the first letter, is now added to the list of research sites added via this modification.

To: Eileen Kohlenberg  
Adult Health  
213 Moore Building,

From: UNCG IRB

Date: 6/19/2009

RE: Notice of IRB Exemption  
Exemption Category: 2.Survey, interview, public observation  
Study #: 09-0003

Study Title: The Impact of Faith Community Nursing on a Culturally Diverse Community

This submission has been reviewed by the above IRB and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

Study Description:

The purpose of this study is to evaluate a demographic instrument and an impact questionnaire that will be used in a future study.

Study Specific Details:

This amendment, dated 6/12/09, addresses the following:

Addition of eleven sites: First Presbyterian Church, Grace Community Church, Guilford Park Presbyterian, Jewish Family Services, Oak Ridge UMC, Prince of Peace Lutheran, Proximity UMC, St. Paul the Apostle Catholic Church, Saint Pius X Catholic Church, Shiloh Church of God in Christ, United Montagnard Christian Church.  
Increase in enrollment to a total expected of 100, due to addition of sites.  
These changes do not alter the exempt status of the study

Investigator's Responsibilities

Please be aware that any changes to your protocol must be reviewed by the IRB prior to being implemented. The IRB will maintain records for this study for five years from the date of the original determination of exempt status.

CC: Cynthia Shores

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<http://webmail.roadrunner.com/do/mail/message/preview?msgId=INBOXDELIM3894&l=...> 6/22/2009





Cynthia Shores <cishores@uncg.edu>

---

## IRB Notice

1 message

IRB <irbcorre@uncg.edu>

Mon, Jul 6, 2009 at 3:46 PM

To: Eileen\_Kohlenberg@uncg.edu

Cc: cishores@uncg.edu

To: Eileen Kohlenberg  
Adult Health  
213 Moore Building,

From: UNCG IRB

Date: 7/06/2009

RE: Notice of IRB Exemption

Exemption Category:

Study #: 09-0003

**Study Title:** The Impact of Faith Community Nursing on a Culturally Diverse Community

This submission has been reviewed by the above IRB and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

**Study Description:**

The purpose of this study is to evaluate a demographic instrument and an impact questionnaire that will be used in a future study.

**Study Specific Details:**

This admendment dated 7/2/09 makes the following changes:

1. Added 5 additional research sites.
2. Added 25 additional participants.

These changes do not alter the exempt status of the study.

**Investigator's Responsibilities**

Please be aware that any changes to your protocol must be reviewed by the IRB prior to being implemented. The IRB will maintain records for this study for five years from the date of the original determination of exempt status.

CC: Cynthia Shores

---



Cynthia Shores <cishores@uncg.edu>

## IRB Notice

2 messages

IRB <irbcorre@uncg.edu>  
To: Eileen\_Kohlenberg@uncg.edu  
Cc: cishores@uncg.edu

Tue, Jul 21, 2009 at 8:33 AM

**TO:** Eileen Kohlenberg  
Adult Health  
213 Moore Building,

**FROM:** UNCG IRB

**DATE:** 7/21/2009

**RE:** Notice of Receipt

IRB <irbcorre@uncg.edu>  
To: Eileen\_Kohlenberg@uncg.edu  
Cc: cishores@uncg.edu

Tue, Jul 21, 2009 at 9:18 AM

**To:** Eileen Kohlenberg  
Adult Health  
213 Moore Building,

**From:** UNCG IRB

**Date:** 7/21/2009

**RE:** Notice of IRB Exemption  
**Exemption Category:**  
**Study #:** 09-0003

**Study Title:** The Impact of Faith Community Nursing on a Culturally Diverse Community

This submission has been reviewed by the above IRB and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

### Study Description:

The purpose of this study is to evaluate a demographic instrument and an impact questionnaire that will be used in a future study.

### Study Specific Details:

This amendment, dated 7/20/2009, addresses the following:

1. Addition of Our Lady of Grace church as site.
2. Increase in enrollment due to addition of site.
3. Change to consent form to omit sentence referencing total number of participants since the total number of participants is not known, it will not be specified.

<https://mail.google.com/a/uncg.edu/?ui=2&ik=8ca9f8fc81&view=pt&search=inbox&th=1...> 2/21/2011



These changes will affect the exempt status of the study.

**Investigator's Responsibilities**

Please be aware that any changes to your protocol must be reviewed by the IRB prior to being implemented. The IRB will maintain records for this study for five years from the date of the original determination of exempt status.

CC: Cynthia Shores

---

APPENDIX G

PERMISSION LETTERS FROM PARTICIPATING FAITH COMMUNITIES



**Jackson Park United Methodist Church**

715 Mable Avenue  
Kannapolis, NC 28083

*Rev. Chuck Halipilias*  
*Pastor*

June 25, 2008

Cynthia Shores  
231 Greenhill Road  
Ramseur, NC 27316

Dear Cynthia,

I apologize for taking so long to get back with you. My pastor was at the United Methodist Annual Conference the first week of June, and I was on vacation the next week for 10 days. I hope it is not too late to send this letter.

My pastor and I would like to pledge our support for your project. We are willing to help in any way with the information needed.

Please let me know what you need. We look forward to hearing from you.

Sincerely,

A handwritten signature in cursive script, appearing to read "Paula P. Lambert".

Paula P. Lambert, RN  
Volunteer Parish Nurse  
Jackson Park United Methodist Church

A handwritten signature in cursive script, appearing to read "Rev. Chuck Halipilias".

Rev. Chuck Halipilias  
Pastor  
Jackson Park United Methodist Church

Church Office  
704-932-0501

FAX  
704-932-2214

Parsonage  
704-932-2321



Cynthia Shores <cishores@uncg.edu>

## Faith Community Nursing--Pilot Study

5 messages

Cynthia Shores <cishores@uncg.edu>

Fri, Oct 17, 2008 at 2:02 PM

To: hopeyost@clc.net

October 17, 2008

Thank you for speaking with me this afternoon. As I explained during our conversation, I am working on my doctorate degree in nursing at The University of North Carolina at Greensboro (UNCG). My dissertation will examine the impact of faith community nursing in culturally diverse communities from the perspectives of congregational members, clergy representatives, and faith community nurses.

The Institutional Review Board (IRB) at UNCG will approve this study and ensure that ethical research principles are followed. There are no physical risks or financial benefits to participation in this study. Participation is voluntary, and confidentiality and anonymity are guaranteed. A consent form with contact information will be included for participants. Returning the questionnaires in the postage-paid envelopes will be considered as consent to use the responses.

Prior to my actual study, I need to complete a pilot study using a small number of participants. These individuals will complete the demographic instrument, answer the impact questions, and provide feedback about the data collection tools. This process will take approximately one hour. I hope to complete my pilot study by the end of the year. Following data analysis, I will provide you with a report of results from the pilot study and from the larger study.

Pam Hurley, RN, Director of Parish Nursing and Health Ministry, has been informed about this study and has provided a list of churches and faith community nurses to contact. The Institutional Review Board of Carolinas Medical Center-Northeast has already approved this study. If you would be willing for your church to participate in the pilot study, would you please send me a letter of support on your church letterhead that can be included with the IRB application? A sample of the required content is included at the end of this letter.

If the UNCG Institutional Review Board approves this study, I will ask for a list of participants that meet certain inclusion criteria. At that time, I will randomly select three individuals from the list and will mail them the research documents. I will also mail research documents to a clergy representative and to the faith community nurse. There will be no other contact with participants and their names and addresses will not be used for any other purpose. This study will not affect any care or services that individuals receive from the nurse.

As I indicated in our conversation, I am attaching a copy of the research documents (11 separate files). Thank you again for your time.

Sincerely,












Cynthia I. Shores, MSN, RN  
Email address: [cishores@uncg.edu](mailto:cishores@uncg.edu)  
Home phone number: 336-824-6200

Sample of required content for letter of support:

This letter provides support and permission for Cynthia I. Shores to conduct a pilot study with participants from Calvary Lutheran Church in Concord, NC. This pilot study will be one part of her dissertation research. I understand the proposed research will be reviewed and approved by UNCG Institutional Review Board for Research Involving Human Participants prior to data collection.

---

11 attachments

-  **Demographic Instrument All About Me.doc**  
37K
-  **Pilot Study Consent to Act as a Human Participant August 27 2008.doc**  
34K
-  **Pilot Study Letter of Introduction for Faith Community Members August 27 2008.doc**  
26K
-  **Pilot Study Letter of Introduction for Clergy Representatives and Faith Community Nurses August 27 2008.doc**  
26K
-  **Pilot Study Impact Questionnaire for Clergy Representatives Sept 7 2008.doc**  
30K
-  **Pilot Study Impact Questionnaire for Faith Community Nurses Sept 7 2008.doc**  
30K
-  **Pilot Study Impact Questionnaire for Members Sept 7 2008.doc**  
31K
-  **Research Instrument Evaluation Tool for Clergy Representatives Sept 7 2008.doc**  
208K
-  **Research Instrument Evaluation Tool for Faith Community Nurses Sept 7 2008.doc**  
207K
-  **Research Instrument Evaluation Tool for Members Sept 7 2008.doc**  
208K
-  **IRB exempt review one page summary Sept 5 2008.doc**  
27K

---

Hope Yost <[hopeyost@ctc.net](mailto:hopeyost@ctc.net)>  
To: Cynthia Shores <[cishores@uncg.edu](mailto:cishores@uncg.edu)>

Mon, Oct 20, 2008 at 6:56 PM

Cynthia,

I spoke with the church council tonight and they have given permission for you to use our church as one of the sites for your pilot study. The pastor will prepare the letter of support and I will get the names of the clergy and members out to you. I will be out of town this weekend so I will not be able to start working on this until next

week. In the meantime I need your address so we can send the letter of support. I also need to know to whom the letter needs to be addressed.

Hope Yost, RN, PhD  
Parish Nurse  
Calvary Lutheran Church  
950 Bradley Street  
Concord, NC, 28025  
[Quoted text hidden]

**FREE Animations for your email - by IncrediMail!**

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**Cynthia Shores <cishores@uncg.edu>**  
To: Hope Yost <hopeyost@ctc.net>

Wed, Oct 22, 2008 at 10:38 AM

Thank you so very much. The letter of support can be addressed to "UNCG Institutional Review Board" and myself. My mailing address is 231 Greenhill Road, Ramseur, NC 27316. When the study has been approved by UNCG IRB, I will let you know and then you can send me the names and addresses of potential participants. I hope it does not take more than a month to get the approval. The specific inclusion criteria are that they must have mental capacity to consent, be 18 years of age or older, able to read, write, and understand English, and have had 3 contacts/interactions with or services from the faith community nurse in the past year. I do appreciate your help with this project and I will provide your church with a report when the study is complete.  
[Quoted text hidden]

**Cynthia Shores <cishores@uncg.edu>**  
To: eileen\_kohlenberg@uncg.edu

Wed, Oct 22, 2008 at 10:47 AM

I looked at this message a few minutes ago--YES!  
[Quoted text hidden]

**Eileen Mieras Kohlenberg EGKOHLEN <egkohen@uncg.edu>**  
To: Cynthia Shores <cishores@uncg.edu>

Wed, Oct 22, 2008 at 12:28 PM

Cynthia,  
This is great news. "You go, girl!"

Eileen Mieras Kohlenberg, PhD, RN, NEA-BC  
Associate Dean for Graduate Programs  
President, North Carolina Nurses Association  
PI, Online Nursing Administration Grant  
UNCG School of Nursing  
Rm. 213 Margaret Moore Nursing Building  
PO Box 26170



Greensboro, NC 27402-6170  
Phone: 336/334-5261  
FAX: 336/334-3628  
Email [eileen\\_kohlenberg@uncg.edu](mailto:eileen_kohlenberg@uncg.edu)

"Cynthia Shores" <[cishores@uncg.edu](mailto:cishores@uncg.edu)>

10/22/2008 11:47 AM

To [eileen\\_kohlenberg@email.uncg.edu](mailto:eileen_kohlenberg@email.uncg.edu)

cc

Subject Fwd: Faith Community Nursing--Pilot Study

[Quoted text hidden]

---

[Sign Page](#) [Mail](#) [Calendar](#) [Documents](#) [Sites](#) [Contacts](#)
[cshomes@uncg.edu](#) | [Settings](#) | [Clear cache](#) | [Help](#) | [Sign out](#)

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 Reuben Tonnissen: Movies - [55% My Bloody Valentine 3D](#) - 1 hour ago

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[Back to Inbox](#) [Archive](#) [Report spam](#) [Delete](#) [More Actions](#)
[Newer 8 of 182 Older](#)
[Inbox \(48\)](#)
**Pilot study about impact of faith community nursing**
[View](#) [X](#)
[New window](#)
[Starred](#)

Cynthia Shores to Hope

[show details](#) Jan 14 (6 days ago)

[Reply](#)
[Edit all](#)
[Expand all](#)
[Forward all](#)
[Drafts](#)

Good afternoon,

[Sent Mail](#)

First, I would like to thank you again for your help with my research which will examine the impact of faith community nursing. Yesterday, I received a message from my dissertation chairperson that the UNCG IRB has approved the study and that I can now proceed with data collection. The study was previously approved by the IRB of Carolinas Medical Center Northwest and Pam Hurley has been notified of the UNCG IRB approval.

[Drafts](#)

As I mentioned in my email of October 22, I am now asking you to supply me with a list of potential participants and their addresses for my pilot study. Participants must meet the following four inclusion criteria: (1) the individual must have the mental capacity to consent to participation, (2) the individual must be 18 years of age or older, (3) the individual must be able to read, write, and understand English, and (4) the individual must have had three contacts/interactions with you or services from you in the past year.

[All Mail](#)

From the list you provide, I will randomly select three participants and will mail them the research packet. The list of names and addresses will then be destroyed with a crosscut shredder and will not be used for any other purpose. I will not send any reminder notices or additional requests to participants and there will be no follow-up with participants.

[Spam \(179\)](#)

My mailing address is 231 Green Hill Road, Rameur, NC 27316. If you prefer to send the list electronically, my email address is [cshomes@uncg.edu](mailto:cshomes@uncg.edu). My phone number is 336-424-4203. Contact information (phone numbers and email addresses) for the participants is on the consent form which will be included in the research packet.

[Trash](#)

I appreciate your willingness to help. As I indicated previously, I will provide you and your church a written report after the study is complete.

[Contacts](#)

With sincere thanks,  
 Cynthia Shores, PhD, RN

[Reply](#) [Forward](#)
[Chat](#)
[Search](#) [add](#) [or invite](#)

Cynthia Shores

Get mobile help

236301001621678

cd01fcd3a0cb508

Ellen Wilson Ko...

ellen\_wilsonberg

crik\_ukin

Hope Yost

Hurley, Pam

Janet Robinson

Karen Engel KM...

[Colors](#)
[Add Colors](#)
[Labels](#)
[Edit labels](#)

Cynthia,  
 Attached is the list of members names/addresses. Good luck with your research. Please let me know what your findings are.

Hope Yost, RN, PhD  
 Parish Nurse  
 Calvary Lutheran Church  
 Concord, NC 28025

-----Original Message-----

From: Cynthia Shores  
 Date: 1/16/2009 2:31:14 PM  
 To: Hope Yost  
 Subject: [REDACTED]  
 [REDACTED]

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## **Congregational**

UNITED CHURCH OF CHRIST

June 18, 2009

To Whom It May Concern:

This letter provides support for Cynthia I. Shores to collect data from individuals associated with Congregational United Church of Christ of Greensboro, NC. This study will be part of her dissertation research. I understand that the UNC-G Institutional Review Board for Research involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

Julie Peeples  
Senior Minister





## Faith Presbyterian Church

April 14, 2009

Ms. Cynthia Shores  
231 Greenhill Road  
Ramsuer, NC, 27316

Dear Ms. Shores;

This letter provides support and permission for Cynthia Shores to collect data from individuals associated with Faith Presbyterian Church, Greensboro, NC.

This study will be a part of her dissertation research. I understand that the UNCG Institutional Review Board for Research involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

A handwritten signature in cursive script, appearing to read "Lawrence W. Avent".

Lawrence W. Avent, Interim minister



FIRST  
PRESBYTERIAN  
GREENSBORO, NC CHURCH

May 14, 2009

Ms. Cynthia L. Shores, PhD, RN  
231 Greenhill Road  
Ramseur, NC 27316

Dear Ms. Shores,

First Presbyterian Church in Greensboro gives you permission to collect data from individuals associated with our church. I understand that this study will be part of your dissertation research.

From our phone conversation during the first week of May it is my understanding that you will need responses from five (5) individuals: a clergyperson, our congregational nurse, and three members who have received the services of the congregational nurse. I understand that the UNC-G Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Best wishes on your research project.

Sincerely,

The Rev. Peggy F. Matthews  
Parish Chaplain and Director of Pastoral Care

C: The Rev. Dr. Sid Batts, Senior Pastor  
Maggie Turner, RN, Congregational Nurse

617 North Elm Street  
Greensboro, NC 27401

336-373-0445  
FAX 275-9398

Web site:  
[www.fpcgreensboro.org](http://www.fpcgreensboro.org)



## *First United Methodist Church*

Eugene E. Dean, Pastor  
P.O. Box 220, 123 North Fayetteville Street, Liberty, NC 27298  
Church: (336) 622-4682 Fax: 622-5300  
www.firstumclib.com E-mail: FUMC@firstumclib.com

June 23, 2009

Cynthia Shores  
Moses Cone Congregational Nurse Program  
1200 North Elm Street  
Greensboro NC 27401-1020

Dear Ms. Shores:

This letter provides support and permission for Cynthia I. Shores to collect data from individuals associated with the Faith Community Nurse Program in Liberty NC. This study will be part of her dissertation research. I understand that the UNCG Institutional Review Board for Research Involving Human Participants will approve this research and this participant site prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

Eugene E. Dean, Jr.  
Pastor



## GRACE COMMUNITY CHURCH

*"...as He is, so are we in this world." 1 John 4:17*

May 28, 2009

Cynthia I. Shores  
231 Greenhill Road  
Ramseur, NC 27316

To Whom It May Concern:

This letter provides support and permission for Cynthia I. Shores to collect data from individuals associated the Congregational Nurse Program at Grace Community Church in Greensboro, NC. I understand that this study will be part of her dissertation research. Grace Community Church understands that the UNCG Institutional Review Board of Research Involving Human Participants will approve this research and this participant site prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith Community Nursing.

Thank you for asking Grace Community Church to participate in this research.

Sincerely,

Jill Van Veen  
Deacon of Shepherding  
Grace Community Church

643 West Lee Street • Greensboro, North Carolina 27403 • 336-379-1936  
FAX: 336-389-1814 • email: [Office@GraceCommunityChurch.org](mailto:Office@GraceCommunityChurch.org)



**Guilford Park Presbyterian Church**

2100 Fernwood Drive  
Greensboro, North Carolina 27408  
336.288.5452  
[www.guilfordpark.org](http://www.guilfordpark.org)

Virginia Wood, Pastor  
Margie W. Boyd, Associate Pastor

May 11, 2009

To Whom it May Concern:

This letter provides support and permission for Cynthia I. Shores to collect data from individuals associated with Guilford Park Presbyterian Church of Greensboro, NC. This study will be part of her dissertation research. I understand that the UNC-G Institutional Review Board for Research involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

I wish Cynthia Shores God's blessing upon her research. We at Guilford Park are grateful for the congregational nurse with us!

Sincerely,

A handwritten signature in cursive script that reads "Rev. Virginia Wood".

Rev. Virginia Wood



IGLESIA CRISTIANA INTERNACIONAL

David Duarte, Pastor



Thursday, June 25, 2009

**To Whom It May Concern:**

This letter provides support and permission for Cynthia I. Shores to collect data from individuals associated with Iglesia Cristiana Internacional in Greensboro, NC. This study will be part of her dissertation research. I understand that the UNCG Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

David Duarte, pastor

INTERNATIONAL CHRISTIAN CHURCH  
2119 S. Elm-Eugene St.  
Greensboro, NC 27406

336 508 1889  
336 686 4957  
iglesiainternacional@yahoo.com



## Immanuel Baptist Church

April 14, 2009

Ms. Cynthia I. Shores, PhDc, RN  
231 Greenhill Road  
Ramscur, NC 27316

Re: Letter of Support

Dear Ms. Shores:

This letter provides support and permission for Cynthia I. Shores to collect data from individuals associated with Immanuel Baptist Church in Greensboro, N.C. This study will be part of her dissertation research. I understand that the UNC-G Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

  
Pastor J. Russell Reaves

JRR/lc





May 27, 2009  
4 Sivan 5769

**BOARD OF DIRECTORS**

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Steven LeWinter  
Lois Meier

Rabbi Fred Gottman  
Rabbi Eliezer Hersh

**Director**  
Jewish Family Services  
Betsy Gamburg, MSW

**Executive Director**  
Greensboro Jewish Federation  
Marilyn Forman Chandler

To Whom It May Concern:

This letter provides support and permission for Cynthia I. Shores to collect data from individuals associated with Jewish Family Services in Greensboro, NC. Our nurse, Gilda Friedman, will provide you with names once she has spoken with and received permission from her clients here at Jewish Family Services.

This study will be part of Ms. Shores' dissertation research. I understand that the UNCG Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

Betsy Gamburg, MSW  
Director

Constituent Agency of the Greensboro Jewish Federation

5509-C West Friendly Avenue Greensboro, NC 27410-4211 Tel: (336) 852-4829 Fax: (336) 852-4346 Email: [www.shalomug.org](mailto:www.shalomug.org)



Begin, Belong, Become

OAK RIDGE  
UNITED METHODIST CHURCH



April 10, 2009

ATTN: Congregational Nurse Program  
Moses Cone Health System  
1200 North Elm Street  
Greensboro, North Carolina 27499-2011

This letter provides support and permission for Cynthia L. Shores to collect data from individuals associated with Oak Ridge United Methodist Church in Oak Ridge, North Carolina. This study will be part of her dissertation research. I understand that the UNCG Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

Rev. Dr. Michael D. Kurtz  
Senior Pastor  
Oak Ridge United Methodist Church  
2424 Oak Ridge Road  
Oak Ridge, North Carolina 27310  
336-643-4690

2424 Oak Ridge Road  
Oak Ridge, NC 27310

[www.oakridgeumc.com](http://www.oakridgeumc.com)

Church (336) 643-4690 • Weekday School (336) 643-7838 • Fax (336) 643-2065

**Our Lady of Grace Church**

*The Mrs. Julian Price Memorial*

201 S. Chapman Street

GREENSBORO, NORTH CAROLINA 27403

June 17, 2009

To Whom It May Concern:

This letter provides support for Cynthia I. Shores to collect data from individuals associated with Our Lady of Grace Catholic Church of Greensboro, NC. This study will be part of her dissertation research. I understand that the UNC-G Institutional Review Board for Research involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

  
Fr. Fidel Melo

Pastor



PRINCE OF PEACE LUTHERAN  
CHURCH

1100 Curtis Street  
Greensboro, NC 27406  
(336) 378-9738

The Reverend John E. Mack, Jr., Pastor

May 20, 2009

Cynthia I. Shores, PhD, RN  
231 Greenhill Road  
Ramseur, NC 27316

Dear Ms. Shores:

I am The Rev. John Mack Jr. and also the pastor of Prince of Peace Lutheran Church. Prince of Peace Lutheran Church has been involved in the Moses Cone Congregational Nurse Program for a number of years. The purpose of this letter is to grant you, Cynthia I. Shores, support and permission to collect data from individuals from Prince of Peace Lutheran Church in Greensboro, NC to be used as part of your dissertational research. I understand that the UNCG Review Board for Research Involving Human Participants will review and approve this research prior to collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Please let me know if I or members of Prince of Peace Lutheran church might be of any assistance to your research.

Shalom,

John E. Mack Jr., Pastor

May 19, 2009

To Whom it May Concern,

This letter provides permission for Cynthia I. Shores to request information from persons associated with Proximity United Methodist Church in Greensboro, North Carolina for the purpose of collecting data as part of her dissertation research. I understand that the UNCG Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection. I also understand that persons choosing to participate will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

A handwritten signature in blue ink, appearing to read "Rev. Mark R. Smith", with a stylized flourish at the end.

Rev. Mark R. Smith, Pastor  
Proximity United Methodist Church



William Booth, Founder  
Shaw Clifton, General  
Maxwell Peener, Territorial Commander  
Major Vern Jewett, Divisional Commander  
Majors Paul & Karen Egan, Corps Officers

April 21, 2009

To Whom It May Concern:

This letter provides support and permission for Cynthia L. Shores to collect data from individuals associated with The Salvation Army of Greensboro Center of Hope in Greensboro NC. This study will be part of her dissertation research. I understand that the UNCG Institutional Review Board for research Involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

Jackie Lucas  
Center of Hope Executive Director



SHILOH CHURCH OF GOD IN CHRIST  
Pastor Robert A. Taylor

203 E. Vandalia Road  
Greensboro, NC 27406

336-273-0797 phone  
336-273-0796 fax

May 22, 2009

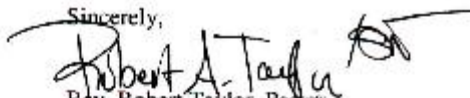
Dear Sirs:

I want to thank Cynthia for her work in this area and want to provide support and permission for this collection of data.

This letter provides support and permission for Cynthia L. Shores to collect data from individuals associated with Shiloh Holiness C.O.G.I.C. in Greensboro, NC. This study will be part of her dissertation research. I understand that the UNCG Institutional Review Board for Research Involving Human Participants will approve this research and this participant site prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Thank you for the opportunity to be involved in this study.

Sincerely,

  
Rev. Robert Taylor, Pastor

RAT/slw



## St. Matthews United Methodist Church

600 East Florida Street – Greensboro, North Carolina 27406 – Church (336) 272-4505

Fax (336) 272-5877 – e-mail smatt600@bellsouth.net

April 20, 2009

To Whom It May Concern:

Re: Cynthia I. Shores, PhD, RN

On behalf of the nurses in the congregation here at St. Matthews United Methodist Church, I am pleased to support and give permission for Cynthia I. Shores to collect data from persons associated with St. Matthews UMC in Greensboro, NC.

It is my understanding that this study will be part of her dissertation research and that the UNCG Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection.

I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

We do wish Cynthia the very best as she gathers this research data. If you have any questions, please do not hesitate to call.

Peace and grace,

  
Dr. Arnetta E. Beverly  
Senior Pastor

cc: Mrs. Margaret Burton





2717 HURST TEN CREEK RD  
GREENSBORO, NC 27410  
OFFICE: 336-294-4696  
FACSIMILE: 336-294-6149  
WWW.STPAULCC.ORG

May 29, 2009

To Whom It May Concern:

This letter provides support and permission for Cynthia L. Shores to collect data from individuals associated with St. Paul the Apostle Catholic Church in Greensboro, N.C. This study will be part of her dissertation research. I understand that the UNCC Institutional Review Board for Research Involving Human Participants will approve this research and this participant site prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

Colleen Assal  
Director of Outreach  
St. Paul the Apostle Catholic Church





*St. Philip A.M.E. Zion Church*

*1330 S. Ashe Street Greensboro, NC 27406  
Church # 336-272-1301 - Fax # 336-379-9081  
Rev. Clarence J. Shuford, Jr., Pastor*

April 13, 2009

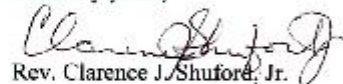
Moses Cone Congregational Nurse Program  
1200 North Elm Street  
Greensboro, NC 27401-1020

Ref: Congregational Nurse Research  
Cynthia I. Shores, PhD, RN

Dear Ms. Lelia Moore,

This letter provides support and permission for Cynthia I. Shores to collect data from individuals associated with St. Philip A.M.E. Zion Church in Greensboro, NC. This study will be part of her dissertation research. I understand that the UNCG Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely yours,

  
Rev. Clarence J. Shuford, Jr.



## Saint Pius X Catholic Church

220 State Street Greensboro, NC 27405-5198 336-272-4881 / 272-8598 Fax 336-274-8112

May 14, 2009

**To Whom it May Concern:**

This letter provides support and permission for Cynthia L. Shores to collect data from individuals associated with St. Pius the Tenth Catholic Church in Greensboro, North Carolina. This study will be part of her dissertation research. I understand that the UNCG Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

Reverend Monsignor Anthony J. Marcaccio, V.F.



**TRINITY AFRICAN METHODIST EPISCOPAL ZION CHURCH**

631 East Florida Street  
Greensboro, North Carolina 27406

Ph. 336/274-4670  
Fax 336/274-4510  
e-mail Trinity631@aol.com

April 9, 2009

The Institutional Review Board  
University of North Carolina at Greensboro

To whom it may concern:

I am writing this letter of support for Ms. Cynthia I. Shores who I understand is working on her doctorate degree in nursing. I also understand that she is working with the Moses Cone Congregational Nurse Program to help gather information as part of her dissertation research. This letter provides support and permission for Cynthia I. Shores to collect data from individuals associated with Trinity A.M.E. Zion Church, Greensboro, North Carolina. I understand that the UNCG Institutional Review Board for Research Involving Human Participants will complete questionnaires to assess the impact of fact community nursing. I will be more than happy to assist Ms. Shores in any way that I can. Trinity A.M.E. Zion Church will also assist Ms. Shores in this project.

If you have any questions, please feel free to call me at:  
336-274-4670

Sincerely

Michael A. Frencher, Sr., D.Min. Pastor



1204 Picard Street, Greensboro, NC 27405

Email Address: [Revumcc@yahoo.com](mailto:Revumcc@yahoo.com)

Web site: [www.montagnarducc.org](http://www.montagnarducc.org); Web blog: [www.rffm.blogspot.com](http://www.rffm.blogspot.com)

Tel: 1(877) 621 1040 (Church Office)

336 508 0951 (cell Phone)

*To God Shall be Glory*

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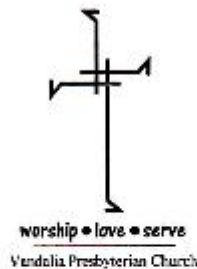
Nov 28, 2009

To Whom It May Concern:

This letter provides support for Cynthia I. Shores to collect data from individuals associated with United Montagnard Christian Church of Greensboro, NC. This study will be part of her dissertation research. I understand that the UNC-G Institutional Review Board for Research involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

Sincerely,

Rev. Y'Hin Nie  
Pastor



101 W. Vandalia Rd.  
Greensboro, NC 27406  
336.275.3605  
vanpres@bellsouth.net  
vanpres.blogspot.com

June 12, 2008

Dear Lelia Moore,

This letter provides support and permission for Cynthia I Shores to collect data from individuals associate with Vandalia Presbyterian Church in Greensboro, NC as a part of her study for her dissertation research.

I understand that the UNCG Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection. I also understand that participant will complete questionnaires to asses the impact of faith community nursing.

We are pleased to support her in this manner and look forward to hearing her results.

PEACE!

A handwritten signature in black ink, appearing to read "Mark A. Sandlin".

Mark A. Sandlin  
Minister of Word and Sacraments



June 10, 2009

To Whom it May Concern:

This letter provides support and permission for Cynthia I. Sheres to collect data from individuals associated with Westminster Presbyterian Church in Greensboro, NC. This study will be part of her dissertation research. I understand that the UNCG Institutional Review Board for Research Involving Human Participants will review and approve this research prior to data collection. I also understand that participants will complete questionnaires to assess the impact of faith community nursing.

After receiving permission from individuals who have participated in the program Westminster's Congregational Nurse, Barbara Akins, will provide their names.

Marilyn Fish  
Executive Director of Church Operations

[www.westpreschurch.org](http://www.westpreschurch.org) 336.399.3785  
ADMINISTRATIVE OFFICE: 3906 West Friendly Avenue, Greensboro, NC 27410

## APPENDIX H

### ARRANGEMENT OF ITEMS IN RESEARCH PACKETS

Letter of introduction (see Appendix C)

Consent form (see Appendix D)

Demographic instrument (see Appendix A)

Impact questionnaire (see Appendix B)

Research instrument evaluation tool (see Appendix E) (only for pilot study participants)

Stamped, addressed return envelope

## APPENDIX I

### LETTER OF SUPPORT FROM FAITH COMMUNITY NURSING PROGRAM



MOSES CONE HEALTH SYSTEM

1200 North Elm Street  
Greensboro, NC 27401-1020  
336-832-7000

Writer's Direct Number

June 19, 2008

Ms. Cynthia Shores  
231 Greenhill Road  
Ramseur, NC 27316

Dear Ms. Shores,

Thank you for your research that will examine the impact of the Moses Cone Congregational Nurse Program on the Guilford County community. I support your project and am willing to evaluate your data collection instruments and findings for face and content validity. I understand the project proposal will be reviewed and approved by The University of North Carolina at Greensboro Institutional review Board for research Involving Human Participants prior to data collection.

If you need further information in support of this project, please contact me at 336-832-8604.

Respectfully,

Lelia Moore  
Congregational Nurse Coordinator  
Moses Cone Health System

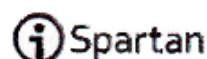


## APPENDIX J

### LETTER OF PERMISSION TO USE NURSING INTERVENTIONS

UNCG Mail - RE: permission request re: Nursing Interventions Classification 5/E

Page 1 of 3



Cynthia Shores <cishores@uncg.edu>

#### RE: permission request re: Nursing Interventions Classification 5/E

1 message

Jones, Jennifer (ELS-OXF) <J.Jones@elsevier.com>  
To: cishores@uncg.edu

Fri, Oct 16, 2009 at 6:16 AM

Dear Cynthia Shores

We hereby grant you permission to reprint the material detailed below at no charge in your thesis subject to the following conditions:

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