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Factors That Affect the Sustainability of Faith Community Nurse Programs in Christian Faith Communities

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FACTORS THAT DETERMINE THE SUSTAINABILITY OF FAITH COMMUNITY NURSE PROGRAMS IN CHRISTIAN FAITH COMMUNITIES

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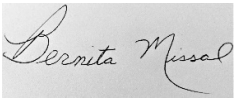
Project Advisor Signature: 

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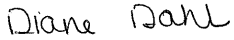
Dean/Chief Nursing Administrator Signature: 

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Abstract

FACTORS THAT DETERMINE THE SUSTAINABILITY OF FAITH COMMUNITY NURSE PROGRAMS IN CHRISTIAN FAITH COMMUNITIES

Background: With the increasing number of people who are homebound or have chronic illnesses, the faith community nurse (FCN) is able to provide whole person care to people in faith communities.

Purpose: The purpose of this critical review of the literature is to identify factors that affect the sustainability of FCN programs in faith communities.

Theoretical Framework: The roles and understanding of FCN continue to evolve and expand as the needs of patients and faith communities increase. Ziebarth's Evolutionary Conceptual Model for Faith Community Nursing was applied to this literature review. This theoretical model allows for the definition of and practice of FCNs to change in order to improve the understanding and acceptance of this nursing specialty.

Methods: A critical review of the literature was conducted which included relevant research studies and literature pertaining to the factors attributed to FCN programs. Articles and studies from 1997-2020 were included in this search based on the limited amount of research and literature on FCN.

Results: Thirteen studies were reviewed which revealed strengths and weaknesses that impacted the sustainability of FCN programs. Identifiable factors included clergy and congregational views of the church's role in health, perceptions and knowledge of FCNs, and barriers to FCN programs. Results indicated that lack of financial support, lack of

resources, rejection of the role of the FCN and lack of time were all barriers which led to difficulty in being able to sustain FCN programs.

Conclusions: While most clergy and congregation members had positive views of the role of the church in health and of FCNs, there was a general lack of support for health programming due to financial constraints and competition for time and space in church programming. There is also a lack of knowledge of FCNs within faith communities, schools of nursing and among other health practitioners. All of these factors were shown to impact the sustainability of FCN programs.

Implications for practice: The sustainability of FCN programs impacts the extent to which FCNs are able to provide care to individuals and the community. FCN programs that maintain sustainability have positive outcomes and are able to reach a larger number of people with whole person care. Specific ways to improve sustainability of FCN programs have been indicated in the literature, and include continual re-defining of the FCN role and increasing the knowledge and exposure of FCN among clergy and congregational members. Other methods that were recommended to improve sustainability, and ultimately improving patient outcomes include further research to identify additional factors that affect FCN programs. The literature also indicates that research requires larger, less homogenous sample sizes in order to provide a more accurate, comprehensive view of FCN sustainability. By expanding on partnerships between faith communities, schools of nursing and health care organizations, this can lead to increased support, finances and resources for FCN programs, which could ultimately lead to improved and more sustained whole person care.

Keywords: faith community nursing, parish nursing, church nursing, church health, community health, sustainable health programs and faith health programs.

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Chapter One: Introduction

Faith Community Nursing (FCN), also known as Parish Nursing (PN) or congregational nursing, is a nursing specialty recognized by the American Nursing Association and was formally introduced in the United States in 1984 by Granger Westberg, a Lutheran pastor. FCN is currently being practiced in over 28 countries (Wordsworth, 2014) and is made up of nurses from various faith traditions, including Christian, Jewish and Muslim. The underlying factor that differentiates FCN from other nursing specialties is the "intentional care of the spirit" (American Nurses Association & Health Ministry Association, 2005; 2012). FCNs are registered nurses (RNs) who have successfully completed an approved FCN Foundations course.

This nursing specialty focuses on wholistic or whole person care. Nursing interventions are aimed at caring for the patient as a whole; this includes caring for their physical, emotional, spiritual, financial, vocational and social well-being. Ziebarth (2016b) describes four theological hypotheses that are at the core of wholistic health. The first is the concept that the place where a person receives care matters. The second is that of the nature of the person. This considers how we value people. The third hypothesis focuses on sickness and health, including spiritual, physical, relational, vocational and emotional health. The final hypothesis considers healing agents, which focus on teamwork, with God being the most important team member (Ziebarth, 2016b). The Faith Community Nursing Scope and Standards (American Nurses Association & Health Ministries Association, 2005; 2012) outline the role and responsibilities of the FCN, as well as the limitations placed on nurses functioning as FCNs, which include not providing hands on care, such as wound care or medication administration, as the FCN is not working under the direction of a physician. Functions of the FCN include health education, health promotion, visitation, health assessments, disease management, spiritual care, coordination of care, and

collaboration with other health care providers (Dyess, Chase & Newlin, 2010; Ziebarth, 2014). As of 2010, it was estimated that 15,000 FCNs served in various faith communities both in the United States and several other countries (Patterson & Slutz, 2011). Most FCNs work within a church or congregational setting, although there are also FCNs based in hospital and community health provider settings. The services provided by FCNs are free, and most FCNs work in an unpaid status. Faith communities are appropriate places to provide care to individuals who may be wary of receiving care in more traditional settings, but who feel safe and cared for in their place of worship (Hixson & Loeb, 2018). FCN programs are able to provide care where it might otherwise be missing (Dyess, Chase & Newlin, 2010). There are factors that either promote FCN programs, or act as barriers to the sustainability of these programs. There are no absolute, identifiable factors that lead to program success (Ziebarth, 2014b).

Statement of Purpose/Research Question

Based on research by leaders within FCN, a common theme has emerged regarding the challenge to maintain sustainable FCN programs. The ability to sustain FCN programs impacts their effectiveness, which is crucial for ongoing community care and sustainable programs that receive healthcare system funding (Ziebarth, 2016a). While there has been increasing research into the nursing interventions and improved patient outcomes associated with FCN, there has been little research into the factors that affect the sustainability of these programs (Bokinskie & Kloster, 2008; Thompson, 2010). Several factors have been identified that either facilitate the viability of FCN programs, or are seen as barriers to the programs. According to Bokinskie and Kloster (2008), the key factors that were seen as obstacles to the success of FCN programs include the lack of pastoral support, lack of congregational support, limited financial support, and limits on the FCN's time. There is a global commonality among FCN programs, including

a need for improved funding, increasing education and awareness among the public about the role of FCNs, enlisting nurses and volunteers for the program, and building interdenominational relationships (Wordsworth, 2014). The question to be addressed in this literature review is: "What are the factors that determine the sustainability of FCN programs in a Christian faith community?"

Need for Critical Review of a Nursing Problem

There has been an influx of literature and research into FCN in the past decade. Current FCN research has demonstrated four main areas of study: the perception of FCN by faith communities, interventions and roles of FCN, documentation and assessment of FCN, and the creation of and application of FCN interventions (Devido et.al. 2018). These are important factors when looking at the perceived barriers and successful methods to FCN programs, as they help to identify what measures and interventions are working, and their impact on health outcomes as well as the economic impact of these interventions. However, there is limited research or literature looking at the barriers or successes that affect the sustainability of FCN programs (Bokinskie & Kloster, 2008).

Despite FCNs working collaboratively with clergy members, there has been little research into the view of clergy regarding the influence that they have on congregational health (Baruth, Bopp, Webb & Peterson, 2015; Thompson, 2010; Rowland & Isaac-Savage, 2014). Much of the literature pertaining to FCN program sustainability is between seven to fifteen years old. Despite the age of many of the articles and studies, they continue to be referenced throughout current FCN practice and literature, and can be considered classic, reliable resources. Classic literature is deemed admissible if other literature is not found or is inadequate (Bernhofer, 2015). Of the literature and research that is available concerning barriers and successes to FCN programs, a

significant amount is found in books, the FCN Foundations course curriculum, or is anecdotal, comprised of an author's experiences on the subject. The majority of the research has been qualitative, with limited quantitative research being conducted. Based on the age and limited availability of articles on this subject, the ongoing discussion of barriers to FCN programs, as well as the increased need for whole person nursing care, it was deemed that a critical review of this problem was needed.

Significance to Nursing

The cost of healthcare in the United States has increased over ten times in the past twenty years, and reached $8,915 per person annually in 2012 (Yeaworth & Sailors, 2014). The U.S. Census Bureau estimates that by the year 2030, one in five people will be age 65 or older (Hixson & Loeb, 2018). Over two-thirds of FCN interactions occur with individuals ages 66 or older (Yeaworth & Sailors, 2014). Since the introduction of the Patient Protection and Affordable Care Act (PPACA), there have been changes to the Medicare program, and the costs to both beneficiaries as well as health care providers (Ziebarth, 2015a). Of those receiving "fee-for-service" Medicare benefits, close to one-fifth who are discharged will be readmitted to the hospital within 30 days (Ziebarth, 2015). It is estimated that of those readmissions, up to three-fourths could possibly be prevented at a savings of approximately $12 billion annually (Ziebarth, 2015). In 2013, Medicare withheld one percent of reimbursement payments to hospitals with readmissions prior to 30 days post-discharge (Yeaworth & Sailors, 2014). In 2008, the Henry Ford Macomb hospitals in Michigan reported a savings of $280,050 as a result of FCN interventions (Brown, et.al. 2009). This one example demonstrates the potential significance of FCN and how it can benefit both patients and health systems. Faith Community Nurses are in a unique position to be able to reach a large number of people within their congregations and

communities. People that are part of a faith community frequently feel more secure obtaining health services from a faith-based health ministry versus non-religious choices (Joel, 1998; Baruth et al., 2015). Nursing interventions aimed at health education and promotion can reach beyond the walls of the faith community and have significant positive health outcomes for countless people in the community. There is a potential for larger numbers as the health education provided could be disseminated electronically across the globe, impacting FCN programs around the world (Ziebarth & Hunter, 2016). Evidence based nursing interventions, such as falls prevention classes, can reduce the risk of falls and injuries in seniors and increase their ability to live independently (Hixson & Loeb, 2018). Because a large number of FCNs work in unpaid positions, there is limited financial cost to a congregation (Ziebarth, D. 2016a). It is imperative to identify the factors that influence FCN programs. If these programs are not able to be sustained, it could have devastating financial and health related consequences for both patients and communities.

Conceptual Model/Theoretical Framework

There have been several theoretical models used to describe the philosophy and interventions used in faith community nursing. However, these different models have tended to only focus on one or two attributes of this nursing specialty, such as health promotion, or spiritual care. A new theoretical model was designed by Deb Ziebarth, based on Rodgers' evolutionary conceptual model. Rodgers' development of an evolutionary conceptual model arose as it was determined that goals and the description of certain concepts are not stagnant, but change over time (McEwen & Wills, 2014,). An evolutionary conceptual model may result in identifying outcomes that warrant continued research and enhancement (McEwen & Wills, 2014). Applying an evolutionary conceptual model also provides comprehension of former views and how those

may be modified or transformed in the future (Ziebarth, 2014a; 2016a). Ziebarth's model defines faith community nursing comprehensively and also allows for future research and evidence-based practice within FCN (Ziebarth, 2014). By using Rodgers' evolutionary concept analysis (Ziebarth, 2014), Ziebarth was able to use this model in order to describe the roles of the FCN. Included in the role description of FCNs, Ziebarth was also able to use Rodgers' model to describe wholistic health care, which is an integral part of the care delivered by FCNs (Ziebarth, 2016). The different roles, or, domains of FCN include health promotion, faith integrating, empowering, coordinating, disease managing and accessing health care (Ziebarth, 2014). It is difficult to quantify the actual number of nursing diagnoses or interventions used by FCNs in each of these domains, as they are highly subjective and tend to overlap into the other domains.

As the roles, practice locations and names of FCN have changed over the years, the views of FCN have changed as well. This requires a changing theoretical model, which allows for the change in the definition of FCN, as well as redefining the attributes associated with FCN. Based on the need for a model that would accommodate changes, Ziebarth developed a new FCN model, known as the Faith Community Nursing Conceptual Model (Figure 2) (Ziebarth, 2014). Ziebarth based this model from an earlier model developed by Solari-Twadell et al. (Figure 1), (1991). Ziebarth's model can be visually described using sets of concentric circles. The inner-most circle comprises the nurse/client relationship. As this relationship expands, the nurse is able to provide wholistic health care. As a result of this wholistic care, faith integration is able to occur. The outer-most circles depicted in the model consist of the different domains of FCN, including health promotion, coordination of care, disease management, empowering and assessing health care (Ziebarth, 2014). This model of FCN is beneficial when searching for studies and literature related to the sustainability of FCN programs. By using the definition of

FCN and description of roles, as well as the nurse/client relationship, this model can allow for discrimination of studies that are related to FCN interventions versus those that discuss factors affecting the sustainability of programs. Because it is an evolutionary model, as described above, it allows for changes in the definitions and roles of FCN (Ziebarth, 2014), thus, is an appropriate model to use when identifying program effectiveness. This model can also be used to help educate clergy and other health care providers about the effectiveness of FCN interventions and the positive patient outcomes that result from FCN interventions. It also is effective in describing the definition of FCN as well as the roles and responsibilities of this nursing specialty. By increasing the awareness and education of FCN, as well as providing an accurate definition of it, this could improve perceptions about and support for FCN, leading to increased sustainability of FCN programs (Ziebarth, 2014).

Summary

In conclusion, FCN is a nursing specialty recognized by the ANA. They have developed the scope and standards of FCN, as well as the definition of FCN (ANA & HMA, 2012). The roles and definition of FCN continue to evolve as the knowledge and views of FCN grow within medical and faith communities. There has been limited research or literature produced about the potential barriers or successes that can be attributed to the sustainability of FCN programs. Much of the literature and research is between five and fifteen years old and is largely anecdotal or qualitative in nature. In order to capture all of the components of FCN, Ziebarth's Conceptual Model of Faith Community Nursing has been identified as an appropriate model on which to base this nursing specialty. This model is evolutionary, which allows for changes in the roles and description of FCN, as the views and definitions of it continue to evolve. The model looks at the nurse/client relationship as the basis for all of the nursing interventions and domains,

including intentional care of the spirit (ANA and HMA, 2012) that are integrated and work together within FCN practice.

Chapter Two: Methods

Faith Community Nursing (FCN) is an evolving specialty as new concepts emerge and knowledge of FCN continues to gain traction in both the medical and faith communities (Ziebarth, 2014). However, it is still largely unknown or misunderstood, as will be discussed in chapters three and four of this literature review. Due to the relative newness of FCN, and the lack of knowledge that encompasses it, there is limited research or literature on the subject of FCN, particularly on the subject of factors that influence the sustainability of FCN programs. This chapter will discuss the methods used to search for relevant research studies and literature pertaining to the factors attributed to FCN programs. These methods will include search strategies used, inclusion and exclusion criteria for studies, a summary of the types and number of selected studies, as well as evaluation criteria of the research studies.

Search Strategies Used to Identify Research Studies

Faith Community Nursing (FCN) is known by several different terms, including FCN, parish nursing (PN), congregational nursing, church nursing and community nursing. Other terms that are associated with FCN programs are Congregational Health Ministries (HCM), Health Ministries (HM), and Health and Wellness Activities (HWA). These programs were evaluated and included as different faith communities may refer to FCN programs by these different names. Due to the variety of names used for this specialty, search words required parts of, or combinations of each of these terms, and required using multiple search sites to find appropriate studies and literature. The key terms used in the searches included parts of, or all of the following: faith community nursing, parish nursing, church nursing, church health, community health, sustainable health programs, health promotion and faith health programs. The inclusion of multiple key terms allowed for an expanded search and increased number of articles to be

considered for review. The databases that were searched included CINAHL (Cumulative Index to Nursing and Allied Health Literature), CLICsearch through the Bethel University library, Google Scholar and PubMed. Literature searches also involved looking at references from recently obtained articles and research studies. Articles and studies from 1997-2020 were included in this search based on the limited amount of research and literature on FCN. An in-person meeting with the Bethel University reference librarian yielded helpful tips in refining the search terms and learning how to properly navigate the above-mentioned search databases.

Criteria for Including or Excluding Research Studies

While many studies were found concerning faith community nursing, the majority of them focused on the nursing interventions involved with FCN, not the factors that influence the sustainability of the FCN programs, which is the focus of this literature review. However, it should be noted that the literature did reveal nursing interventions that did improve sustainability, including FCN efforts to be more visible in the faith community, and to increase awareness and knowledge of FCN among clergy and congregational members. It was necessary to define inclusion and exclusion criteria for the studies, in order to identify those studies that were most closely associated with the focus of this review.

Inclusion criteria consisted of studies that included components of faith and health, sustainable health promotion programs and addressed, at least in part, the problem that is the focus of this review. Due to the limited amount of research and literature on sustainable FCN programs, the age of searched articles was also increased to include those over five to eight years old. Articles from 1997 to 2019 were included. This allowed classic articles to be included which have been deemed by experts in FCN to be relevant to the sustainability of FCN programs. Both quantitative and qualitative studies were chosen for inclusion, as the majority of

studies found were qualitative in nature. International studies written in English were also included in order to discover commonalities among global FCN programs. Authors and research studies from England, Australia and Canada were included in these international studies. Additional literature that met the inclusion criteria were further literature reviews, books and anecdotal literature. Of the 74 articles were reviewed, 39 articles and three books met the inclusion criteria. This additional literature was included as there are few studies within this nursing specialty, and a variety of literature can help to give a more comprehensive look at the problem being addressed. Research studies that met the inclusion criteria were then added to the literature matrix and reference list. Anecdotal literature, literature reviews and books were added to the references.

Exclusion criteria of studies and articles was based on those that did not address faith-based health programs, health promotion within a faith community or perceptions of health within the context of a faith setting. This was an important factor, as the definition of FCN includes "the intentional care of the spirit" (ANA & HMA, 2012). Other exclusion criteria included literature that did not address the sustainability of FCN programs, or ones that did not discuss facilitation of nor barriers to FCN programs.

Number and Types of Studies Selected

Abstracts of 74 articles were read at the beginning of this literature review. Of the 39 articles and three books that met the inclusion criteria, thirteen articles were ultimately chosen to be included in the literature matrix, as they were research studies. The remaining literature was anecdotal or consisted of literature reviews. All but one of the articles were qualitative studies, as the bulk of FCN research is qualitative in nature. One study was a quantitative mixed-methods study. Of these studies, seven were surveys, five were one-to-one interviews, with one interview

described as ethnographic and one as naturalistic. There was also one mixed-methods study. In addition to these thirteen articles, three books about FCN were selected, including the American Nursing Association and Health Ministry Association Scope and Standards for Faith Community nursing (ANA, 2005; ANA & HMA, 2012). Nine author perspective/expert opinion articles were also chosen, two case studies and seven literature reviews. While these additional articles and literature were not direct research studies, they were selected for this literature review as they directly addressed the issue of factors that influence the sustainability of FCN programs. Only the first thirteen articles were included in the matrix, as they were direct research studies.

Criteria for Evaluating Research Studies

The Johns Hopkins Nursing Research Evidence Appraisal Tool was used to evaluate the level of the studies. All of the articles were subject to this appraisal tool to determine if they met the criteria of a research study. The Johns Hopkins Evidence Level and Quality Guide was used in conjunction with the appraisal tool. The guide defines and rates three levels of research evidence, including Levels I, II and III. Level I evidence includes experimental studies, randomized control trials, (RCTs) explanatory mixed methods and systematic review of the RCTs. Meta-analysis may or may not be included in the systematic reviews. Level II evidence includes mixed methods, quasi-experimental studies, systematic reviews with a combination of quasi-experimental and RCT studies. These studies may or may not include meta-analysis. Level III evidence includes non-experimental and qualitative studies, as well as meta-syntheses, systematic reviews of several RCTs, and quasi-experimental studies (Dearholt & Dang, 2018). Of the articles included in the matrix, twelve of the thirteen articles were considered a Level III, they were all non-experimental, qualitative studies, including a mixed-methods study. There was also one level II study, which was a mixed-methods quantitative study. Mixed-methods studies

use both qualitative and quantitative research, and are considered Level II evidence (Dearholt & Dang, 2018). The quality rating for each of the thirteen matrix articles was rated as good to high. Studies with a good rating have an adequate sample size, fairly consistent results, conclusions and recommendations, and a fair amount of control on the study (Dearholt & Dang, 2018). High research evidence is defined as having a sufficient sample size, specific conclusions and uniform results and recommendations (Dearholt & Dang, 2018).

Summary

In conclusion, several search databases were used to find studies related to the topic of factors that affect the sustainability of FCN programs. These databases included CINAHL, PubMed, CLICsearch and Google Scholar. Several combinations of key terms were used as FCN is also known by other terms such as parish nursing, church nursing and congregational nursing. This allowed for an increased list of possible studies to be included. Both inclusion and exclusion criteria were used when considering the appropriateness of studies and articles to be used for this review. Inclusion criteria required that the literature discussed faith and health as key elements. Studies and articles older than five years were also included due to the limited amount of research and literature on the subject. Exclusion criteria was used to exclude articles and studies that did not have the faith-health connection. Twelve of the thirteen articles in the matrix were a Level III and one was rated a Level II. Each study was rated as high or good quality, based on the Johns Hopkins Evidence Quality Appraisal Tool and Evidence Level Guide (Dearholt & Dang, 2018).

Chapter Three: Literature Review and Analysis

As studies were reviewed and considered for inclusion in the matrix, the age of the articles was increased to allow articles older than five years, as there is limited research regarding the sustainability of faith community nursing programs (FCN). Common themes were identified when compiling the results of the studies. These included the perceptions of the role of faith community nurses, the role of the church in providing health services, and identifiable barriers and strengths of FCN programs which affected their sustainability. The thirteen studies that were included in the matrix, with identifiable strengths and weaknesses of the studies, including small sample sizes of several of the studies and homogeneity of the samples which made it difficult to generalize the results.

Matrix Article #1:

PICO Question: What factors determine the sustainability of FCN programs in a Christian church for two or more years after program initiation?

Article: https://onlinelibrary-wiley-com.ezproxy.bethel.edu/doi/epdf/10.1111/j.1525-1446.2009.00828.x

Source: Thompson, P., (2010). Clergy knowledge and attitudes concerning faith community nursing: Toward a three-dimensional scale. *Public Health Nursing,* 27(1), 71-78. doi: 10.1111/j.1525-1446.2009.00828.x

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To pilot test a new instrument to measure attitudes and knowledge about faith community nursing (FCN). **Sample/Setting:** Clergy in the United Church of Christ (UCC) n=95. **Participant demographics:** Caucasian: 97%, Male: 77% Married: 85%, Full time: 82% Ordained: 97% **Church setting:** Suburban: 44.1% Rural: 29.4% Urban: 20.6% **Church demographics:** Caucasian: 95% Hispanic: 0-10% **Johns Hopkins Evidence Appraisal** **Level of Evidence**: Level III **Quality:** Quality B	**Methods:** A mailed survey **Instruments:** 3-scale survey: 1) Knowledge Scale: looked at knowledge of what FCNs do 2) Attitude Scale: pastors' attitudes about FCN 3) Opinion Scale asked pastors if they felt that certain programs were appropriate to have in a church. Data collection: SPSS for Windows 12.0. ANOVA, Cronbach's alpha	35.8% of 95 surveys returned. Internal Consistency Reliability (ICR)= α Mean Score (X) **Pastors reported:** -- 85.3% had RNs in church -- 41.2% said 3-30 members lacked health insurance. -- 11.8% Studied churches had FCN Attitude scale: No significant differences (α=.94), (+) attitudes of FCN, (X=4.07; SD=0.58) Knowledge scale (Lowest scores): FCNs give spiritual counseling/wound care, (α=.88), (X=3.93) (SD =0.48) **Opinion scale:** Pastors beliefs: programs appropriate, question need for meal delivery to sick/elderly or visiting families in crisis. (α=.95), X=4.03, SD =0.69 **Conclusion:** #1: Few FCNs in UCC. -- Decreased clergy/church support/knowledge prevent RNs to become FCNs (contrary to #2) #2: Most pastors have (+)attitudes knowledge of FCNs, although a few pastors wrote negative comments #3: Further survey testing could ID FCN program barriers	**Strengths:** -- High internal consistency reliability for each scale. -- Good quality transparency and verification -- Insightful interpretation of the data. -- High reliability of all three scales, from .88 to .95. -- Mean scores above 3.50 **Limitations:** Homogeneity and small sample size Wording of survey not acceptable among each faith, specifically the words "God", "church" and "congregation". The small return rate may indicate participant bias.

Author Recommendations: Validity and reliability could be improved with larger sample sizes in multiple faith communities, and to survey clergy and members of congregations. Validity could also be improved by administering the survey to FCNs and those with no knowledge of FCN. Changing certain words, such as church, God and congregation could reflect the faith community better. Administering the survey two weeks apart could allow for test-retest reliability.

Implications: The survey could be useful in identifying challenges to faith community nursing programs.

Matrix Article # 2

Article: https://journals-sagepub-com.ezproxy.bethel.edu/doi/pdf/10.1177/0898010118801414

Source: Devido, J., Doswell, W., Braxter, B., Terry, M., Charron-Prochownik, D., (2018). Exploring the experiences, challenges, and approaches of parish nurses in their community practice. *Journal of Holistic Nursing,* 20(10), 1-9. doi: 10.1177/0898010118801414.

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To explore the personal practices, experiences and challenges of parish nurses (PN) in their communities. **Sample/Setting:** English speaking (PN) from PN & Health Ministry program in U.S. (n=48). Pittsburgh area:73% FL OH, AZ, NY, MN: 27%. Female: 100%, Caucasian: 83% RN: 96% BSN or higher: 61% **Johns Hopkins Evidence Appraisal Level of Evidence:** Level III **Quality:** A: High Quality	**Methods:** • Mixed methods concurrent embedded design with focus groups (subject attend 1 of 11) digitally recorded • Data collected using semi-structured interview guide, by video/tele-conferencing, face-to-face • Inductive approach also used for themes/ subthemes/descriptions/ codes to emerge • ATLAS.ti (7.1.7) software used to maintain and organize data. • Qualitative descriptive analysis was used to develop data summary	**4 Themes emerged:** • Gaining entry through trust • Enhanced focus on spiritual caring • Accomplishment despite challenges • Practice making a difference **Benefits of PNs:** • Provide health education • Improve patient health outcomes • More time/high trust levels • Concept of "presence" emerged • Comfortable giving spiritual care Challenges of PNs: • Decreased programming/funding • Decreased continuing education • "Be experts in everything" • Being professionally isolated **Conclusion:** • PNs give wholistic/spiritual care • More time with patients. • Support networks decrease isolation/disseminate information	**Strengths:** • Adequate sample size • Validity and reliability enhanced by coding data individually and together • Independent transcriptionists and M.A.T. experts for coding • Data saturation achieved **Limitations:** • Many examples related to diabetes and might not be generalized to other PNs. • The study also included two LPNs who self-selected to participate, as they saw themselves as PNs. • No reliability, mean score or SD listed

Author Recommendations: To create a PN support network by developing and evaluating programming to form connections/relationships with other PNs

Implications: A support network for parish nurses could help to share practice information among members. This could provide encouragement for the nurses, and could be a source of continuing education and sharing of practice strategies and interventions. Parish nursing programs could be implemented and sustained as the nurses feel supported and receive needed education for their practices.

Matrix Article #3
Article: https://onlinelibrary-wiley-com.ezproxy.bethel.edu/doi/epdf/10.1111/j.1525-1446.2006.00602.x

<table>
<tr><td colspan="4">Source: Catanzaro, A., Meador, K., Koenig, H., Kuchibhatla, M., & Clipp, E., (2007). Congregational health ministries: A national study of pastors' views. Public Health Nursing, 24 (1), 6-17</td></tr>
<tr><th>Purpose/Sample</th><th>Design (Method/Instruments)</th><th>Results</th><th>Strengths/Limitations</th></tr>
<tr>
<td>Purpose: To compare perceptions of pastors with/without congregational health ministries(CHMs) and characteristics of CHMs.
Sample/Setting:
349 pastors (N=349) from 80 Christian denominations:
Catholic:60%
Protestant: 40%
Participant demographics:
Male: 90.3%
Married:77%
Caucasian:90.4%
Johns Hopkins Evidence Appraisal Level of Evidence:
Level III
Quality:
A: High Quality</td>
<td>Quantitative, cross-sectional clergy survey with 6 domains:
1.Pastor/church demographics
2.Church's role in health
3.Rate and outcomes of CHM
4.CHM characteristics
5.CHM participation factors
6.Likert scales for domains 2 and 3
-- 4- week reminders sent
-- Final letter and $2 bill if no response
Data analysis:
-- SPSS 12.0.
-- Chi-square and t-test.
-- Variables significant at bivariate level included in a backward stepwise logistic regression to ID factors of churches with/without CHMs.</td>
<td>>CHMs in churches that are:
Mainline/Catholic, large, wealthy, suburban, married clergy
Clergy with CHMs reported:
-- need for church help in CHM
-- > health promotion, disease prevention, emotional support
-- (+) health-supporting outcomes
CHMs: existed on average for 6.2 years
Factors influencing CHM:
--Nurse's idea (35.6%), CHM pre-existed (28.7%), Other clergy (22.8%).
Factors for not having CHM:
--Lack knowledge (66.9%), lack funds (59.1%), lack support from church board (53%)
Clergy views:
--83% without CHM would consider
--3.5% without CHM would not have
--> CHM involvement if (+) clergy view of church's role in health needs
Conclusion: Many pastors support CHMs but need education on role of faith community nurse (FCN)/CHMs. Collaboration with other churches/hospitals/nursing schools could help with financial/resource limitations of church for a CHM. The full impact of FCNs working in CHMs won't be realized until CHMs
are adequately funded and FCNs considered full time.</td>
<td>Strengths:
Strong statistical data compares churches with/without CHMs, and demographics of pastors' perceptions of CHMs, listed in tables in study.
Limitations:
Study age > 12 years
Hard to generalize results due to: Only U.S. Christian churches, low response rates, high sample rate
male/Caucasian clergy, no verification of accuracy of self-reports of clergy, or effectiveness of CHMs.</td>
</tr>
<tr><td colspan="4">Author Recommendations: The authors recommend further research in results of faith community nurse interventions, the impact of religious context on faith-based care, and which congregational health models lead to better health outcomes and are most cost effective.</td></tr>
<tr><td colspan="4">Implications: Nursing schools need to educate students about faith community nursing, including how an individual's health care decisions are based on their faith beliefs and traditions. As faith community nurses require further continuing education, nursing schools may be an opportune location for continuing education classes.</td></tr>
</table>

Matrix Article #4
Article: https://journals-sagepub-com.ezproxy.bethel.edu/doi/full/10.1177/1524839913480799

Source: Odulana, A, et al. (2014). Examining characteristics of congregation members willing to attend health promotion in African American churches. *Health Promotion Practice*, 15(1), 125–133. doi:10.1177/1524839913480799

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To determine how different church and church members' views/interest in health promotion (HP) in a faith-based setting was connected to their participation in HP OR Health Ministry (HM) programs in their church. **Sample/Setting:** Adult church members (n=1,204) in 11 mainly African American churches in North Carolina. **Johns Hopkins Evidence Appraisal** **Level of Evidence:** Level III **Quality:** A High quality	--Descriptive statistics identify demographics. --Bivariate associations --Chi-Square test assessed participant preferences in receiving health information **Congregational Health Assessment (CHA)** --demographics, health behaviors and beliefs, church characteristics, health goals, preference in obtaining HP information. **Self-Monitoring Approach (SCM)** --For data analysis --Organize variables in groups: cognitive, demographic, behavioral or environmental --Connection of groups and participation in HP activities.	**Church members:** > (76%) in HP activities if their church had current HM programs and if healthy food offered at HP events. >Participation in HM activities if had health concerns/illness and >age. > attend church <3x/week, physically active. ½ made healthy food choices. >Church has role in HP. >worried about own health, friends/family >desired resources for living healthy, Scripture lessons about healthy lifestyles. >lived near church, family health concerns, church HM, healthy food options. **Conclusion:** Stronger partnerships among churches and health care providers can help to decrease health disparities in African American churches, and enhance members' beliefs about how the church can promote health and learn more about healthier behaviors.	**Strengths:** --Adequate sample size --Variables showed cognitive, environmental, behavioral factors. --African American demographic --increased health disparities/chronic illness, results in increased need for HP -- Unadjusted bivariate associations. -- CHA pilot tested before use to reveal relevance and understanding --Clergy feedback on CHA before sending out to participants. **Limitations:** --Members with greater views of and participation in HP programs could lead to bias and reduced strength of similarities. --Unable to generalize for all African-Americans. --Cross-sectional design could indicate causal pathways.

Author Recommendations: Information obtained be used to evenly distribute resources that are limited so the church's and congregation members needs can be better met, instead of only using it to work with those churches that are ready to implement health promotion programs. Collaborative efforts between research investigators and churches.

Implications: Health promotion is an expectation in providing care for African-Americans. Collaboration between researchers and church leaders can identify chronic health illnesses, leading to increased empirical work to identify racial disparities. This collaboration may also result in health promotion and interventions in churches and communities.

Matrix Article #5

Article: https://www-sciencedirect-com.ezproxy.bethel.edu/science/article/pii/S0149718914000172

Source: Whitt-Glover, M., et al., (2014). Utility of a congregational health assessment to identify and direct health promotion opportunities in churches. *Evaluation and Program Planning, 44*, 81–88.

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: A way to identify participants for health ministry (HM) programs in African American churches and how to get churches to gather health-based data from church members and explain health and if they had a health ministry program. Sample/Setting: 24 African American churches **Johns Hopkins Evidence Appraisal** **Level of Evidence:** Level III **Quality:** A High quality	--**Convenience sample** of churches took part in year-long Health Ministry Institute (HMI) to assist churches to design sustainable health promotion programs. HMI Participants trained before administering survey. **Congregational Health Assessments (CHA)** --Determine health conditions/behaviors. --50 questions, (+/-) answers --5-point Likert scale. --No identifying data **Data collection** --Entered by church volunteers. --Analyzed by statistician using STATA version 12.	-- 71% of surveys returned -- 100% of churches had HM; -- 63.5% of participants aware of HM (men>women with p=0.03) -- 75% Concerned for own health -- 84% Concerned for health of family/friends/congregation -- Church attendance 2x/week determined p-Value **Desire to learn:** -- Healthy living=88% (p=0.02) -- Communicate with providers=68% p=0.001 -- Health resources=87% p=0.002 -- Biblical healthy living=94% p=0.008 -- How health impacts community/church=88% -- p=0.024 **Conclusion:** CHA revealed participant's health concerns and can be used to assess health of church members. CHA can be used to start church HM. Trained volunteers able to gather data to educate on health activities.	**Strengths:** -- 71% returned surveys with limited training of health ministry leaders. -- CHA study data comparable to state/national data. --indicates results accurate of sample size --high validity resulting from confidence level of sample, general population -- Statistician analyzed data. **Limitations:** -- No data on response rate of churches that used CHA. -- Unsure if data represents churches or individual survey participants. -- Possible sample bias if those taking survey were more health conscious. --Surveys done by paper/pencil --Churches made own copies and distributed them, impacting large congregations or limited resources

Author Recommendations: Include online surveys for future CHAs. Collaborate with churches for health research to determine/create faith-based interventions for chronic illnesses common to African American congregations along with their preferred health activities/programs.

Implications: CHAs can be used to assess health and health concerns of church leaders and congregation members. Health ministry leaders can be trained to collect health information for researchers, in a short amount of time. CHAs may also help churches create successful and sustainable health programs.

Matrix Article #6

Article: https://web-b-ebscohost-com.ezproxy.bethel.edu/ehost/pdfviewer/pdfviewer?vid=0&sid=d6e4f722-bcc6-4501-a0bb-3396968d35c9%40sessionmgr120

Source: Bopp, M., Webb, B. L., & Fallon, E. A. (2012). Urban-rural differences for health promotion in faith-based organizations. *Online Journal of Rural Nursing & Health Care, 12*(2), 51. doi:10.14574/ojrnhc.v12i2.25

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: 1) Identify differences between rural and urban faith-based organizations (FBOs) with Health and Wellness Activities (HWA). 2) Determine differences in health and behaviors among rural and urban clergy/faith leaders. **Sample/Setting:** Clergy/faith leaders (n=824) 72.9% primary leader 17.8% secondary leader >90% Caucasian Rural (n=225) Urban (n=599) Methodist (41.1%) Lutheran (20.4%) Other **Johns Hopkins Evidence Appraisal** **Level of Evidence:** Level III **Quality:** B Good	--Convenience sample/cross-sectional study of U.S. --Axio Learning Systems, Manhattan, KS for the online survey system. --Top three denominations of each state identified using Pew Forum data. --Data collected March-December 2009. -- Behavioral Risk Factor Surveillance System used to measure physical activity -- Sample described with descriptive statistics/frequencies. --$\chi 2$ analysis and t-tests determined differences in rural vs. urban FBOs. --Statistical Package for the Social Sciences, version 17.0 (SPSS) for analysis. -- Significance levels p=0.05	-- Barriers to HWAs were lack of: --Resources/staff time --congregation interest --volunteers/lay leaders No HWAs: Rural FBOs >urban FBOs (x^2=3.00, df=1, p=0.04 Fewer HMAs: Rural (3.73$\pm$2.89) < urban (4.98$\pm$3.25; t=4.92, df=781, p<0.001 Urban FBOs >health classes, screenings, health fairs, sports/physical activity. Rural FBOs barriers = lack of lay leaders, interest. Urban barriers= Conflicts with other FBO activities. **Conclusion:** There are significant differences in HWAs in rural congregations compared to urban congregations. Identifying barriers and strengths to HWAs can lead to developing improved programming.	**Strengths:** An adequate sample size was used. Good validity based on $\chi 2$. **Limitations:** Sample pool of possible participants limited due to lack of current contact information from some denominations. Participant bias as those who had interest or motivation in survey more apt to complete survey. Self-report study also subject to bias. Predictors of HWA or changes to HWA hard to limited due to cross-sectional design

Author Recommendations: Further research is needed, using a variety of methods in order to increase the likelihood of increased survey response rates and more in-depth studies.

Implications: The strengths and barriers that were identified can increase knowledge of factors that are different between urban and rural HWAs. The results can also identify future research that is needed, and interventions that will lead to improved patient outcomes.

Matrix Article #7

Article: https://link-springer-com.ezproxy.bethel.edu/article/10.1007/s10943-014-9924-1

Source: Baruth, M., Bopp, M., Webb, B., & Peterson, J. (2015). The role and influence of faith leaders on health-related issues and programs in their congregation. *Journal of Religion and Health, 54*(5), 1747-1759. doi:10.1007/s10943-014-9924-1

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To look at clergy's influence on health issues, their views on health problems in their churches and what types of health activities were at their churches **Sample/Setting:** Clergy (n=24) **Johns Hopkins Evidence Appraisal** **Level of Evidence:** Level III **Quality:** B: Good	A qualitative study conducted with one -to-one interviews done by a trained interviewer. 5 question interview focused on health views/own health practices. Data analyzed with NVivo 8.0, which organized/coded data.	**Clergy:** -- Could identify health challenges of congregations. -- Most (n=21) reported having at least 1 health-related activity in their church. **Clergy involvement in HWAs:** -- Actively involved (n=10) -- Others involved (n=9) -- Delegated to others (n=5) -- No involvement (n=2) Clergy influence on health: -- Have influence (n=15) -- Little influence (n=8) **Clergy personal health as influence on church health:** -- Want to role-model (n=16) -- Encourage good health (n=8) **Conclusion:** Pastors have the potential of educating their congregations about health issues due to their influence and ability to reach many people at once.	**Strengths:** Coders (the authors) and researchers developed coding guide. Transcripts each independently coded by 2 of 4 coders Views from clergy adds to limited research/literature on subject. **Limitations:** Potential study bias as participants given small incentive. May have also had more interest in health/been healthier., although 75% participants overweight/obese Limited generalizability due to sample taken from only 2 regions, and might not represent clergy from other parts of the U.S.

Author Recommendations: By having churches partner together with universities or community health organizations, or conducting a community-based research project could potentially help churches to develop more sustainable health programs.

Implications: Future faith based health promotion programs can be identified and developed based on the study results.

Matrix Article #8

Article: https://link.springer.com/article/10.1007/s10943-009-9306-2

Source: Williams, R., Glanz, K., Kegler, M., & Davis, E. (2012). A study of rural church health promotion environments: Leaders' and members' perspectives. *Journal of Religion and Health, 51*(1), 148-160. doi:10.1007/s10943-009-9306-2

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To study the views of a church's health promotion (HP) between church members and leadership. It also examined the correlation between beliefs of clergy and HP (programs, policies, messages, facilities) **Sample/Setting:** Churches(n=33) Clergy (n=40) Church members (n=96) Churches: >50% 200+memberships 57.4% Caucasian 60% Baptist **Johns Hopkins Evidence Appraisal** **Level of Evidence:** Level III **Quality:** B Good	Church leaders from congregations which had members involved in the Healthy Rural Communities 2 (HRC2) study were interviewed. Participants received a monetary gift card. Survey questions based on health beliefs and practices of participants and their church. Data analyzed with SPSS Version 15.0 and put into 3 categories. Cronbach's alpha tested data on health messages and programs. Spearman Rho correlation coefficients determined association of clergy's views on health promotion and messages.	**% Clergy with health-related sermons:** (sermon appropriateness mean=2.5, SD=1.5, median= 3) -- Healthy eating (55%),Weight loss (47.5%), Activity (77.5%), Not smoking (70%) **One-to-one appropriate conversations:** (mean=3.3, SD=1.2, median=4) -- Healthy eating (80%), Weight loss (75%), Activity (82.5%), Not smoking (90%) **Perceived interest in clergy health talks:** (mean=1.1, SD=1.2, median=1) -- Diet (30%) -- Activity (42.5%) -- Smoking (42.5%) No significant correlations (r) on survey between clergy and church members **Conclusion:** Clergy can be recognized as health counselors as their beliefs grew about inclusion of health topics in sermons and how Scripture discusses health. This led to increased health messages in the church.	**Strengths: Unique study:** -- First study comparing health views of clergy and church members. -- Studied clergy not involved in greater intervention-type studies. -- Done with rural church leaders, Research limited in rural settings. -- Data from mainly Caucasian churches. Most previous data from African-American churches. -- Good reliability, allowing results to be observe separately and collectively. **Limitations:** Findings may not be generalizable: -- All clergy male, full time -- Most clergy from Baptist churches -- Small sample from each church -- Study conducted in rural community -- Individual aspects decreased due to multiple survey questions -- Small sample size -- Self-reporting could indicate bias

Author Recommendations: Future research is needed to identify additional beliefs and determine how those health beliefs could help promote health programs in churches. Objective observational studies are also needed to determine actual health beliefs and environments versus what is reported.

Implications: Other health beliefs of clergy that weren't studied in this research investigation could match areas of a church's health promotion environment and values. Clergy will be more comfortable to include health promotion into church programming if they know the health information that their church members want.

Matrix Article #9

Article: https://oce-ovid-com.ezproxy.bethel.edu/article/00005217-201409000-00016/HTML

Source: Whisenant, D., Cortes, C. & Hill, J. (2014). Is faith-based health promotion effective? Results from two programs. *Journal of Christian Nursing*, 31(3), 188–193. doi: 10.1097/CNJ.0b013e3182a5f5a2

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To look at health benefits of 2 biblically based health promotion programs at both urban and rural churches with varying resources. **Sample/Setting:** Less intervention group: (n=35) (all women) More intervention group: (n=21) (15 women, 6 men) **Johns Hopkins Evidence Appraisal** Level: II **Level of Evidence:** Quality: Good B	A mixed methods study was done using 2 different health promotion programs in 2 different groups/churches Group 1 had less intervention and group 2 had more interventions. Demographic data collected at beginning and end of the program. t-tests used with church 2 to identify changes in data pre and post program.	**Group 1 results:** -- Decreased weight -- Decreased blood pressure **Group 2 results:** -- Decreased weight --Decreased serum cholesterol t(4.30) -- Decreased diastolic blood pressure t(3.91) -- Decreased systolic blood pressure t(4.22) -- Decreased waist size t(5.97) -- Decreased heart rate t(2.65) **Conclusion:** Christian nurses are able to guide others and give them resources for education and improving or sustaining good health. Both of the Scripture based health programs used in this study can give people the resources and education they need to have healthier lives.	**Strengths:** Improvements in health were seen in both study groups, those with less resources, and those with more. **Limitations:** Church 1 used self-reporting, which could lead to participant bias. The church 1 sample size was also small and homogenous, decreasing the generalizability of results. Church 2 had limitations on number of participants as well as time limitations. This church demographic also homogenous and all middle to upper class and from a large urban church. This decreases generalizability of findings.

Author Recommendations: The authors recommend identifying and utilizing health care providers within churches as volunteers to help with the programs. They also recommend obtaining already prepared health materials from approved sources such as the American Diabetes Association.

Implications: Churches are able to provide health promotion activities and programs, no matter the type or amount of resources they have. Programs aimed at health promotion have the potential to reach large numbers of people which can lead to improved health outcomes and foster healthier lifestyles.

Matrix Article #10

Article:https://journals.lww.com/journalofchristiannursing/Abstract/2008/01000/Effective_Parish_Nursing__Building_Success_and.5.aspx?sessionEnd=true

Source: Bokinskie, C., J., & Kloster, K., P. (2008). Effective parish nursing: Building success and overcoming barriers. *Journal of Christian Nursing, 25*(1), 20-25. doi:10.1097/01.CNJ.0000306000.35370.71

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To determine barriers and successful factors of Parish Nurse (PN) programs **Sample/Setting:** RNs who had completed the PN Course at the Concordia College PN Center >PNs Lutheran Phase 1(n=431) Phase 2(n=435) Phase 3(n=463) **Johns Hopkins Evidence Appraisal Level of Evidence:** Level III **Quality:** B Good	Exploratory, descriptive survey conducted over 3 years, in 3 phases. SPSS, Version 13.0 used for data analysis. Revised survey at each phase to gather more data.	**Barriers include:** -- Lack of time/energy -- Lack of resources -- Lack of education of clergy/congregation -- Lack of support -- Lack of finances **Successes include:** -- Adequate time -- Support of family/clergy/church -- Good communication with clergy -- Personal spiritual development -- Continuing education for PN -- Help/volunteers -- Health ministry team **Conclusion:** A strong, collaborative clergy-PN relationship is crucial to a successful PN program. A successful PN program is also based on having an active health ministry team, and that the PN is spiritually mature and willing to grow in their own faith.	**Strengths:** Face and content validity strengthened as survey created by expert PNs and reviewed by Concordia College PN alumni. Survey revised during each phase to gather more data Survey was anonymous 40% response rate **Limitations:** Limited research and literature on topic Article 11 years old Sample homogenous, all in upper Midwest, which limits generalizability to other regions and cultures, faith traditions.

Author Recommendations: Further research is needed within PN. This includes expanding the definition of "successful" PN programs, and further understanding of the views of the congregation on the role of the PN. Research into the relationships between PNs, clergy, church members and health ministry teams is also needed. The authors also recommend continuing to educate clergy and churches about PN.

Implications: Parish nurse programs may be more successful and sustainable when PNs are in a paid position or have economic support. Success and sustainability are also improved when there are time commitments and education for pastors and the faith community. This will allow PNs the ability to provide wholistic nursing care to their faith communities.

Matrix Article #11

Article: https://journals-sagepub-com.ezproxy.bethel.edu/doi/pdf/10.1177/104365969901000114

Source: Chase-Ziolek, M. (1999). The meaning and experience of health ministry within the culture of a congregation with a parish nurse. *Journal of Transcultural Nursing,* 10(1), 46-55.

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To understand the meaning and experiences of health ministry of a faith community with a faith community nurse (FCN), looking at both emic and etic views. **Sample/Setting:** 19 participants, including clergy, health care practitioners and congregation members of an urban , multi-ethnic United Methodist Church. **Johns Hopkins Evidence Appraisal** **Level of Evidence:** Level III **Quality:** B Good	An ethnographic study was conducted over 16 months using various data collection methods, including review of written documents (sermons, handouts and bulletins), observing participants and interviews, including semi-structured and informal interviews. Transcripts of data were coded. A word-processing program was used to combine information.	18 of 19 participants viewed being part of the congregation as positively impacting their health. Participants viewed health ministry as one of the ministries of the church. Participants viewed health ministry as reflecting the church's values of caring for people. Participants viewed the health ministry as part of the church, but not fully integrated in the church. **Conclusion:** Churches recognize the importance of health ministries such as FCN as a core value of caring for others. However, it is seen as one of several ministries within a church, and not a fully integrated part of the church.	**Strengths:** Using multiple data collection methods provides rigor and strength to the research. Data was coded to identify groups of cultural knowledge and cover terms. **Limitations:** Limited generalizability due to small sample size taken from only 1 church. This may not represent clergy or congregational views from other churches, denominations or those in rural settings. There was only one data collector, which was the investigator. This may lead to bias.

Author Recommendations: Nurses can promote the care that occurs naturally in churches by facilitating lay health promoters. This will assure that health care is not strictly provided for by the nurse, which could diminish a faith community's natural health promotion actions.

Implications: There is a need for the knowledge of transcultural nursing in order for health ministries, including FCN, to provide culturally congruent care within faith communities, and to not impose health ministries.

Matrix Article #12

Article:file:///Users/marymartin/Documents/Bethel%20Masters%20program/Capstone%20articles%20FCN%20barriers:factors/Articles%20to%20add%20to%20Matrix/Value%20and%20Meaning%20of%20Faith%20Community%20Nursing:%20Client%20and%20Nur...%20:%20Journal%20of%20Christian%20Nursing.webarchive

Source: Mock, S., Gabrielle. (2017). Value and meaning of faith community nursing: Client and nurse perspectives. *Journal of Christian Nursing,* 34(3), 182-189. doi:10.1097/CNJ.0000000000000393

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To explore the value and meaning of faith community nursing (FCN). Sample/Setting: 10 participants 3 FCNs (all female) and 7 clients(2 male, 5 female) Participants Caucasian, ages 28-85.from a large Presbyterian church in an affluent community of a large Midwestern city. **Johns Hopkins Evidence Appraisal** **Level of Evidence:** Level III **Quality:** B Good	A qualitative study conducted with one -to-one interviews done by phone and in homes, churches and coffee-shops. Anonymity provided by coding participants. Coding and analysis of field notes and interviews conducted using qualitative research platform NVivo10.	Five themes emerged from coding nursing and client interviews, which describe the meaning and value of FCN to participants in this community. These include: tasks and services offered, nursing expertise, spirituality, familiarity, and community support. **Conclusion:** Those who have greater exposure to FCNs and their programs have greater support for them.	**Strengths:** Anonymity provided through coding of participants. Field notes and interviews were coded and analyzed. **Limitations:** Invitation for study participation was not made to entire congregation. This may limit generalizability due to small sample size. Limited generalizability due to sample taken from only 1 church with homogenous congregation.

Author Recommendations: Further research is needed to identify the health benefits of particular services in comparison to the resources used for FCN programs. Research is also needed regarding the monetary support of FCN programs.

Implications: Support for, and sustainability of FCN programs is based on the exposure that clients and congregations have to FCN programs. By increasing education of the FCN role and services, it can increase exposure to FCNs, thus, increasing support.

Matrix Article #13

Article: https://www.jstor.org/stable/3427658

Source: Chase-Ziolek, M., Gruca, J., (2000). Clients' perceptions of distinctive aspects in nursing care received within a congregational setting. *Journal of Community Health Nursing,* 17(3), 171-183.

Purpose/Sample	Design (Method/Instruments)	Results	Strengths/Limitations
Purpose: To research the views of clients who received care/services from nurses in congregations. **Sample/Setting:** 11 participants with minimum 5 nurse intereactions. 5 women, 6 men 10 Caucasian 1 African-American Church A:5 participants Church B:6 participants Ages :46-79 years **Setting:** 2 Catholic churches **Johns Hopkins Evidence Appraisal** **Level of Evidence:** Level III **Quality:** B Good	Naturalistic inquiry was used for the qualitative study. Pilot study from a 3rd church conducted to refine interview technique and guide (not included in study results) Interviews by research assistant using interview guide of 6 questions (open ended) and recorded. Audiotapes transcribed verbatim. Data analyzed by researchers using content analysis. Main points categorized. Data analysis used with criteria of consensus.	All participants reported beneficial interactions. **Benefits in 2 categories:** -- Distinctive qualities of nurse-client interactions in a congregational setting -- Distinctive qualities of the church setting as a site of care -- 36% had nurses identify an undiagnosed problem with subsequent follow-up/treatment -- 100% reported nurses doing blood pressure screenings -- 82% reported more personal/positive/less anxious nurse visit than with clinic physician. -- 1 participant had decreased physician visits as result **Conclusion:** The interaction participants received from nurses was just as important as the care. They felt cared for and described benefits of getting care in the church versus medical setting. They also reported that nurses advocated for them and had improved access to healthcare.	**Strengths:** -- Objectivity using trained research assistant -- Used content analysis for objectivity. -- Pilot study conducted at non-participating church to refine interview guide and process. **Limitations:** -- Research from 1998 -- Researchers were the nurses providing care to participants, leading to possible bias. -- Article from 2000. -- Small sample size -- Decreased validity /reliability -- Limited setting to 2 Catholic churches, leading to decreased generalizability.

Author Recommendations: Healthcare professionals need to recognize the benefits of care received in congregational settings. Further research is needed to look at views of clients after first nurse interaction in a congregation.

Implications: Nurses and nurse educators should recognize the value that patients place on therapeutic communication and having nurses spend increased time with them. Therapeutic communication and increased time spent with patients can be supported by educating pastors and churches about the benefits of these nursing interventions. Churches can be a clinical site for nursing students, where they can learn about self-care, various caregiving models, effective therapeutic communication skills and how to encourage patients.

Major Findings

Common themes emerged when synthesizing the results of the studies and included analysis of Congregational Health Ministries (CHM), Health Ministries (HM), Health and Wellness Activities (HWA) and Faith Community Nursing (FCN) programs. Each of these programs were evaluated as some churches use the name CHM, HM or HWA instead of FCN programs. The predominant themes identified included the following: perception of the church's role in health, perception and knowledge of FCN, the role of the FCN, clergy-FCN relationship, experience with FCN, financial support, personal FCN qualities, resources, time and support of FCN. These themes indicated either support of and sustainability of FCN programming or the struggle to initiate or sustain such programs. Several of these themes are found in the two tables, used with permission by Bonkoskie & Kloster, 2008, and are included after the conclusion of chapter four. Table 1 lists factors that are associated with successful FCN programs and Table 2 identifies barriers to FCN programs.

Perception of the Church's Role in Health

Among clergy and congregational members, the studies indicated varying perceptions about what role the church has in health. In a study conducted by Thompson (2010), survey results showed that 41.2 % of clergy members were aware of congregational members who lacked health insurance. Further research which assessed clergy's view of health revealed that a large majority of clergy were able to identify health challenges that congregational members were facing. This study further looked at the views that clergy had about health in general, including their personal health. Of the 24 survey participants, 15 clergy indicated that they had influence on the health of church members. Half of the participants indicated a desire to role-model health, and one-third felt it was important to encourage health among church members.

This study concluded that clergy have the ability to educate and influence their churches and can reach a large number of people at a time. This can lead to the development and sustainability of FCN programs (Baruth et al., 2015).

Additional studies also surveyed clergy concerning their views of health, and found that the majority of clergy had included health-related topics in their sermons, had one-to-one conversations with church members about health-related concerns and that there was a perceived interest in health talks. Through clergy discussions and sermons about health, it could result in increased health promotion activities in the church (Rowland & Isaac-Savage, 2014; Williams et al., 2012). When clergy expressed that it was good for a church to play a role in health, there were increased congregational health ministry involvement, as FCNs viewed this as supportive to the health programs (Catanzaro et al., 2007; Chase-Ziolek, 1999).

Views of congregational members also impacted the sustainability of FCN programs. In a study conducted on African American churches, it was concluded that when health promotion programs were offered in the church, over 76 % of members participated in those programs. There was also an increased perception from participants in the study that the church has a role in health promotion (Odulana et al., 2014). When Congregational Health Assessments (CHAs) were conducted, it revealed the health concerns that the study participants had. One study that looked at the congregational perspectives of HMs such as FCN had very high participation, with 71 % of all surveys being returned. The results from this survey showed that the majority of participants were aware of the HM programs in their churches, and that the majority also had a desire to learn about healthy living, including Biblical healthy living, health resources and how health impacts the church. Biblical healthy living was described as learning about healthy living from a Biblical perspective. The study found that participants equated healthy eating and

physical activity to being a more upright or virtuous Christian, while individuals with unhealthy behaviors, such as poor eating habits, were seen as more sinful. These findings indicate that the churches in this survey had a favorable view of the church's role in health, and the positive impact that HMs had on the health of church members and their families (Whitt-Glover et al., 2014). Results from CHAs can be used to identify the health needs of a congregations and to initiate FCN programs in order to meet those needs (Whitt-Glover et al., 2014). Health ministry programs such as FCN were seen as a reflection of how the church cares for people. However, these health ministry programs were seen as one of many ministries that were ongoing, and which were not a fully integrated part of the church. Lay leaders also need to be involved in health ministry programs in order to more fully integrate FCN programs into the church, leading to higher success rates of FCN programs (Chase-Ziolek, 1999).

Perception and Knowledge of FCNs

The studies included in this literature review revealed that FCN program sustainability was directly impacted by the perception and knowledge that clergy, congregational members and other health care providers had about FCN. While the perception of FCNs was often evident in the studies included in this literature review, there was a lack of knowledge concerning what FCNs actually did. One study revealed that pastors had an overall positive view of FCNs but scored low on the survey concerning their knowledge of what the FCNs did (Thompson, 2010). Several pastors were able to describe some of the interventions conducted by FCNs, but they also stated that FCNs provided wound care, which is not accurate, as FCNs do not provide hands-on physical cares. The author concluded that decreased clergy knowledge of FCN prevented some nurses from becoming FCNs (Thompson, 2010). Of clergy that were surveyed, 66.9 % reported that they did not have CHM such as FCN programs due to the lack of knowledge they had

regarding these health programs (Catanzaro et al., 2007). Decreased knowledge of FCN by both clergy and church members was seen as a barrier to program sustainability (Bopp, Webb & Fallon, 2012). Increased education for pastors regarding FCN led to improved sustainability of FCN programs (Bokinskie & Kloster, 2008).

Client perception and knowledge of FCNs also was shown to impact the sustainability of FCN programs. Clients who had an understanding of the services provided by the FCN and who recognized the expertise of the FCN reported having increased support for FCN programs (Mock, 2017).

Role of the FCN

FCNs are in a unique position to provide specialized care to individuals in a faith community. The studies indicated that the role of the FCN has a direct correlation to the sustainability of FCN programming. The role of the FCN includes, but is not limited to: health educator, conduct health screenings, provide wellness resources, and provide spiritual care. These roles allow for the FCN to build trusting relationships with clients, which improves the support for the programs (Devido et al., 2018). The intentional care of the spirit is the hallmark role that differentiates FCN from other nursing specialties (American Nurses Association & Health Ministries Association, 2005; 2012). Providing wholistic, or whole-person care, is also an important role of the FCN. FCNs also provide health education, encourage health promotion, conduct blood pressure screenings and follow up with clients. These FCN interventions resulted in improved patient health outcomes, which led to increased support for FCN programs (Devido et al., 2018; Whisenant, Cortes & Hill, 2014).

Clergy-FCN Relationship

Sustainability of FCN programs is directly impacted by the relationships between clergy and the FCN. One study revealed that program success was enhanced when there was a strong clergy-FCN relationship, and when they collaborated with each other. This study also determined that it was important to have good communication between the FCN and the pastor in order for the program to be successful. The FCN does not compete with or replace clergy, but collaborates with them, and enriches health ministries. Clergy also act as a bridge between the FCN and church leadership and the congregation (Bokinskie & Kloster, 2008). Literature also indicated that when there was good communication between nurses and clergy, and they are able to work together collaboratively, CHMs and other faith-based health programs were able to provide sustainable health options for individuals (Catanzaro et al., 2007). Clergy are considered the leader of the faith community, but do not typically have medical knowledge. The FCN is able to educate clergy and other faith leaders on health and medical issues. It is important for the FCN and clergy to create a trusting relationship. The FCN is able to do this, in part, by recognizing and maintaining professional boundaries and preserving confidentiality. Highly skilled FCNs who had achieved high levels of trust and developed strong relationships with both clergy and clients required little or no direct supervision (Young, 2015). Clergy recognized that the roles of both the clergy and the FCN allows for "living the mission" of the church and leads to assurance of the FCN program. Clergy also became more aware of the valuable relationships that had been formed between FCNs and church members, and how the FCN was able to meet their needs (Tuck & Wallace, 2000).

Experience with FCN

Support of FCN programs from congregational members was increased when an individual had received care from the FCN, which resulted in familiarity of the nurse and their

role. As the time spent by an FCN caring for an individual increased, the better the individual could describe the role of the FCN and the impact that they had on a church. Those individuals who were familiar with the FCN and had received care from them were more likely to want increased support of the FCN from church leadership (Mock, 2017). Furthermore, clients who were interviewed regarding their interactions with an FCN reported positive experiences with the FCN. They described feeling less anxious with the FCN than with their physician and had less overall visits to their physician as a result of the FCN interactions. They also reported that the FCN had identified a previously undiagnosed medical problem, and that all of the FCNs conducted routine blood pressure screenings, which they viewed positively. These interactions were seen as a benefit to the individuals, who described the church as a distinct site of care for people. They also reported feeling cared for by the FCN (Chase-Ziolek & Gruca, 2010). These findings are similar to what was described by Mock (2017) which stated that those who had received care from an FCN were more supportive of FCN programs.

Financial Support

Financial support has been identified as a key factor in whether FCN programs are sustainable or not. Both FCNs and the clients they care for have stated that FCNs would be able to provide more care to individuals if there was additional financial support for the programs (Mock, 2017). A lack of financial support has been indicated as a major barrier to FCN program success (Bokinskie & Kloster, 2008; Bopp, Webb & Fallon, 2012; Devido et al., 2018; Rowland & Isaac-Savage, 2014). One study revealed that 59.1 % of clergy reported that a lack of financial resources was considered a barrier to the initiation of or sustainability of CHMs such as FCN programs. This same study suggested that sustainability could be enhanced by having CHMs collaborate or partner with other churches, schools of nursing or hospital systems

(Catanzaro et al., 2007). FCN positions are frequently part time or unpaid, which is seen as a barrier to program sustainability, especially when younger FCNs are needing a paid position. However, those FCNs that were nearing retirement were more prepared to work in an unpaid position, and viewed it as a positive determinant for program viability (Bonkoskie & Kloster, 2008).

Personal FCN Qualities

The personal qualities of an FCN also impact the success or failure of an FCN program. FCNs who are spiritually mature and continue to grow in their own faith had improved sustainability of FCN programs compared to those FCNs who were not as mature in their own faith lives. Program success was also dependent on the amount of energy that an FCN put forth in their work, as well as the ability of the FCN to be organized and had a plan for the program (Bokinskie & Kloster, 2008). Trust that was developed between an FCN and a client was identified as an important factor in being able to sustain FCN programs, as FCNs were able to gain entry into the lives of individuals (Devido et al., 2018). FCNs who felt a sense of accomplishment despite challenges that may have occurred had an increased ability to sustain FCN programming (Devido et al., 2018).

Resources

Two of the research studies determined that FCN program success was also dependent on other resources such as volunteers, continuing educational opportunities for FCNs, and the ability to network with other FCNs. Churches which had active health ministry teams and volunteers were better equipped to have successful FCN programs (Bokinskie & Kloster, 2008). Additional literature also stressed the importance of having volunteers participating in the health ministry programs such as FCN, which ultimately led to improved program success. This has

been expressed by FCN leaders in several countries, including Finland, Germany, Ukraine, the United Kingdom, Georgia and the United States (Wordsworth, 2014). Feelings of professional isolation or the nurse's belief that they must be "an expert in everything", created barriers to being able to maintain FCN programs (Devido et al., 2018). Support networks helped FCNs to feel less isolated, and were also seen as an effective way of disseminating information to the nurses. When the nurses felt supported and that they were not alone, and when they were able to obtain educational resources, it resulted in increased program sustainability (Devido et al., 2018). An additional study concluded that collaborative programs between faith communities and educational partners, such as schools of nursing, have the highest level of sustainability and success. This study also determined that when faith health programs did not collaborate with community partners, it led to decreased program support and sustainability (Whitt-Glover et al., 2014).

Time

Time constraints were also identified as barriers to FCN program sustainability. When there was not adequate time available for FCN activities, or if staff do not have time to help, there is a risk that the program will not be able to be maintained (Bopp, Webb & Fallon, 2012; Bokinskie & Kloster, 2008). Time was also regarded as a positive factor that led to increased FCN program success. FCNs reported that they were able to spend an increased amount of time with their clients, which led to the concept of being present with clients. Both increased time spent with clients and being present with them led to an enhanced level of trust and more positive views of FCNs, which resulted in increased support of the programs (Devido et al., 2018).

Support of FCN

The literature also indicated that a general support of FCN by church leadership, members and the greater community also led to more sustainable FCN programs. Research findings of clergy perceptions of CHMs indicated that 53 % of clergy reported that a lack of support from the church board as the reason that their church did not have a CHM (Catanzaro et al., 2007). Additional literature also supports the findings that FCN or HWA support from church leadership is associated with increased sustainability of health ministry programs (Bopp & Fallon, 2013). Clients who had received care from an FCN stated that they were concerned that FCN programs would be difficult to sustain without additional support from the church. These clients also stated that the FCN would be able to do more if they had more support from the community (Mock, 2017). Only one study discussed family support as being an important factor in the sustainability of FCN programs (Bokinskie & Kloster, 2008). One study looked at the HWAs of both urban and rural congregations. The results of the study found that the main barriers to having HWAs in rural congregations was a lack of interest and a lack of lay leaders. In comparison, the main barriers to the formation of HWAs in urban congregation was the conflict of time and available space needed for these health activities (Bopp, Webb & Fallon, 2012).

Strengths and Weaknesses of the Research Studies

There were several common themes associated with the strengths of the research studies, including the confidentiality of participants, unique demographics of the studied populations, high validity and reliability of the studies, and improved health of the participants. Anonymity of study participants was identified in several of the studies and was provided through coding of participants as well as using anonymous surveys for data collection. A second strength of the studies was the unique demographic that comprised the study participants. Few studies have

looked at the perspectives of health that are unique to clergy and congregations. These studies explored the views of clergy regarding their perceptions of health and the role of the church in health. Additional populations and demographics that were unique to these studies included comparing health perceptions of rural versus urban faith communities, and the study of African-American faith communities. Several of the studies also indicated a high level of validity and reliability. Validity was demonstrated as surveys were created and reviewed by experts and leaders within faith community nursing. Reliability was shown through the use of pilot testing of surveys prior to being administered to the actual study participants. Independent statisticians and analysts were used in several of the studies to analyze the data, leading to increased reliability. Coding was developed for the studies by both the researchers, and independent coders. Investigators were able to observe the data results, both individually and collectively, resulting in increased reliability (Williams, Glanz, Kegler & Davis, 2012). Multiple data collection methods allowed for rigor and strength of the studies (Chase-Ziolek, 1999). Another strength of the studies revealed an improvement in overall health, and was not dependent on the availability of resources (Whisenant, Cortes & Hill, 2014).

The research studies also revealed several weaknesses. Several of the studies had a limited number of study participants. One reason for this included low survey response rates (Catanzaro et al, 2007; Thompson, 2010). Another reason for small sample sizes that was revealed in one study was the lack of contact information for potential participants in some of the denominations (Bopp, Webb & Fallon, 2012). Several studies had a largely homogenous sample (Thompson, 2010; Catanzaro et al., 2007; Williams, Glanz, Kegler & Davis, 2012; Whisenant, Cortes & Hill, 2014; Bokinskie & Kloster, 2008; Chase-Ziolek, 1999; Mock, 2017) or were based in only one geographical region (Odulana et al., 2014; Baruth, Bopp, Webb & Peterson,

2015; Williams, Glanz, Kegler & Davis, 2012; ; Bokinskie & Kloster, 2008; Chase-Ziolek, 1999; Mock, 2017;Whisenant, Cortes & Hill, 2014; Chase-Ziolek & Gruca, 2000). Due to small sample sizes, homogeneity and limited geographic locations, the generalizability of the results was limited. It was difficult to determine if these study results would be able to be applied to other geographic regions, denominations or be representative of individuals and groups with varying economic, cultural or ethnic identities.

Bias could be indicated in several of the studies due to pre-study participant views of health, self -reporting, or if the motivation or interest of the participants was a factor. Self-reporting of participants was indicated in several of the studies, which could indicate bias (Williams, Glanz, Kegler & Davis, 2012; Whisenant, Cortes & Hill, 2014). There was potential sample bias indicated in multiple studies. Bias was considered if participants tended to be more health conscious prior to initiation of the survey (Odulana et al., 2014; Whitt-Glover et al., 2014; Baruth, Bopp, Webb & Peterson, 2015). Potential bias was also considered if participants were more interested in or motivated by the study (Bopp, Webb & Fallon, 2012), or received small incentives to complete the survey (Baruth, Bopp, Webb & Peterson, 2015). The age of the articles was a weakness of a majority of the studies.

Other weaknesses were also identified, including the age of the articles, low reliability of some studies, the need for re-wording surveys, the availability of resources and how FCNs identified themselves. The age of the articles was a weakness of a majority of the studies. Several of the studies were older than five years, due to the limited amount of research concerning the sustainability of FCN programs. Reliability was low in several of the studies as there were no test, re-test studies conducted. One author identified a weakness that indicated the need to re-word survey tools in order to be acceptable to a variety of faith traditions, stating that

words such as “God”, “congregation” or “church” are not used by everyone (Thompson, 2010). One study identified the survey tool as being a weakness of the overall study. The survey was done by paper and pencil, with the churches responsible for making and distributing the surveys. Those churches that were larger or had fewer resources were not always able to make or distribute the surveys (Whitt-Glover et al., 2014). One final weakness that was acknowledged in the research was the self-identification of some nurses as FCNs, without having taken or completed an approved FCN preparatory course, and thus, self-selected to participate in the study (Devido et al., 2018).

Summary

In conclusion, there were a limited number of studies that look specifically at factors that affect the sustainability of FCN programs. This required inclusion of studies related to church health ministries, even if specific discussion of faith community nursing was not mentioned. Due to the limited number of studies, it was also necessary to include studies older than five years in order to have a more comprehensive review of the topic. The studies revealed themes that were congruent with FCN programs and identified both strengths and barriers of FCN programs. The factors that were seen as having the biggest impact on FCN program sustainability included the perception of the church’s role in health, the perception and knowledge of FCNs, the role of the FCN and the clergy-FCN relationship. Additional factors that affected sustainability included experience with FCNs, financial support, personal FCN qualities, resources, time and further support for FCN programs. Validity was strong in those studies which ensured the review of survey content by leaders and professionals within FCN. Reliability was demonstrated through the use of pilot testing of surveys prior to use, as well as the use of independent statisticians and analysts. Weaknesses were also revealed in the studies

and included relatively small sample sizes and homogeneity of the samples, which made it difficult to generalize the findings. Further weaknesses included the survey tools that were used in the studies, as the wording may not be able to be applied to other faith settings and difficulty in using the survey. A final weakness that was identified was how FCNs self-identified, as the studies revealed that not all FCNs were properly educated as FCNs.

Chapter Four: Discussion, Implications, and Conclusions

There has been a limited scope of research into the factors that affect the sustainability of Faith Community Nursing (FCN) programs. The majority of the research has focused on the role of FCN, nursing interventions and the outcomes based on FCN interventions. As a result, the majority of information regarding the sustainability of FCN programs comes from anecdotal literature and other literature reviews. There were several common themes that emerged in both the research studies and the referenced literature that detail what factors contribute to whether FCN programs are successful or not. These included knowledge of FCN roles and responsibilities, clergy and congregational views of health and the role of the church in health, financial support, availability of resources, time and support for the FCN program. (Bokinskie & Kloster, 2008; Thompson, 2010). The literature also revealed the importance of FCN programs, which are directly affected by the success or barriers that determine sustainability of the programs. Churches have been recognized as safe places to provide nursing care, including health promotion and education. These nursing services are able to reach marginalized people in the community who may otherwise not receive adequate health care. FCN programs thus are critical in regard to nursing education, nursing services and nursing research (Shores, 2014).

Literature Synthesis

The literature indicates a consensus among authors as to identifiable factors that affect the sustainability of FCN programs. FCN programs rely on collaboration between the nurse, clergy and congregational members in order to develop the church into a place for health, which broadens the mission of health promotion within the faith community (Tuck & Wallace, 2000). Clergy and congregational support for FCN services and programs may be enhanced by educating the church about the results of research that have studied the value and patient

outcomes of such programs (Chase-Ziolek & Gruca, 2000). The sustainability of FCN programs is also based on how the role of the FCN is defined and the perception of the church's role in health. Other influences into the sustainability of programs that were acknowledged in the literature included economic and time factors. The availability of volunteers also has been identified as contributing to program sustainability (Wordsworth, 2014; Bopp & Fallon, 2013). Lastly, knowledge of faith community nursing, as well as the initial preparation of and continuing education of FCNs, contributed to the sustainability efforts of programs. The education of nursing students about FCN was also identified as a factor that affected FCN programming. Partnerships between academic institutions and faith communities resulted in nursing students being exposed to FCN, together with providing resources for the FCN and increasing congregational awareness of the FCN role (Otterness, Gehrke & Sener, 2007). Educating the church about faith community nursing may also impact the sustainability of the FCN program (Mock, 2017). The factors that affect the success of FCN programs are not unique to the United States, and resonate with FCNs in Europe. There, they have also distinguished similar elements that impact sustainability, including public knowledge of the FCN role, the recruitment and training of volunteers, development of interdenominational relationships and economic support (Wordsworth, 2014).

Barriers to FCN Programs

The literature identified key factors as barriers to FCN practice and program sustainability. These barriers include a lack of education or support of FCN, clergy and congregational perceptions of health, lack of financial resources, lack of additional resources and FCN isolation.

Lack of Education or Support of FCN.

The lack of education or support of FCN among clergy was cited as a predominant barrier to FCN program sustainability (Bonkoskie & Kloster, 2008; Catanzaro et al, 2007; Thompson, 2010; Bopp & Fallon, 2013). The results from one study indicated that a lack of education among clergy about FCN hindered some nurses from pursuing FCN (Thompson, 2010). The literature also stated that it was difficult to sustain FCN programs when there was a lack of support from congregations, nurses and other health professionals (Bonkoskie & Kloster, 2008). Over half of clergy that were surveyed stated that the reason that their church lacked a CHM was due to the absence of support for the program by the church board (Catanzaro et al., 2007). Clergy were seen as a major factor in whether or not there was a good or poor relationship between the FCN and church leadership (Bonkoskie & Kloster, 2008). Another study revealed that 66.9 % of clergy did not have CHM or FCN programs because they lacked awareness of these programs (Catanzaro et al., 2007). When there was a lack of education about FCN by both clergy and congregational members, it was perceived as a barrier to the success of the FCN program (Bopp, Webb & Fallon, 2012).

Clergy and Congregational Perceptions of Health.

Clergy perception about the church's role in health also noted as a barrier to FCN sustainability. FCNs indicated that it was difficult to sustain an FCN program if clergy did not believe that the church should be involved in providing health care within the church (Thompson, 2010; Bopp & Fallon, 2013). When there is a lack of interest concerning health among church leadership or health ministry members, it is difficult to sustain FCN programs (Bonkoskie & Kloster, 2008).

Lack of Financial Resources.

Another barrier that was identified was the lack of financial resources, including being allowed only a minimal budget as well as FCNs who worked in unpaid or only part-time positions. Due to the lack of funding, many FCNs work in unpaid positions, often times being referred to as volunteers instead of unpaid staff (Ziebarth, 2014b). This may lead to FCNs not being valued as professionals, which can be seen as a barrier to the practice. According to Ziebarth 2016a), when funding support for FCN programs is in danger, the sustainability of the programs is in jeopardy. The literature indicated that it is not financially feasible for many younger nurses to work in unpaid or part-time positions (Bonkoskie & Kloster, 2008) (Table 2). Nurses who did not receive any monetary support or budget from their church struggled to maintain a successful program, as they lacked the funds needed to purchase supplies and equipment such as blood pressure cuffs, pay for educational partners to provide health promotion classes for participants or to pay for items such as a locking filing cabinet in order to secure confidential patient information. Financial barriers from community partners such as hospital systems also can lead to decreased sustainability of FCN programs. FCN programs are considered missional and do not generate money for hospitals or other organizations with whom FCNs may be partnered. This means that the FCN programs rely on the profitability of those partner organizations. When profits exist, sustainability tends to not be threatened. However, when those partner organizations do not show a profit, missional programs such as FCN are at threat of being discontinued (Ziebarth & Hunter, 2016).

Lack of Additional Resources.

While the lack of financial resources was viewed as a major barrier to FCN program success, the lack of additional resources was also identified as a barrier to FCN

programs. The lack of time was considered a barrier when FCNs had to compete with available church meeting times. The lack of time among volunteers was also considered a barrier, as there was not adequate time to devote to the FCN programs (Bopp, Webb & Fallon, 2012; Bokinskie & Kloster, 2008). When there were not adequate volunteers, or if there was not a health ministry team in the church, it led to increased difficulty in sustaining FCN programs (Bonkoskie & Kloster, 2008).

FCN Isolation.

A final barrier that was identified by FCNs included feelings of isolation and needing to be "experts of everything" as they provide care to people with various health needs (Devido et el., 2018). It is common for there to only be one FCN in a church, leading to practice isolation (Devido et el., 2018). Lack of collaboration with community organizations also led to feelings of practice isolation, resulting in decreased program support and sustainability (Whitt-Glover et al., 2014).

Factors Leading to Sustainable FCN Programs

This literature review also distinguished factors that led to successful, sustainable FCN programs, including support for the FCN program, the church's perception of health, adequate resources and the attributes of the FCN work.

Awareness and Support for FCN programs.

Findings from the literature indicate that FCNs who are part of a network feel supported and encouraged to continue in their practice (Devido et al., 2018). According to Bonkoskie & Kloster, 2008 (Table 1) , the most crucial factor in FCN program sustainability was support from clergy. Additional literature also indicated that the success of FCN programs was dependent on clergy support (Catanzaro et al, 2007). Together with clergy support, there was improved

sustainability of FCN programs when pastors had an increased awareness and knowledge of FCN (Bokinskie & Kloster, 2008). The greatest strength that FCNs have is the confidence and dependability that they have with a church (Schroepfer, 2014). Increased sustainability can be achieved as hospitals and other health agencies require calculable results to justify the allotment of public spending by using cost savings or analysis data in order to increase acceptance of FCN networks and collaboration with health agencies (Brown et al., 2009).

The Church's Perception of Health.

Positive clergy and congregational views of health, including the church's role in health, led to increased sustainability of programs as well. The value and importance of health is imperative in churches in order to support FCN programs. This is evidenced in Finland, which has had FCN, or as it is called there, *diakonie,* since 1867 (Wordsworth, 2014, 2016). Each local state-run church in Finland is required to have a pastor, youth worker, social worker or FCN, indicating a positive view that the church has in its' role in health and healing (Wordsworth, 2014). Both clergy and congregational support were imperative to having a successful FCN program, as well as support from health care practitioners (Bonkoskie & Kloster, 2008; Chase-Ziolek, 1999). The literature revealed that when clergy had a positive view of health and believed that the church should be involved in health, it resulted in increased health program involvement, and FCNs viewed this as supportive to the health programs (Catanzaro et al., 2007; Chase-Ziolek, 1999). Sustainability of health promotion programs, including FCN programs within churches, was more significant when those programs were directed at ongoing strengths and resources of the faith community (Plunkett & Leipert, 2013).

Adequate Resources.

Volunteers and health ministry teams were identified as valuable resources which contributed to more successful and sustainable FCN programs (Bonkoskie & Kloster, 2008). The importance of volunteers to successful FCN ministries has also been identified by FCNs in Europe. FCN leaders in Finland, Germany, Georgia, Ukraine, and the United Kingdom have also reported that successful FCN programs rely on volunteers (Wordsworth, 2014). Time was also considered as a valuable resource which led to FCN program sustainability. Due to the nature of FCN work, FCNs tend to spend more time with their clients and families. This was attributed to being present with clients. By spending more time with clients and being able to be present with them led to increased trust and more positive views of FCNs. This ultimately resulted in increased support and sustainability of FCN programs (Devido et al., 2018). Lastly, when nurses were able to be part of a network, where they could receive both continuing education, resource information and emotional support from other FCNs, it led to increased success of the FCN programs (Devido et al., 2018).

Attributes of the FCN Work.

The literature recognized that FCN program success depended on the FCN's ability to be with individuals, and not focus on nursing responsibilities (Bonkoskie & Kloster, 2008). Attributes of the FCN work itself such as flexible hours and autonomy in practice led to increased sustainability of programs (Plunkett & Leipert, 2013). Positive attributes of FCN which are also attributed to strengths of an FCN program include the ability of the nurse to have time and be present with individuals, as well as be able to integrate faith into their practice and to provide wholistic care (Devido et al., 2018). Finally, the opportunity for the FCN to develop

spiritually and work according to one's faith beliefs led to increased sustainability of FCN programs (Bonkoskie & Kloster, 2008).

Implications for Nursing Practice

The ability of Faith Community Nursing (FCN) programs to be successful and sustainable have significant implications for nursing practice. This has been revealed in the research studies as well as the additional literature identified in this review. Faith Community Nursing, also known as Parish Nursing, is a means for churches to gain access into the community (Patterson & Slutz, 2011). As was discussed earlier in chapter one, the ability to sustain FCN programs impacts their effectiveness, which is crucial for ongoing care of people in the community and sustainable programs that receive healthcare organizational funding (Ziebarth, 2016a). The literature indicates that FCNs that have the support of clergy, church leadership and the congregation have increased sustainability of FCN programs. It is important for FCNs to communicate and collaborate with pastors, since they are the "gate keepers" of their churches (Catanzaro et al., 2007). Having the financial resources as well as other programming needs, such as a space to work, needed equipment and continuing educational opportunities are also precursors to sustainable FCN programs (Hixson & Loeb, 2018). Successful FCN programs are able to collaborate with hospitals and other health care agencies to provide comprehensive care. FCN programs that are sustainable can benefit hospital systems that they are partnered with (Hixson & Loeb, 2018). Nursing interventions conducted by FCNs may lead to decreased hospital readmissions, and benefit hospitals financially due to reduced costs, help the hospital meet state and national goals and lead to grant funding (Ziebarth, 2015b). FCNs are able to coordinate care and identify potential complications during patient encounters (Schroepfer, 2016). There will be an increase in positive patient outcomes when FCN programs are able to be

sustained and successful. Patient outcomes, including emotional, physical and spiritual health, improve when they receive nursing care that is offered through a faith community (Schroepfer, 2016). The FCN is oftentimes the only health professional in their faith community (Devido et al., 2018). Due to the unique nature of FCN, which is the intentional care of the spirit (ANA, 2005; ANA & HMA, 2012), FCNs are able to provide whole person care during each patient encounter. People who are part of a church or faith community frequently feel more secure when receiving care from a church as opposed to secular-based healthcare options (Joel, 1998; Hixson & Loeb, 2018). Individuals who felt trust in the FCN expressed that this trust helped to influence them to participate in healthy lifestyles (Whitt-Glover et al., 2014). Care recipients may also benefit financially from FCN interventions (Dyess, Chase & Newlin, 2010). One research review revealed that of the ten patients who had received care in their homes by an FCN, and had been able to delay or prevent the move to a long-term care facility, there was a savings of approximately $10,000 per patient (Dyess, Chase & Newlin, 2010).

With adequate financial support, FCNs are able to purchase needed equipment and supplies in order to conduct blood pressure screenings, have access to a computer to use for emails, documentation and finding community resources, or attend continuing educational seminars. FCN programs that provide a paid position are more likely to be sustainable. Unpaid FCN positions are less feasible for nurses who are needing an income (Bonkoskie & Kloster, 2008). Being provided with an office and a locked filing cabinet provide the FCN with a space in which to work, and to keep equipment and confidential documentation. In a study conducted by Mock (2017), both FCNs and those who have received care from an FCN reported their uncertainty of FCN program viability without financial support from the church. When programs are not sustainable, FCNs are limited in the services they are able to provide to

individuals. They also stated that the nurses would be able to provide more services with increased monetary and community support. FCNs who are asked to collaborate with clergy and church leaders experience increased levels of support, which leads to increased abilities to sustain the programs. When churches are able to provide health promotion programs, such as through FCNs, they are able to reach a greater population, providing individuals with healthier lifestyle choices and improved overall health (Whisenat, Cortes & Hill, 2014). Educating clergy about the health information that their congregation desires can lead to increased health promotion programming that is successful and sustainable (Williams, Glanz, Kegler & Davis, 2012). Clergy surveys can also help to identify barriers to FCN programs, which can result in decreased sustainability (Thompson, 2010). Conducting Congregational Health Assessments (CHAs) is one way of identifying the health needs of the congregation. CHAs can also help to structure the FCN programs, leading to more specific nursing interventions that can improve patient care (Whitt-Glover et al., 2014).

Additional nursing implications initiated by FCNs include those focused on nursing education. This literature review revealed that even among nurses and other health professionals, FCN is not widely known or recognized. Baccalaureate and graduate nursing schools need to prepare students adequately for faith community nursing. One way to do this is to develop partnerships between faith communities and schools of nursing can benefit both entities, including academic opportunities and financial benefits for both (Catanzaro et al., 2007). FCNs are able to provide nursing students with a rich community health learning experience, with a focus on population health within unique cultural communities. It is important to include consideration of how different religious beliefs and practices influence health related decisions, in order to provide whole person care (Otterness, Gehrke & Sener, 2007). Additional academic

advantages of these partnerships include implementing faith community nursing into the curriculum of nursing programs at both the baccalaureate and graduate level (Otterness, Gehrke & Sener, 2007). Students are afforded the opportunity to learn about this nursing specialty and the impact it has on the community, resulting in some students pursuing faith community nursing due to their clinical experience with an FCN (Otterness, Gehrke & Sener, 2007). The demand for more continuing education in faith community nursing may increase as more health care services shift to community settings, with BSN and Graduate nursing schools the logical place for this education. One student said, "I find myself getting more passionate about this [parish nursing and community assessment] because I know it's real and it's needed" (Otterness, Gehrke & Sener, 2007, p.41).

Faith communities benefit from partnerships with academic institutions as well. During collaborative efforts with churches, FCNs may receive valuable information about their congregations when nursing students conduct congregational health assessments as well as increasing the nurse's experience with health needs assessments and increasing resources that may benefit the faith community (Otterness, Gehrke & Sener, 2007). Partnerships with academic institutions were noted to lead to increased program success and sustainability (Whitt-Glover et al., 2014). A final benefit of partnerships between faith communities and schools of nursing is that it can augment positive views of the FCN role with the congregation and help the FCN to be more visible (Otterness, Gehrke & Sener, 2007). With increased education and awareness of FCN, there may be an increase in the number of nurses interested in FCN, which will increase the number of FCNs available to provide care. Networks aimed at supporting FCNs, and providing for the dissemination of information and educational opportunities helps FCNs to feel supported and less isolated. This, in turn, can increase feelings of support and

encouragement, resulting in FCNs being able to sustain their programs (Devido, Doswell, Braxter, Terry, Charron-Prochownik, 2018). The opportunity for FCNs to network with one another using technology such as online knowledge sharing platforms provides valuable resources for FCNs. Access to resources such as this have the potential to improve the success of FCN programs, ultimately leading to improved patient outcomes (Ziebarth & Hunter, 2016).

Recommendations for Nursing Research

Currently, there is little research regarding the impact that FCN programs have on patient outcomes. A contributing factor to the limited research into faith community nursing is that most FCNs are not trained to conduct research (Dyess, Chase & Newlin, 2010). The authors recommend that FCNs be partnered with doctoral prepared nurses to conduct research as well as increasing research findings through publications (Dyess, Chase & Newlin, 2010). Further research is needed to identify further determinants that impact how FCN programs are successfully implemented and which have a positive influence on patient outcomes (Schroepfer, 2016). There is even less research that specifically looks at the factors that impact the sustainability of FCN programs. This research needs to include identifying the role of the FCN and analyzing of the cost benefits of FCN programs in faith communities. Research also needs to examine health organizations and the broader community, medical benefits and how FCNs collaborate with hospitals regarding transitional care strategies following patient discharge (Schroepfer, 2016). Conducting test-retest studies may lead to improved reliability in future research (Thompson, 2010). Due to homogeneity of the samples in several of the studies, it is recommended that samples include a broader portion of the population, in order to increase generalizability of the results (Thompson, 2010; Catanzaro et al., 2007). Researchers have also indicated the need to re-word survey tools in order to be acceptable to a variety of faith traditions

(Thompson, 2010). It has also been recommended that the method of survey delivery be changed to include online surveys to ease financial burden or time constraints for congregations (Whitt-Glover et al., 2014). Recommendations have also been made regarding the establishment of partnerships between churches and researchers which could lead to designing health interventions and health promotion with churches and the community (Odulana et al., 2014). Partnerships between churches and researchers may also encourage further studies which focus on the inequalities of health care among minorities (Odulana et al., 2014). Plunkett and Leibert advocate for additional research into the characteristics and importance of health promoting, faith-community based events as well as FCN interventions (2011).

Researchers indicate a need for further studies that target the sustainability of FCN programs. Recommendations for these studies include explaining what the word "success" means in regard to the success of, or lack thereof, FCN programs (Bonkoskie & Kloster, 2008). Faith Community Nurse researchers also advocate for additional studies to identify how FCN program benefits are viewed by congregational members and how the FCN interacts with the clergy, church leadership and church members (Bonkoskie & Kloster, 2008). The literature indicates limited research into the views of clergy on the church's role in health, and clergy of views of health in general. The authors recommend further research to look at the clergy perceptions of health and how it may impact FCN programs (Baruth, Bopp, Webb & Peterson, 2015). Research into clergy perceptions on health is also recommended to determine the impact that clergy have on health programs within churches that serve the African American communities (Rowland & Isaac-Savage, 2014). Additional research that looks at the various ways that FCN programming can be fiscally supported has been suggested by Mock (2017).

Integration and Application of Theoretical Framework

Due to the evolutionary nature of the theoretical model, FCN will continue to be re-defined as the roles, expectations and practice locations of FCNs change based on the needs of a given community. This will in turn contribute to factors of sustainability. In order for an FCN to explain this nursing specialty, Ziebarth recommends that an FCN have an "elevator speech" describing the value of FCN to either a healthcare system or a faith community (2015b). Applying and integrating Ziebarth's evolutionary conceptual model through continual assessment of FCN programs provides definition of the FCN role, resulting in the advancement of the perception and knowledge of FCN within the community, health care organizations and faith communities (Ziebarth, 2016a). Increasing the knowledge and perception of FCN will lead to better understanding of the worth of FCN programs, thus improving support of and sustainability of FCN programming (Ziebarth, 2016a). Ziebarth also recommends that the FCN becomes familiar with the beliefs and values of the hospitals or other health care organizations that may offering financial help to the FCN programs (2016a). This will help the FCN to collaborate with health systems in order to provide care. This collaborative relationship is depicted in Ziebarth's theoretical model (Figure 2).

In order for the FCN to create a sustainable program, they need to become visible within the faith community. By being active in the church, writing health articles for the congregation, and being present during services helps to make the FCN visible and known to the congregation and the community (Durbin et al., 2013). This, in turn, allows the FCN to build trusting nurse-client relationships, and they are seen as accessible and approachable (Figure 2). The role of the FCN and the knowledge of what they do evolves as congregational members have more interactions with them (Mock, 2017). This evolving knowledge of FCN roles and how they

provide care leads to increased support of FCN programs, allowing for increased nurse-client interaction, which is displayed in Ziebarth's theoretical model (Figure 2), which is described above. When the role of the FCN is more effectively defined, it can improve the understanding that clergy and congregational members have of FCN programs, which may decrease the stigma that some individuals feel when seeking help (Mock, 2017). In order to determine how a health ministry is seen within a church, knowledge of the role of the FCN is required (Chase-Ziolek, 1999). Individuals identified the church as a place for health promotion in the community (Plunkett & Leipert, 2011). This can be observed in Ziebarth's Evolutionary Conceptual Model, in which the faith community is an integrated part of the community health initiative (Figure 2). When collaboration between the faith community and the community health initiative, it leads to the ultimate goal of the nurse-client relationship, which is wholistic health functioning (Ziebarth, 2016b; Figure 2). "The coexisting roles of the nurse and spiritual leader are ways of living the mission and making a commitment to parish nursing. The initiation of the parish nursing program is the result of the fit with the church's mission" (Tuck & Wallace, 2000, p. 293).

Application of the Theoretical Model

Application of Ziebarth's Evolutionary Conceptual Model affects each of the different FCN domains, including health promotion, disease management, coordinating, empowering, accessing healthcare and faith integration. Each of these domains can be applied to Solari-Twadell's Old Conceptual Model for Parish Nursing, as displayed in Figure 1. However, Ziebarth's Evolutionary Conceptual Model expands these domains, and allows the FCN the ability to incorporate and integrate the domains into FCN practice, as seen in Figure 2. Due to the evolutionary nature of the model, it allows FCN to be redefined as the roles, names and perceptions of this nursing specialty continue to change. The model consists of concentric

circles, with the nurse-client relationship making up the innermost circle. The next circle describes attributes of the FCN, such as trusting, approachable and accessible. Above that is a circle describing aspects of wholistic care. The outer two circles comprise the FCN domains. Wholistic health functioning is the ultimate goal of the nurse-client relationship (Ziebarth, 2014a). When this theoretical model is applied to each domain, there is an increased ability to sustain FCN programs (Ziebarth, 2014a). Much of the literature discussed health promotion and disease management as part of the FCN role, and activities that clients considered an important part of the FCN program. Activities such as health education regarding heart health, healthy food choices, exercise and blood pressure screenings were viewed as having the largest impact that the FCN could make regarding congregational health (Ziebarth, 2014a). As the FCN continues to increase interactions among individuals, the perceptions they have of the FCN and the role they have expand. Patients who have had more exposure to FCNs expressed increased trust, and an improved nurse-client relationship (Tuck & Wallace, 2000). Management of disease occurs when the FCN visits patients, helping the patient to find resources or referrals regarding their disease, health prevention activities, helping the patient to manage their medications or other concurrent therapies and providing health education, support groups or health counseling (American Nurses Association & Health Ministry Association, 2005; Ziebarth, 2014a). Coordination occurs when the FCN plans meetings, groups and activities, plans health informational materials, and case management. Other instances of coordination occur when compiling reports, collecting information and managing the patient health record (Ziebarth, 2014a).

The theoretical model also impacts empowerment of both the patients and students that the FCN may be working with. The FCN is able to empower their patients through health

education, encouraging them, educating patients about their illness through return demonstrations and teaching individuals how to navigate healthcare (American Nurses Association & Health Ministry Association, 2005; Ziebarth, 2014a). Another way that the theoretical model is applied to empowerment is when a preceptorship or mentorship is developed between the FCN and a nursing student (Ziebarth, 2014a; Otterness, Gehrke & Sener, 2007). FCN programs that partner together with schools of nursing and other community groups are better able to gain the approval and understanding of the role of FCNs from nursing faculty and students and how FCNs integrate with individuals and the community (Whitt-Glover et al., 2014). Accessing healthcare is also a component of the Evolutionary Conceptual Model. The model is applied when FCNs help patients to maneuver through an oftentimes complex healthcare system (Ziebarth, 2014a). This helps patients to be able to more easily access healthcare services.

Finally, the theoretical model can be applied to faith integration. While each of the other five domains may occur separately or in conjunction with another domain, faith integration was interwoven into each of the other domains. This can be observed in the concentric circles displayed in Figure 2. Providing spiritual care is an integral part of FCN practice and the FCN has the unique role of being able to combine health and spiritual care together (Devido et al., 2018). The "intentional care of the spirit" is the cornerstone of FCN (American Nurses Association & Health Ministry Association, 2005; 2012).

Summary

In conclusion, the literature identified commonalities to factors that were seen as either successes or barriers to faith community nursing programs (FCN). These factors relate to financial support of FCN programs, knowledge of FCN, perspectives of the church's role in

health, ability of the FCN to network with other nurses, and whether the FCN or church had the time to devote to FCN programming. The literature revealed a direct correlation between how well the FCN was able to sustain programs and the nursing implications which were impacted by sustainability. When FCN programs were successful and sustainable, nurses were able to implement more nursing interventions and provide increased services. When FCN programs were not sustained, or there were barriers to the programs, the FCN was not able to implement crucial interventions. Other nursing implications that were revealed included developing partnerships with schools of nursing and health systems such as hospitals. The authors each reported a need for further research into the sustainability of FCN programs. Other recommendations for research included looking at developing partnerships between faith communities and schools of nursing, as well as further inquiry into collaboration between FCNs and other health care services. Lastly, Ziebarth's Evolutionary Conceptual model was applied to determine factors that affect the sustainability of FCN programs. Using this model was useful in being able to define the ever-changing role of the FCN, and how the FCN integrates within the faith community and medical community while providing wholistic care to an individual. Application of this model allows the FCN to identify barriers or positive factors that affect the sustainability of the programs, and helps the FCN to make the necessary changes which lead to more successful programming.

Table 1

Factors Associated with Successful Faith Community Nurse Programs

(Bokinskie & Kloster, 2008). Used with permission.

FACTORS Associated With a Successful Parish Nursing Ministry as Reported in All Three Phases of the Study

Factors	Phase 1 Data (N = 431) (%)	Phase 2 Data (N= 435) (%)	Phase 3 Data (N= 463) (%)
Clergy support	88.4	96.6	94.4
Congregational support/involvement	76.9	93.6	91.4
Personal faith beliefs	53.0	79.4	76.9
Personal spiritual development	48.6	75.4	76.5
Active health cabinet/wellness council	30.6	76.8	72.6
Assistance/volunteers	*	55.4	53.1
Other	3.4	7.6	6.9

*Response option not included in Phase 1.

Table 2

Barriers to Faith Community Nurse Programs

(Bokinskie & Kloster, 2008). Used with permission.

BARRIERS to Parish Nursing Ministry as Reported in All Three Phases of the Study

Factors	Phase 1 Data (N = 431) (%)	Phase 2 Data (N= 435) (%)	Phase 3 Data (N= 463) (%)
Time/scheduling constraints	71.5	84.8	75.2
Lack of financial support	48.6	63.2	65.8
Lack of congregational support/involvement	32.4	65.3	62.9
Inactive or no health cabinet/wellness council	21.7	58.2	57.5
Lack of assistance/volunteers	*	56.6	57.5
Lack of clergy support	35.4	47.8	48.8
Other	17.8	11.0	12.1

*Response option not included in Phase 1.

Figure 1

Old Conceptual Model: Parish Nursing

(Solari-Twadell et.al, 1991). Used with permission

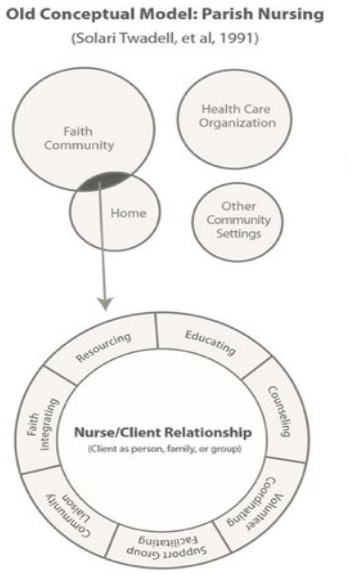
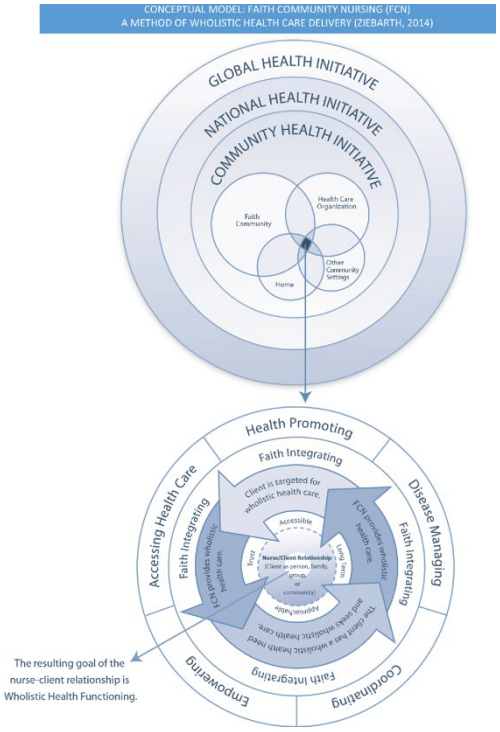


Figure 2
Evolutionary Conceptual Model: Faith Community Nursing
(Ziebarth, 2014). Used with permission



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